American Association for Respiratory Care

Board of Directors Meeting

Tampa Marriott Waterside Hotel and Marina
Tampa, FL

November 5-6, 2015

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and Finance Committee Meetings – November 4, 2015
Board of Directors Meeting – November 5-6, 2015

Wednesday, November 4

1:00-4:00 pm Executive Committee Meeting (Committee Members only) – Il Terrazzo Board Room

4:30-5:30 pm AARC Finance Committee Meeting (BOD and HOD members are encouraged to attend) – Il Terrazzo

Thursday, November 5

8:30 am Color Guard/Flag Presentation at House Meeting – Florida Ballroom, Salons V-VI

9:00 am-5:00 pm **Board of Directors Meeting –** Il Terrazzo

9:00 am Call to Order
Announcements/Introductions
Disclosures/Conflict of Interest Statements
Approval of Minutes pg. 8
E-motion Acceptance pg. 45

General Reports pg. 46
- President pg. 47
- Past President pg. 48
- Executive Director Report pg. 49 (A)
- Government & Regulatory Affairs pg. 60
- House of Delegates pg. 76
- Board of Medical Advisors pg. 78
- President's Council pg. 79 (R) (A)

10:00 am BREAK

10:15 am Standing Committee Reports pg. 84
- Audit Subcommittee pg. 85
- Bylaws Committee pg. 86 (R) (A)
- Elections Committee pg. 93
- Executive Committee pg. 95
- Finance Committee pg. 96
- Judicial Committee pg. 97
- Program Committee pg. 98
- Strategic Planning Committee pg. 101

12:00 pm Lunch Break

1:30 pm Reconvene – JOINT SESSION

3:30 pm BREAK

3:45 pm Specialty Section Reports pg. 102
- Adult Acute Care pg. 103
- Continuing Care-Rehabilitation pg. 104

Diagnostics pg. 105
Education pg. 108
Home Care pg. 110
Long Term Care pg. 111
Management pg. 112
Neonatal-Pediatrics pg. 114
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Surface to Air Transport pg. 116

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Benchmarking Committee pg. 118
Billing Code Committee pg. 119
Federal Govt Affairs pg. 120
Fellowship Committee pg. 122
International Committee pg. 123
Membership Committee pg. 128 (R)
Position Statement Committee pg. 131 (R)
State Govt Affairs pg. 140
Virtual Museum pg. 141

5:00 pm RECESS

5:00 pm Daedalus Meeting

Friday, November 6

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

8:00 am Call to Order

Special Representatives pg. 142
- AMA CPT Health Care Professional Advisory Committee pg. 143
- American Association of Cardiovascular & Pulmonary Rehab pg. 147
- American Heart Association pg. 148
- American Society for Testing and Materials (ASTM) pg. 149
- Chartered Affiliate Consultant pg. 150
- Commission on Accreditation of Medical Transport Systems pg. 151
- Extracorporeal Life Support Organization (ELSO) pg. 152 (R)
- International Council for Respiratory Care (ICRC) pg. 153
- The Joint Commission (TJC) pg. 156
- National Asthma Education & Prevention Program pg. 159
- Neonatal Resuscitation Program pg. 160

10:00 am BREAK

10:15 am Roundtable Reports pg. 161

10:45 am Ad Hoc Committee Reports pg. 163
- Ad Hoc Committee on Cultural Diversity in Patient Care pg. 164 (R)
- Ad Hoc Committee on RTs and Disease Management pg. 167
- Ad Hoc Committee on Advanced RT Practices, Credentialing, and Education pg. 168 (R)

12:00 pm Lunch Break

1:30 pm Reconvene

1:30 pm Other Reports pg. 174
- American Respiratory Care Foundation (ARCF) pg. 175
- Commission on Accreditation for Respiratory Care (CoARC) pg. 184 (A)
- National Board for Respiratory Care (NBRC) pg. 185

2:00 pm UNFINISHED BUSINESS pg. 188

- Taskforce on the Creation of Collaborative Efforts with External Organizations (A)
- Joint Taskforce on a White Paper Regarding Safe Initiation and Management of Mechanical Ventilation
- Strategic Goals Updates

NEW BUSINESS pg. 197

- Policy Review
  - BOD.003 – Board of Directors – Use of AARC Corporate Credit Card
  - BOD.014 – Board of Directors – Attendance at Receptions
- Faces Foundation
- Board Self-Assessment Survey

3:30pm **ANNOUNCEMENTS**

TREASURER'S MOTION

ADJOURNMENT

(R) = Recommendation
(A) = Attachment

Recommendations

(As of October 21, 2015)

AARC Board of Directors Meeting

November 5-6, 2015 • Tampa, FL

President's Council

Recommendation 15-3-8.1 "That the AARC BOD approves the revisions to BOD Policy.001."

Recommendation 15-3-8.2 "That the AARC BOD approves the revisions to 'Attachment D-AARC Awards Guidelines'."

Recommendation 15-3-8.3 "That the AARC BOD approves the revisions to AARC Bylaws Article IX-Presidents Council."

Bylaws Committee

Recommendation 15-3-9.1 "That the AARC Board of Directors find that the Texas Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."

Recommendation 15-3-9.2 "That the AARC Board of Directors find that the Connecticut Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."

Recommendation 15-3-9.3 "That the AARC Board of Directors considers developing a more formal onboarding/orientation program for new committee chairs."

Recommendation 15-3-9.4 "That the AARC Board of Directors considers a future amendment to the Bylaws that will prevent conflicting versions of Bylaws revisions to be under consideration at the same time."

Membership Committee

Recommendation 15-3-24.1 "That the AARC Board of Directors create an Ad Hoc work Group led by the Membership Committee to review and revise the student web site."

Position Statement Committee

Recommendation 15-3-26.1 "That the AARC Board of Directors approve and publish the revised Position Statement 'Electronic Cigarettes'."

Recommendation 15-3-26.2 "That the AARC Board of Directors approve and publish the Position Statement 'Respiratory Therapy Education'."

Recommendation 15-3-26.3 "That the Position Statement Committee develops a position statement on the 'Pulmonary Disease Manager', and presents it at the 2016 Spring Board meeting."

Extracorporeal Life Support Organization (ELSO)

Recommendation 15-3-69.1 "That the AARC Board of Directors investigate some avenues for the AARC and ELSO to collaborate on position statements and/or publications."

Ad Hoc Committee on Cultural Diversity in Patient Care

Recommendation 15-3-29.1 "That the Board of Directors approves a status change of the AARC's Cultural Diversity in Care Management Committee from Ad Hoc Committee to a regular committee."

Recommendation 15-3-29.2 "That the Board of Directors establishes a Cultural Diversity Round Table for its diverse members."

Recommendation 15-3-29.3 "That the Board of Directors recommend to each State Affiliate that they establish a State Culture Diversity Committee with the purpose of recruiting and retaining diverse members in their state."

Recommendation 15-3-29.4 "That the Board of Directors recommend to each State Affiliate that they establish a mentoring program at the state level for diverse members of their state."

Recommendation 15-3-29.5 "That the AARC provide a visible button on the AARC's website to direct members to the diversity webpage."

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

Recommendation 15-3-31.1 "That the Board accept the definition of an Advanced Practice Respiratory Therapist (APRT) as '*The Advanced Practice Respiratory Therapist (APRT) is a trained, credentialed, and licensed respiratory care practitioner who is employed to provide a scope of practice that exceeds that of the registered respiratory therapist. After obtaining the NBRC RRT credential, the aspiring APRT must successfully complete a CoARC-accredited APRT graduate level education and training program that provides a curricular emphasis that enables the APRT to provide evidence-based, complex diagnostic and therapeutic clinical practice and disease management.*'"

Recommendation 15-3-31.2 "That the AARC Board request the Association share the accepted definition with the Tripartite for their acceptance."

Recommendation 15-3-31.3 "That the Board designate a committee, consisting of member representatives of the AARC, NBRC, CoARC, and other organizations as deemed appropriate to use this definition as a basis to perform a job analysis and needs assessment."

Recommendation 15-3-31.4 "That the job analysis and needs assessment results may refine a definition of APRT based on the responses from individuals and organizations in the field of respiratory care."

Recommendation 15-3-31.5 "That the current committee composition would be effective in continuing this work post needs assessment."

Recommendation 15-3-31.6 "That the AARC formally request the NBRC explore the development of the APRT credential and examination."

Past Minutes

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

July 16, 2015 • Phoenix, AZ

Minutes

Attendance

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

Consultants

Mike Runge, BS, RRT, FAARC Parliamentarian
Deb Skees, MBA, RRT, CPFT, Past Speaker
Steve Boas, MD, BOMA Chair

Excused

Bill Lamb, BS, RRT, CPFT, FAARC
Dianne Lewis, MS, RRT, FAARC, President's Council President

Staff

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

Guests

John Hiser, MEd, RRT, FAARC

CALL TO ORDER

President Frank Salvatore called the meeting of the AARC Board of Directors to order at 8:04am MST. Secretary/Treasurer Karen Schell called the roll and declared a quorum.

DISCLOSURE

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

WELCOME AND INTRODUCTIONS

Members introduced themselves and stated their disclosures as follows:

Karen Schell – Advisory member – FDA Pulmonary Allergy Committee – Community member
Lisa Trujillo – CoBGRTE, Committee member of International Outreach
Lynda Goodfellow – NAECB Board member, CoBGRTE member
Sheri Tooley – Chair Advisory Committee Genesseo Community College, Member Advisory Committee SUNY Upstate, Member Advisory Committee Erie Community College
Ellen Becker – CoBGRTE member, Association Asthma Educators, Board of Directors Chicago Asthma Consortium
Tim Op't Holt – CoBGRTE member, NAECB member
Shawna Strickland – Advisory Committee, Tarrant County College RT program
Tim Myers – ARCF Trustee
Steve Nelson – ARCF Trustee
Natalie Napolitano – Research relationships with Aerogen, Nihon-Kohden, Draeger, CVS Health, CoBGRTE member, Allergy & Asthma Network Board member
Gary Wickman – CoBGRTE member
John Lindsey – Advisory Committee member National Park College and Seark College
Keith Lamb – GE, Masimo, Sunovian, Fisher-Paykel
Cheryl Hoerr – Southmedic, Cardinal, Advisory Boards for Rolla Technical Center, St. Louis College of Health Careers, Missouri State University
Cyndi White – Philips, Aerogen, Vapotherm
Tom Kallstrom – ARCF Executive Vice-president, Board member of Allergy & Asthma Network
Kimberly Wiles – Board of Directors Pennsylvania Association of Medical Supplies, Advisory Board member of IUP School of Respiratory Care, Canvas Consulting

APPROVAL OF MINUTES

Natalie Napolitano moved to approve the minutes of the April 24, 2015 meeting of the AARC Board of Directors.

Motion carried

Gary Wickman moved to approve the minutes of the April 25, 2015 meeting of the AARC Board of Directors.

Motion carried

E-motions

Lynda Goodfellow moved to ratify the July 6, 2015 E-motion approval of E15-2-15.1 "That the AARC Board of Directors approve Jacksonville, FL (JW Marriott Sawgrass Resort) as the destination for the 2016 AARC Summer Forum."

Motion carried

SPECIAL COMMITTEE REPORTS

John Hiser, Chair of the International Committee, gave highlights of the written International Committee he submitted. He announced the 2015 International Fellows:

Peifeng Xu (China) – Honolulu, HI and Charlottesville, VA
Musa Muhtaroglu (Cyprus) – Ogden, UT and Greenville, NC
Ramesh Unnikrishnan (India) – Kansas City, KS and Atlanta, GA
Hussain Khatam (Bahrain) – Winston-Salem, NC and Lyons, IL

GENERAL REPORTS

President

Lisa Trujillo moved to accept FM15-2-4.1 "That 75% of the RTs who respond to the 2020 Human Resources survey have, or will be actively working towards, a Bachelor's of Science Degree or higher."

Lynda Goodfellow moved to make a friendly amendment to FM15-2-4.1 to change 75% to 80%.

Motion carried unanimously

Executive Director/Office

Tom Kallstrom gave highlights of his submitted written report. Associate Executive Directors commented about their respective areas.

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

Motion carried

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

Motion carried

Sheri Tooley moved to accept FM15-2-1.3 "That the AARC Board of Directors approve funding of $7,500 over 2 years for a post-graduate grant from the Alpha-1 Foundation."

Motion carried

Karen Schell moved to accept FM15-2-1.4 "That the AARC Executive Office hires a Grants Writer with a salary of up to $110,000 (includes benefits)."

Motion carried

RECESS

President Salvatore recessed the meeting of the AARC Board of Directors at 9:45am MST.

RECONVENE
President Salvatore reconvened the meeting of the AARC Board of Directors at 10:00am MST.

Government and Regulatory Affairs
Cheryl West and Anne Marie Hummel provided a brief up to the written reports, including more detail on specific Medicare policy changes and details regarding particular state legislation. A more in depth discussion will be provided at the Joint House and Board session.

President Salvatore instructed the Board of Directors to go to the Capital Connection website and submit a letter to their representative and all Board members submitted letters while at the meeting.

Board of Medical Advisors (BOMA)
Dr. Steve Boas, BOMA Chair, updated the Board on the recent conference call with BOMA: new AAP BOMA rep, Dr. Lioy. Dr. Papadakos offered a $1,000 award on his own behalf for a student poster. Dr. Christopher said there are more BOMA members who will be participating at the Congress.

STANDING COMMITTEES REPORTS

Bylaws Committee
Lynda Goodfellow moved to accept Recommendation 15-2-9.1 "That the AARC Board of Directors find that the West Virginia Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."
Motion carried

Program Committee
Lynda Goodfellow moved to accept Recommendation 15-2-15.1 "That the AARC Board of Directors approve Jacksonville, FL (JW Marriott Sawgrass Resort) as the destination for the 2016 AARC Summer Forum."
Was done as E-vote on 7/6

Cyndi White moved to accept FM15-2-15.3 "That the AARC Board of Directors approve Tucson, AZ (JW Marriott Star Pass Resort) as the destination for the 2017 AARC Summer Forum."
Motion carried

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

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

SPECIALTY SECTION REPORTS

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

SPECIAL COMMITTEE REPORTS CONT'D

Benchmarking Committee
Karen Schell moved to table Recommendation 15-2-17.1 "That the AARC Executive Office explore database revisions with the vendor who manages the benchmarking database as recommended by the Committee and explore the cost for enhancements and revisions."
Motion carried

Position Statement Committee
Lynda Goodfellow moved to accept Recommendation 15-2-26.1 "That the AARC Board of Directors approve and publish the revised Position Statement 'Definition of Respiratory Care'."
Motion carried

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

Karen Schell moved to amend the title to "Respiratory Therapy Education".
Motion carried

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

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

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

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

(See attachment "A" for all position statements.)

SPECIAL REPRESENTATIVES REPORTS

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

GENERAL REPORTS CONT'D

John Wilgis, Speaker of the House of Delegates, gave highlights of his submitted written report. President Salvatore recognized John Wilgis for his diligent work on the bylaws. President Salvatore introduced the two students who came to observe the Board of Directors meeting.

Lynda Goodfellow moved to un-table Recommendation 15-2-17.1.
Motion carried

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

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

ROUNDTABLE REPORTS

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

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

AD HOC COMMITTEE REPORTS

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

RECESS

President Salvatore recessed the meeting of the AARC Board of Directors at 11:55am MST.

JOINT SESSION

Joint Session was called to order at 1:35pm MST. Secretary/Treasurer, Karen Schell, called roll and declared a quorum.

Membership Chair, Gary Wickman, gave a membership report.

Elections Committee Chair, Jim Lanoha, presented the slate of candidates for the 2015 election:

President-Elect:	Brian Walsh, Sheri Tooley
Director-at-Large:	John Lindsey, Raymond Pisani, Carl Hinkson, Thomas Malinowski, Doug McIntyre, Debra Skees, Gary Wickman, Pattie Stefans
Sleep Section:	Marilyn Barclay, Jessica Schweller
Home Care Section	Zachary Gantt, Debra Schuessler
Neonatal/Pediatrics Section	Steve Sittig, Bradley Kuch

Government Affairs

Cheryl West and Anne Marie Hummel provided an update for the Board and House of Delegates during the Joint Session. West noted several new bills and regs that had occurred prior to the written report, most notably that a State Auditors Report has recommended Hawaii State Licensure is continued and that legislation to continue Texas RT Licensure has been signed by the Governor. Hummel provided an update on the Medicare Telehealth Parity Act, HR 2948. AARC re-launched its Virtual Lobby Week seeking co-sponsorship of HR 2948.

Executive Session

Gary Wickman moved to go into Executive Session at 2:25pm MST.
Motion carried

Executive Session ended at 2:40pm MST.

Mike Runge, Chair of the Ad Hoc Committee for Revisions to AARC Bylaws, reviewed and read all recommendations from April 2015 and Raymond Pisani stated that the Bylaws Committee unanimously approved all recommendations. Each recommendation was opened for questions and comments.

Sherry Milligan gave a presentation on the new membership dues debuting this fall.

President Salvatore adjourned the Joint Session at 3:45pm MST.

RECONVENE

President Salvatore reconvened the meeting of the AARC Board of Directors at 4:10pm MST.

President Salvatore introduced two students who wanted to observe the Board of Directors meeting.

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

OTHER REPORTS

The reports from ARCF, CoARC, and NBRC were reviewed.

Tom Kallstrom informed the Board about the upcoming ARCF Fundraiser to be held in Tampa, FL in November. Tickets are $150 per person on a yacht which includes food and beverage. There will be a drawing for a Caribbean cruise.

Cyndi White moved to accept the other reports.
Motion carried

BYLAWS

Gary Wickman moved to accept **FM15-1-9.3** "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly":
Article II, Section 1.
The American Association for Respiratory Care (AARC) will continue to be the leading national and international professional association for respiratory care. The AARC will encourage and promote professional excellence, advance the science and practice of respiratory care, and serve as an advocate for patients, their families, the public, the profession and the respiratory therapist.
Motion carried (did pass at HOD meeting)

Lynda Goodfellow moved to accept **FM15-1-9.4** "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly":
Article III, Section 7(a).
a. Specialty Sections representing particular areas of interest within respiratory care shall be made available to Active, Associate, and Special Members of the Association. The purpose, organization and responsibilities of Specialty Sections shall be defined in the policies and procedures of the Association. A seat on the Board of Directors, up to a maximum of six seats, ~~will~~ may be granted to those Specialty Sections ~~consisting of at least~~ with a minimum of 1000 active members as defined in the policies and procedures of the Association ~~to be considered for a seat on the Board~~.
Motion carried (did not pass at HOD meeting)

Cyndi White moved to accept **FM15-1-9.5** "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly":
Article IV, Section 1(b).
b. Officers of the Association shall not concurrently be members of the national respiratory care credentialing or accreditation bodies or chartered affiliate staff or voting members of their Board of Directors.
Motion carried (did not pass at HOD meeting)

Karen Schell moved to accept **FM15-1-9.6** "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly": Article IV, Section 4(c and d).
c. Vice President for Internal Affairs - The Vice President for Internal Affairs shall serve as a liaison to the ~~Chartered Affiliates, Specialty Sections, and~~ committees and groups of the Association as designated by the President and perform such other duties as shall be assigned by the President or the Board of Directors. The Vice President for Internal Affairs shall assume the duties of the President-elect in the event of the President-elect's absence, resignation, or disability, but will also carry out the duties of the office of the Vice President for Internal Affairs.
d. Vice President for External Affairs – The Vice President for External Affairs shall serve as a liaison to ~~the sponsors of the Association and to other organizations and associations with which the Association has a relationship~~ committees and groups as designated by the President, and perform such other duties as shall be assigned by the President or the Board of Directors.
Motion carried (did pass at HOD meeting)

Lynda Goodfellow moved to accept **FM15-1-9.7** "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly":
Article V, Section 1(a).

a. The executive government of the Association shall be vested in a board of ~~at least~~ no more than ~~seventeen~~ eighteen (~~17~~ 18) Active Members consisting of at least five (5) Officers, ~~at least six~~ and twelve (~~6~~ 12) Directors-at-Large, and/or ~~a~~ Section Chairs serving as a Director from ~~each~~ Specialty Sections ~~of at least~~ with a minimum of 1000 active members of the Association ~~to be~~ that will be considered for a seat on the Board of Directors as defined in the policies and procedures of the Association. So as long as the number of Section Chairs serving as Directors is at least six (6), the number of at-Large Directors shall be equal to the number of Section Chairs serving as Directors. If the number of Sections Chairs serving as Directors is less than six (6), the number of at-Large Directors shall be increased to assure a minimum of ~~seventeen~~ twelve (~~17~~ 12) ~~members~~ Directors on ~~of~~ the Board of Directors. The Immediate Past Speaker of the House of Delegates, the Chair of the President's Council and the Chair of the Board of Medical Advisors shall serve as non-voting members. Directors shall be elected in accordance with the provisions of Article XII, Section 2 (b).

b. Members of the Board of Directors shall not concurrently be members of national respiratory care credentialing, ~~or~~ national respiratory care accreditation bodies or chartered affiliate staff and/or voting members of their Board of Directors.
Motion carried (did not pass at HOD meeting)

Karen Schell moved to accept **FM15-1-9.8** "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly":

Article VIII, Section 3 (b)

b. The Board of Directors of the Association and all its committees and specialty sections may consult with the Board of Medical Advisors in regard to medical issues. ~~The Board of Medical~~

~~Advisors must approve all matters regarding medical policy.~~ The Board of Medical Advisors shall assist the appropriate committees and specialty sections regarding medical and educational issues.
Motion carried (did pass at HOD meeting)

Karen Schell moved to accept **FM15-1-9.9** "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly":

Article VIII, Section 4

An annual meeting of the Board of Medical Advisors shall be held at the time and place of the Annual Meeting of the Association~~, and other meetings shall be held at such times and places as shall be determined necessary by the Board of Medical Advisors~~.
Motion carried (did pass at HOD meeting)

Karen Schell moved to accept **FM15-1-9.10** "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly":

Article XI, Section 4

~~**SECTION 4. INTERNATIONAL AFFILIATE DUTIES**~~

~~A copy of the minutes of every meeting of the governing body and other business meetings of the International Affiliate shall be sent to the Executive Office of the Association within thirty (30) calendar days following the meetings.~~
Motion carried (did pass at HOD meeting)

Karen Schell moved to accept **FM15-1-9.11** "That the AARC Board of Directors and the House of Delegates approve the following amendment to the AARC Bylaws and re-index accordingly":

Article XII, Section 2 (b) items 1&2
1. The committee shall be composed of five (5) Active Members; three (3) elected by the House of Delegates and ~~two~~ one (1) elected by the Board of Directors and the seated Past President. The Chair shall be selected by the House of Delegates.
2. The term of office for each member except the seated Past President shall be three (3) years. The election of the members shall be staggered, so that no more than 50% of the membership changes each year.
Motion carried (did pass at HOD meeting)
Deb Skees, Past Speaker, shared results of the Bylaws recommendations with the Board of Directors.

RECESS
President Salvatore called a recess of the AARC Board of Directors meeting at 5:10pm MST.

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

_____ _____

Karen Schell Date
AARC Secretary/Treasurer

Attachment “A”

Definition of Respiratory Care
Respiratory Therapy Education
Best Practices in Respiratory Care Productivity and Staffing
Insertion and Maintenance of Vascular Catheters by Respiratory Therapists
Insertion and Maintenance of Arterial Lines by Respiratory Therapists

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

Position Statement

Definition of Respiratory Care

Respiratory Care is the health care discipline that specializes in the promotion of optimum cardiopulmonary function and health and wellness. Respiratory Therapists employ scientific principles to identify, treat and prevent acute or chronic dysfunction of the cardiopulmonary system.

Knowledge and understanding of the scientific principles underlying cardiopulmonary physiology and pathophysiology, as well as biomedical engineering and application of technology, enable**s** respiratory therapists to provide patient care services efficiently. As a health care profession, Respiratory Care is practiced under medical direction across the health care continuum. Critical thinking, patient/environment assessment skills, and evidence-based clinical practice guidelines enable respiratory therapists to develop and implement effective care plans, patient-driven protocols, disease-based clinical pathways, and disease management programs.

A variety of settings serves as the practice site**s** for this health care profession including, but not limited to:

- Acute care hospitals
- Sleep disorder centers and diagnostic laboratories
- Long term acute care facilities
- Rehabilitation, research and skilled nursing facilities
- Patients' homes
- Patient transport systems
- Physician offices and clinics
- Convalescent and retirement centers
- Educational institutions
- Medical equipment companies and suppliers
- Wellness centers

Effective 12/99
Revised 12/06
Revised 07/09
Revised 7/12
Revised 4/14
Revised 6/15
Revised 7/15

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

Position Statement

Respiratory Therapy Education

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

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

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

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

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

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

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

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

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

Position Statement

Best Practices in Respiratory Care Productivity and Staffing

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

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

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

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

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

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

Effective 07/12
Revised 07/15

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

Position Statement

Insertion and Maintenance of Vascular Catheters by Respiratory Therapists

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

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

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

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

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

Effective 07/2015

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

Position Statement

Insertion and Maintenance of Arterial Lines by Respiratory Therapists

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

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

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

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

Effective 07/2015

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

July 17, 2015- Phoenix, AZ

Minutes

Attendance

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

Consultants

Mike Runge, BS, RRT, FAARC Parliamentarian
Deb Skees, MBA, RRT, CPFT, Past Speaker
Steve Boas, MD, BOMA Chair

Excused

Bill Lamb, BS, RRT, CPFT, FAARC
Dianne Lewis, MS, RRT, FAARC, President's Council President

Staff

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

CALL TO ORDER

President Frank Salvatore called the meeting of the AARC Board of Directors to order at 8:02am MST. President Salvatore introduced two students who were invited to observe the Board meeting. Board members introduced themselves and Secretary-Treasurer Karen Schell declared a quorum.

President Salvatore informed the Board of Directors of a meeting with the CoBGRTE Executive Committee and the AARC Executive Committee that took place on Wednesday, July 15, 2015.

Cyndi White moved to go into Executive Session at 8:10am MST.
Motion carried

Karen Schell moved to come out of Executive Session at 9:40am MST.
Motion carried

President Salvatore appointed George Gaebler (Chair), Lynda Goodfellow, Tim Op't Holt, Ellen Becker, Natalie Napolitano, and Gary Wickman to the Taskforce on the Creation of Collaborative Efforts with External Organizations. The goals of this taskforce are as follows:

1. Create action plans related to AARC efforts to be inclusive of organizations with like goals for advancing the profession.
2. Report action plans to the AARC President by August 28, 2015 so that he can review and forward to the BOD by September 4, 2015.

RECESS
Frank Salvatore recessed the meeting of the AARC Board of Directors at 11:40am MST.

RECONVENE
Frank Salvatore reconvened the meeting of the AARC Board of Directors at 11:51am MST.

UNFINISHED BUSINESS
Strategic Plan Workgroups gave updates on their work since the April meeting.

FM 15-2-84.1 Karen Schell moved "that the AARC Board of Directors forward the position papers created by the strategic plan (#2) workgroup to the position statement committee for review and provide feedback for approval by the Board of Directors."

Natalie Napolitano made a friendly amendment to FM 15-2-84.1 to read "that the AARC Board of Directors forward the 'Entry Level Respiratory Therapy Education' position statement to the Position Statement Committee and blend together with the recently approved 'Respiratory Therapy Education' position statement into one document."
Motion carried

POLICY UPDATES
CT.007 – Committees – Judicial Committee Procedures for Processing Complaints and Formal Charges
Tim Op't Holt moved to approve as modified.
Motion carried

FM.020 – Fiscal Management – Guidelines for the Funding of State Legislative Activities
Karen Schell moved to approve the amount of $10,000.
Motion carried

SS.002 – Specialty Sections – Formation, Dissolution, and Conversion of Specialty Sections
Ellen Becker moved to accept for information only.
Motion carried

BOD.024 – Board of Directors – AARC Disaster Relief Fund
Ellen Becker moved to accept the amended changes.
Motion carried

(See attachment "A" for all policies.)

FM 15-2-7.1 Gary Wickman moved to ask President Salvatore that, in collaboration with the Executive Office, to write a letter to the Board of Medical Advisors (BOMA) to ask for their support in moving the minimum educational requirement for entry level respiratory therapy to be at the BS degree level or higher. Further, to request that BOMA craft a white paper or position statement stating the above to be sent to CoARC and NBRC and available to educational programs to use when applying to move their programs to the BS degree for entry level. This should be done by September 1, 2015.
Motion carried

NEW BUSINESS
There was no new business.

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

MOTION TO ADJOURN
Tim Op't Holt moved "To adjourn the meeting of the AARC Board of Directors."
Motion carried

ADJOURNMENT
President Salvatore adjourned the meeting of the AARC Board of Directors at 11:50am MST.

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

_____ _____

Karen Schell Date
AARC Secretary/Treasurer

Attachment “A”

CT.007 – Committees – Judicial Committee Procedures for Processing Complaints and Formal Charges
FM.020 – Fiscal Management – Guidelines for the Funding of State Legislative Activities
SS.002 – Specialty Sections – Formation, Dissolution, and Conversion of Specialty Sections
BOD.024 – Board of Directors – AARC Disaster Relief Fund

American Association for Respiratory Care
Policy Statement

Policy No.: CT.007

SECTION: Committees

SUBJECT: **Judicial Committee Procedures for Processing Complaints and Formal Charges**

EFFECTIVE DATE: December 1980

DATE REVIEWED: July 2015

DATE REVISED: July 2015

REFERENCES:

Policy Statement: The following will define the procedures followed by the Judicial Committee in processing complaints and formal charges against a member or members of the Association who have allegedly violated the AARC Bylaws and/or Code of Ethics.

Policy Amplification:

Definitions:

Association: American Association for Respiratory Care (AARC)

Formal Complaint: A complaint submitted to the Judicial Chairperson which details the specifics of a complaint, and which has been signed and duly notarized. Specifics of the complaint must include: (1) a detailed description of the violation; (2) when, how, and where the violation occurred; (3) the name of the organization or person affected by the violation; (4) the name, address, and telephone number against whom the complaint is being filed; and (5) the name, address, and telephone number of the person making the complaint. The complaint may include more than one individual, organization, and/or violation, if applicable. The complaint and its specifics must be legible.

Valid Complaint: A Formal Complaint judged by the Committee as having substance. Formal Complaint processed into a Formal Charge.

Complaint Without Substance: A Formal Complaint judged by the Committee to be lacking substance. Formal Complaint is dropped from record.

Formal Charge: A Formal Complaint judged valid by the Committee and issued to the charged member as a "Resolution Preferring Charges Against a Member."

Formal Hearing: A Telephone hearing with the Committee, requested by the charged member.

Executive Session: A Committee meeting following a Formal Hearing to determine Committee action.

Substance: A preliminary determination by the Committee that a complaint is grounded in fact and worthy of a formal investigation.

Notary/Notarized: An attestation by a notary public from the state and county of residence of the complaining member who personally witnesses the complaining member sign the complaint and includes the following jurat at the bottom of the complaint – "Comes now [insert name] a notary public in and for the county of [county] and state of [state] who attests that on [date] the above-named member of the AARC, having been duly sworn and upon his/her oath signed the above document of her own free act and deed. Subscribed to and sworn this [day] day of [month], 20__."

Procedure:

1. All improperly completed written complaints received by the Committee Chair shall be responded to within ten (10) working days by certified mail, return receipt requested. Instructions for proper completion of the complaint and time limitations shall be included with the Chairperson's response.
2. Failure of a complainant to return the information needed to complete the specifics of a formal complaint within thirty (30) days of the date of the signed return receipt shall be sufficient reason for abandoning the complaint.
3. The identity of any complainant shall be held confidential and provided to the accused member(s) only if the Committee determines the complaint(s) valid and a formal charge(s) is processed.
4. Upon receipt of a properly completed Formal Complaint, the Chair shall notify the accused member of the specifics of the Formal Complaint within ten (10) working days, by certified mail, return receipt requested.
5. The Chair shall conduct a complete preliminary investigation, as expeditiously as practical, involving only the complainant and the accused member to collect supportive documentation from both parties. The complainant, accused member, AARC President, and Judicial Committee members shall be notified of any serious delays in the investigation. Other individuals or institutions may be asked to submit written statements only with the written permission of the accused member. Such written statements must be acknowledged and sworn to before notaries, before they will be relied upon by the Committee.
6. Following the preliminary investigation, the Formal Complaint and all notarized documentation will be sent to Judicial Committee members for review.
7. The Chair shall schedule a telephonic meeting of the Judicial Committee to analyze the merits of the Formal Complaint and determine by majority vote, whether the Formal Complaint is Valid or Without Substance. This meeting requires a two-thirds presence of the Judicial Committee members, in addition to the Chair. The Chair votes only to bring majority. The AARC legal counsel shall be present to assist the Committee with any legal questions which may arise. Should the Committee determine the Formal Complaint is without substance, the complainant and accused member shall be so notified, within ten (10) working days, by certified mail, return receipt requested.
8. Should the Committee determine the Formal Complaint is valid, a Formal Charge shall be issued to the accused member. A current "Resolution Preferring Charges Against a

Member" shall be prepared, with the benefit of legal counsel, and forwarded to the charged member within fifteen (15) working days by certified mail, return receipt requested.

9. The charged member shall be requested to reply to the specified charges within fifteen (15) working days from the date of receipt of the "Resolution Preferring Charges Against a Member." The Chair of the judicial committee may grant additional time to respond, up to and including 30 days, to the formally-charged member.
10. Notification of Formal Charge shall include a clear statement of the options available to the charged member:
    a. the right not to reply to the Committee's request for response;
    b. the right to provide a detailed response in rebuttal, denial, justification, explanation, or admission of the Formal Charge; and/or
    c. the right to request a Formal Hearing in order to present a direct personal defense to refute the Formal Charge.
11. This notification shall also include a copy of "Judicial Committee Guidelines for Processing Complaints and Formal Charges."
12. If the charged member fails to respond in writing within the time specified for reply, or fails to request additional time, the Committee, by majority vote, may take action it deems appropriate.
13. If the charged member's response is sufficient for Committee action, and no Formal Hearing is requested, the Committee, by majority vote, shall take whatever action it deems appropriate, which may include, on vote of the Committee, the scheduling of a formal hearing.
14. Should the written response, by the charged member, prove to be inadequate by the Committee to refute, explain, justify or admit to the specifics of the charge, the Chair shall:
    a. Request a final, more detailed statement or clarification from the charged member. No further written replies shall be requested.
    b. Re-extend the opportunity for a Formal Hearing, which will serve in lieu of a final written response.

    This request shall be forwarded to the charged member within ten (10) working days of the Committee's determination of inadequate response by certified mail, return receipt requested. The charged member shall be requested to reply within ten (10) working days of his/her receipt of the committee's second request.

15. Without any request for a Formal Hearing, the Committee shall, by majority vote, take action in the case of each charged member within fifteen (15) working days of the receipt of a charged member's final written response. The charged member shall be notified within ten (10) working days of Committee action by certified mail, return receipt requested.

a. If a Formal Hearing is requested, the AARC President shall be notified so that all necessary funds may be appropriated. The Judicial Committee Chair, with the assistance of the AARC executive office, shall schedule a telephonic Formal Hearing to be held within sixty (60) days from the date of receiving the charged member's request for Formal Hearing.
b. The charged member requesting a Formal Hearing shall be notified by certified mail return receipt requested of the date and time of the Formal Hearing and shall be issued

the Formal Hearing guidelines no less than thirty (30) days prior to the date of the Formal Hearing.

c. The Judicial Committee Chair reserves the right to include or exclude presence of non-delineated individuals at the Formal Hearing.
d. The AARC legal counsel will be present at all Formal Hearings and will assist the Committee with any legal questions.
e. The charged member shall be made aware of the membership of the committee prior to the hearing and be afforded an opportunity to request the recusal of any committee member that the charged member reasonably believes to be biased against them. The Chair shall hear and determine any challenge to any committee member on the basis of bias. Should the Chair be alleged to have a bias or interest in the matter, the AARC President shall determine whether to recuse the Chair.
f. At no time shall the Chair or any Committee member attempt to influence any Committee member prior to a Formal Hearing. Any committee member who believes that they may be biased, or who may have any personal knowledge of facts obtained outside the strict rules of the hearing process shall recuse from further consideration in the matter.
g. A Formal Hearing requires two-thirds (2/3) presence of the Judicial Committee members in addition to the Chair. The Chair votes only to bring majority vote.
h. Letters or written statements introduced before the Committee must include the following statement in the body of the letter or statement: "the information provided herein is true and correct to the best of my information, knowledge and belief. The letter or statement shall be notarized.
i. Should the charged member not be present at the Formal Hearing, the Judicial Committee shall proceed with the Formal Hearing and make a decision by majority vote based on available information. A recording of all oral testimony shall be taken.
j. The Judicial Committee Chair shall preside over all Formal Hearings. All individuals present including the Judicial Committee members shall be identified for the record.
k. The Chair will identify the method of recording the Formal Hearing by the Judicial Committee and by the charged member.
l. The Chair shall read the procedures to be followed in conducting the Formal Hearing and inquire of those present if there are any questions concerning those procedures.
m. The Chair shall then read the specifics of the "Resolution Preferring Charges Against a Member."
n. The Chair will then review all documentation concerning the aforementioned "Resolution Preferring Charges Against a Member."

- The charged member and/or his/her legal counsel shall then have the opportunity to rebut.
- The charged member(s) involved shall then present witnesses and/or other admissible documents in defense of their position.
- The Judicial Committee shall have the option of asking relevant questions about each document and/or from each witness presented by the charged member.
- At the completion of the charged member's presentation, the Committee shall ask if the charged member has any further information. If none, the charged member presentation is closed, subject to rebuttal by the Committee.
- The Judicial Committee may consult legal counsel prior to closing the Formal Hearing and going into Executive Session.
- The Chair shall then close the Formal Hearing. The charged member shall be informed that he/she will be notified by the Judicial Committee Chair, within ten (10) working days of the Judicial Committee decision by certified mail return receipt requested.

- The Chair shall reconvene the Committee and declare Executive Session to review the testimony and to vote on action to be taken.
- In those cases where disciplinary action is taken against a charged member, notification of Committee action shall inform the charged member of his/her right to appeal the Committee action directly to the Board of Directors of the Association as defined in Article XI Section 2f of the Association Bylaws. Should a charged member against whom disciplinary action has been taken, fail to appeal Committee action to the Board of Directors of the Association, within the time specified, the Chair shall notify the charged member by certified mail return receipt requested that his/her rights as defined by these policies and AARC Bylaws have been exhausted and that the case is no longer appealable and that the Committee action is now binding.
- Upon advice of Legal Counsel, notification of Association member suspension or termination shall be given to:
    a. National Board for Respiratory Care (NBRC)
    b. The State Board for Respiratory Care of the charged member's state.
    c. State affiliate of member
    d. Local Chapter of member
    e. AARC member via *AARC Times* (only action taken, not names, shall be reported)
    f. Employer of member (upon written request of employer)

Procedure For Appeals to the Board of Directors (EP.1280)

Policy:

All members against whom disciplinary action has been imposed shall be granted the opportunity to appeal such action(s) to the Board of Directors of the Association. The objective of this appeal mechanism is to provide an impartial forum responsible for the review of adjudged evidence. Judicial Committee procedures and the severity of the penalties assessed against members. Under no circumstances shall the right to appeal be denied any member.

Outline of Preliminary Procedures:

All appeals must be received in writing within thirty (30) days of the member's receipt of notification of disciplinary action, and must be forwarded directly to the AARC President.

Appeals received beyond the thirty (30) day deadline shall be returned to the appellant, by certified mail within five (5) working days of its receipt by the AARC President with notification of its invalidity.

Any and all appeals must detail, in explicit terms the basis for the appeal and justifications which might warrant the reversal or modification of Judicial Committee actions.

Any appeal based upon the submission of new evidence or the reversal of testimony shall be forwarded to the Judicial Committee for preliminary review and recommendations.

Upon receipt of a valid appeal the AARC President shall request the original case file and hearing transcript, if any, from the Judicial Committee Chair.

The AARC President shall forward all case materials to the officers and directors of the Association within twenty (20) days of the receipt of the member's appeal. Within thirty (30) days of the President's receipt of the member's appeal, the Board of Directors, by majority mail or conference call vote shall:

Determine if the appeal is or is without merit.

1. Determine if all formal Judicial Committee procedures were followed appropriately.
2. Determine if Judicial Committee actions were appropriate for member responsibility.
3. Determine whether or not the strength of the appeal warrants reversal or modification of committee action.
4. Determine whether or not the appellant should be granted a formal hearing before the Board to present his/her case.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: FM.020

SECTION: Fiscal Management

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

EFFECTIVE DATE:

DATE REVIEWED: July 2015

DATE REVISED: July 2015

REFERENCES: FA0486

Policy Statement:

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

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

Policy Amplification:

1. Requirements of State Societies:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Methodology for Disbursement of Funds:

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

1) Total current assets and current liabilities.
2) Expected revenues and disbursements per the state society's budget.
3) The amount of money the state society has spent to date on its legislative/regulatory/policy effort.

4) Consistency of the state society's position with AARC policy, position and standards. The AARC President, AARC Executive Committee, in consultation with the Executive Office, will determine if the legislative/regulatory/policy content merits financial support.
5) State Society preparation to mount a response to the legislative/regulatory/policy initiative.

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

C. Affiliates requesting funding shall only specify the amount required. Funds will be allocated on a 60% grant and a 40% no interest loan basis (e.g., $2,000 requested = $1,200 grant and $800 loan). The maximum request may not exceed $10,000.

D. The disbursement of funds shall:
1) Generally the full amount of the allocation be disbursed to the state society as soon as is practically possible AFTER AARC Board approval and implementation of the contract described in b) below
2) Be contingent upon issuance and acceptance by both parties of a contract, memorandum, or agreement stating terms and conditions relating to the allocation of funds. Terms shall include
   i. Repayment of the loan portion of the allocated funds will commence within six months following the initial disbursement of the funds to the society by AARC.
   ii. Presentation of invoices by the society to the AARC Executive Office (Controller) supporting the Society's expenditures within six months of the AARC's funds disbursement. If invoices are not presented within such six months after AARC disbursement, any "Excess Disbursement" (Defined as monies received by the State Society from AARC which are not supported by invoices presented) must be immediately returned to the AARC and the loan repayment terms will be adjusted accordingly. Extension of this six month period for extenuating circumstances may be granted by the Executive Office.
   iii. Provision for loan repayment via Society Revenue Sharing withholding on any loan payment that is delinquent for more than 60 days.
   iv. Depending on the circumstances other terms of repayment may be established by the AARC Executive Office and the AARC Controller as well.

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

American Association for Respiratory Care
Policy Statement

Policy No.: SS.002

SECTION: Specialty Sections

SUBJECT: **Formation, Dissolution, and Conversion of Specialty Sections**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: July 2015

DATE REVISED: July 2007

REFERENCES:

Policy Statement:
The Association Board of Directors shall retain the responsibility and authority to form**,** dissolve and convert Specialty Sections.

Policy Amplification:

1. The Association Board of Directors may establish a Specialty Section by a 2/3-majority vote if there are at least 350 active members interested in establishing a specialty section.

2. The President shall appoint a Chairperson for newly established Specialty Sections, subject to ratification by the Board of Directors.

3. Specialty Section dues shall be established by the Board of Directors as part of the budgetary process.

4. The President may appoint liaisons from the Board of Directors to each Specialty Section.

5. As outlined in the AARC Bylaws (Article 5, Section 1), a Section Chair from each Specialty Section of at least 1000 active members of the Association will serve on the Board of Directors as a Section Director. So long as the number of Section Directors is at least six (6), the number of At Large Directors shall be equal to the number of Section Directors. If the number of Section Directors is less than six (6), the number of At Large Directors shall be increased to assure a minimum of twelve (12) Directors. The Board shall then be comprised of six (6) Officers and a minimum of twelve (12) Directors for a total of at least eighteen (18) active members.

6. If the active membership of a section exceeds 1,000 active members on December 31st of a year in which the section does not have a serving section director, the Chair of the Section will be sworn in as a Section Director at the next annual business meeting of the Association. The term of the Section Director shall be for the remaining term of the Section Chair.

7. If the active membership of a specialty section is no longer at least 1,000 members as of December 31st of the year preceding completion of the term of the section director the following will occur:

    A. The President shall notify the Specialty Section Director of the specialty section not meeting the requirements of the bylaws in writing that they have until the next scheduled Board of Directors meeting to increase their membership of the section to exceed 1,000 active members as outlined in the bylaws.

    B. This notification shall provide the Specialty Section Chairperson with the opportunity to meet the requirements of the bylaws.

    C. If the Specialty Section Director and the Specialty Section cannot meet the requirements of the bylaws and is unable to increase its active membership of the section to exceed 1,000 active members as outlined in the bylaws, the current Specialty Section Director shall serve out their remaining term of office as the Specialty Section Director and the incoming Specialty Section Director will serve as the Specialty Section Chair.

    D. The President will notify the specialty section director of the outcome of the Board deliberations in writing.

    E. AARC and Section members will be informed of the decision of the Board of Directors at the earliest opportunity via approved Association channels of communication.

8. If the Specialty Section does not have at least 350 total members as of December 31st of the year preceding completion of the term of the Section Chair, the following will occur:

    A. The President shall notify the Specialty Section Chair that the Specialty Section is not meeting the section membership policy.

    B. This notification shall provide the Specialty Section Chairperson with the opportunity to show cause, in writing, why the Specialty Section should not be converted to a Roundtable by the next scheduled Board of Directors Meeting.
    C. The President shall notify the Chairperson of the Specialty Section of the outcome of the Board deliberations in writing.

    D. AARC and Section members shall be informed of the conversion of the Specialty Section at the earliest opportunity via approved Association channels of communication.

9. In any situation in which reductions in the number of Section Directors will result in the number of At Large Directors exceeding the number of Section Directors, and at least twelve (12) Directors will be serving, the number of At Large Directors nominated by the Elections committee and elected by the membership in the next Association election shall be reduced so the number of At Large and Section Directors on the Board of Directors following the installation of those Directors shall be equal.

10. If at any time the number of Section Directors decreases below six (6), the number of At Large Directors nominated by the elections committee and elected by the membership in the next Association election will be increased so that there will be twelve (12) Directors serving following installation of those persons.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.:BOD.024

SECTION: Board of Directors

SUBJECT: **AARC Disaster Relief Fund**

EFFECTIVE DATE:

DATE REVIEWED: July 2015

DATE REVISED: July 2015

REFERENCES:

Policy Statement*:* The AARC president may activate the Disaster Relief fund for AARC members in the event of a federal or state declared disaster.

Policy Amplification:

1. In the event of a federally and state declared disaster the state President and/or House delegate will notify the AARC Executive Office of a disaster declaration.

2. The AARC Executive Office will communicate to the AARC President.

3. The Executive Office will provide Disaster Relief Forms to the State Affiliate President(s) as well as requesting AARC members.

4. The Application review process will be conducted as follows:

    a. Members of good standing in the AARC prior to the onset of the disaster are eligible for a grant.
    b. The member fills out an application for assistance and sends that form directly to the AARC; where membership status is verified.
    c. The AARC President will send the member's application to the appropriate State Affiliate President for verification that the member is in an affected area and sustained property loss or damage.
    d. The State Affiliate President submits their approval or disproval of the application to the AARC Executive Office in writing. The Executive Office will inform the member of the status of their application (i.e. cut a check or decline the application with documentation of reasons for the action).

5. Members of good standing in the AARC prior to the onset of the disaster are eligible for a grant. Funds will be allocated based on criteria set by the AARC President at the time of the disaster until all designated funds have been expended.

a. Funding will also include payment of membership dues.

6. The AARC President will authorize a call to all AARC Members for donations to the Disaster Relief Fund at any time it is deemed appropriate and/or necessary.

7. Records relating to the disbursement of Disaster Relief Funds will be available to any AARC member upon written request of their State Affiliate President.

8. The AARC President may consider activating the fund upon request of an affiliate president in the event of a state or local governmentally proclaimed state of emergency or disaster.

E-Motions

(Since Last Board Meeting in July 2015)

None

General Report

President Report

Submitted by Frank Salvatore – Congress 2015

Presidential Committee and Goals Additions/Changes Needing Board Approval:

1. I've accepted the resignation of Arianna Villa as the Continuing Care/Rehab Section Chair. I will make an appointment in my 2016 Goals and Committee book that will be ratified by the 2016 Board on November 10, 2015.

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

1. July 23-24, 2015 – Georgia Society for Respiratory Care Conference – Savannah, GA
2. September 25, 2015 – Meeting with Dr. George Burton and Tom Kallstrom – Dayton, OH
3. September 30, 2015 – Arkansas Society for Respiratory Care Conference – Hot Springs, AR
4. October 9, 2015 – Indiana Society for Respiratory Care Conference – Indianapolis, IN
5. October 22, 2015 – Virginia Society for Respiratory Care Mountain Air Conference – Blacksburg, VA

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

1. **Taskforce on the Creation of Collaborative Efforts with External Organizations** – The committee presented action plans to me in September and I've decided that I'd make it part of the discussion for our November meeting under "old business". I'll attach a copy of their report to my President's report for your review and preparation for discussion at the meeting.

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

1. Letter of Support to Senators Alexander, Murray and Casey for the Advancing Hope Act of 2015 (June 2015)
2. Comments to CMS related to Medicare and Medicare Programs; Reform of Requirements for Long-Term Care Facilities (August 26, 2015)
3. Presented the 2015 AARC BOD with a Self-assessment survey (September 2015)

It has been an honor and a privilege to serve this profession as its President this past year. I've enjoyed meeting many of our members, non-members and students from around the country. This position has afforded me with an even broader look at our profession and continues to help me grow as a Respiratory Therapist and leader. I am also proud of the board and the executive office. The board has done some very timely and responsible work towards advancing our profession and working us towards meeting our strategic goals. Once again the executive office under the leadership of Tom Kallstrom continues to serve our profession in a manner that has allowed us to grow and has continued to be a value added part of our membership. As we move into the transition year, I look forward to my final year as your President and look to help Brian Walsh prepare for his two years. I hope I can be a good mentor as George Gaebler has been for me. As always, thank you for your service to our patients and profession.

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

Past President Report

Submitted by George Gaebler – Congress 2015

Verbal report at meeting.

Executive Office

Submitted by Tom Kallstrom – Congress 2015

Recommendations

None

Report

Welcome to Tampa. We look forward to hosting a productive Fall 2015 BOD meeting and the 61st International Congress this year. It has been a busy year and productive year. Below is an update since the July Board meeting.

Meetings & Conventions:
The 2015 Summer Forum in Phoenix, AZ was a very successful meeting for the AARC. Contrary to the belief that desert locations are not as well attended as other locales (i.e. beach), this year's meeting attracted more than 330 attendees, which not only exceeded budget, but is at (or slightly above) customary attendance figures in more luxurious location. A pre-course was held for Educators titled, "Focus on the Future: Respiratory Therapy Program Administration" which focused on the future of Respiratory Care education administration. This was a successful course with more than 100 educators in attendance. As has become customary, the Welcome Reception also served as a fundraising opportunity for the ARCF where almost $1,400 was raised for the Foundation.

In 2014, attendee feedback shed light on concerns over excessive food costs in Marco Island. This was not the case in 2015 while competitive lodging and restaurant costs are a necessity to attract visitors to Phoenix in July. The Executive Office will continue to make efforts to keep costs manageable for SF attendees.

Next year's Summer Forum is scheduled for June 26 – 28, 2016 in Ponte Vedra Beach, FL at the Marriott Sawgrass Resort.

AARC Congress 2015:

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

• AARC Congress 2015 will be held in Tampa, FL at the Tampa Convention Center.

• The Executive Office was successful in securing sufficient lodging requirements for all Congress attendees by securing a room block kept in the confines of the downtown Tampa area. In 2011, overflow room requirements had to be contracted in the Tampa Westshore area that required additional costs for shuttles and was a large source of dissatisfaction for those attendees lodging in the Westshore room block.

• The AARC has continued its partnership with a2z, a technology service provider that allows for an enhanced exhibitor experience. Exhibitors are able to make purchases and select booth

location at this year's meeting on-line, while attendees were able to preview the exhibit hall floor plan and learn more about participating exhibitors and the products they sell. Attendees were also able to email exhibitors to set up on-site appointments.

• Convention News Television will be back for a 3rd year in a row to provide video and news coverage of the meeting.

• Patrick Reynolds (of the RJ Reynolds Family) will deliver the keynote address. Mr. Reynolds is President and founder of Tobaccofree.org, a non-profit dedicated towards a Smoke Free America. Mr. Reynolds (keynote speaker in 1991) will provide an update on what has transpired in the last 25 years and progress that is being made regarding the fight against tobacco.

• Olympian Amy Van Dyken is scheduled to deliver the Closing Ceremony address. Ms. Van Dyken will discuss her life long fight against asthma, the role of the respiratory therapist in her care, and will share her favorite stories about her Olympic experience. Most notable, Amy will conclude the presentation by discussing her new fatal ATV accident last year and how she has overcome adversity.

• 3 Pre-courses: Mechanical Ventilation (Adult & Pediatric), Vascular Access Workshop and Chronic Hypoxemia; Managing the Patient Across the Continuum.

• 30 minute lectures and a mandatory 5-minute Q&A, all with the same start/stop time so that attendees can maximize CRCE

• ~ 225 presentations, accounting for more than 22 CRCE

• ~ 150 speakers with 24 first time presenters

• 8 scheduled breakfast/lunch symposia over 3 days

• Exhibit hall hours (11:00- 4:00 Tues., 9:30 - 3:00 Wed., and 9:30 - 2:00 Thur.)

• Dale Needham MD will deliver this year's Thomas L. Petty Memorial Lecture titled; "Surviving the ICU: Taking a Step Back into the Future". This presentation will discuss the importance of early ambulation in the ICU…even for mechanically ventilated patients.

• Charles Durbin MD will deliver the Donald F. Egan Scientific Memorial Lecture titled; "Monitors: Improving Safety or Increasing Risk?" This presentation will discuss the importance of physiologic monitoring (and its limitations) as well as the understanding of knowing what the monitor is telling us (and how to react).

•Nathan Cobb MD will present the Phil Kittredge Memorial Lecture. This lecture will discuss the evidence (and potential role) of using eCigarettes in the treatment of tobacco cessation.

Membership:

As of October 1, 2015 our membership numbers were 48,699. We will have a more current number to report at the board meeting in November.

Student Early Bird
Even though we are not yet done with the year, it appears that the student early bird renewal has been a success. With 3 months left to go in the year, the number of students renewing for Active members is at 27.6%. This is higher than any previous years and any additional conversions will just add to this.

	Total grads	Members as of 9/15	%
2013	6328	1352	21.37%
2014	5896	1377	23.35%
2015	5924	1637	27.63%

Retired Members
We have 80 members of record. We will continue to promote this but it is concerning that this number is lower than we expected.

Facebook Marketing
This was an effective way of driving traffic to our site and creating some engagement. We identified approximately 200 non-members we are attempting to cultivate for membership.

Dues Increase
In process. No negative feedback to date.

Win Back Program
We have continued our email campaign to reengage lapsing members with good success. Of the 18,390 lapsing members, we have recaptured 2,869 of them. (15.6%). While it is staggering that we have that many lapsing members, it is a good percentage overall over what can typically be expected on a renewal effort.

Advocacy and Public Awareness:

NBRC Collaboration
The AARC and NBRC has successfully implemented the NBRC/CRCE information-sharing program. The marketing team will work with the NBRC to notify the membership.

AAMI Collaboration
The AARC has been collaborating with AAMI on several projects for the last year. The AAMI is advancing the ventilator alarm safety initiative with three webinars in 2015: one aimed at the bedside nurse and two aimed at the respiratory therapist. Shawna Strickland and AARC member Jenifer Burke (nurse practitioner at Rush University) presented the “Nurses and Respiratory Therapists-Working Together for Safe Alarm Systems Management” webinar in May and Dario Rodriquez presented “Enhanced Patient Safety with Ventilator Alarms” in September. Angela King and Ronda Bradley will deliver the last webinar, focused on alarms in a non-clinical setting, in December 2015.

Recruiting for the Profession
There were two major events for recruiting in the next calendar year. The next USA SEF event will be held in April 2016. Carolyn Williams has agreed to coordinate that event again.

Professor’s Rounds and Current Topics in Respiratory Care
The 2015 Current Topics in Respiratory Care series has been well received and the 2016 topic

selection process is complete. Recording will take place in Tampa, FL, during AARC Congress 2015.

Respiratory Care Education Annual
The RCEA published issue 24 in September 2015. The call for papers for 2016 is underway. Recruitment for a new editorial board member is ongoing.

Pulmonary Disease Educator course in Dallas
The Pulmonary Disease Educator course was held in September in Dallas. Course registration was strong (170) and the feedback was positive. The AARC executive office has been collaborating with AACVPR, COPD Foundation, AAN, CF Foundation, and others to determine next steps.

CDC Strategic National Stockpile Ventilator Workshops
The AARC was contracted by the CDC to deliver three SNS ventilator workshops in 2015. The AARC has recently received confirmation that the CDC has approved an RFP for four SNS workshops in 2016 with a potential fifth workshop to be determined in late October. The four confirmed sites are the North Regional Respiratory Care conference in Wisconsin/Minnesota in April 2016, the California Society for Respiratory Care conference in June 2016, the Ohio Society for Respiratory Care conference in July 2016, and the TriState Respiratory Conference in Arkansas/Louisiana/Mississippi in August 2016.

Pfizer Grant
The AARC received a Pfizer grant for the development of "Clinician Training on Tobacco Dependence for Respiratory Therapists." The project includes development of a training course to assist respiratory therapists in initiating the smoking cessation conversation and referring patients to formal smoking cessation programs. The project also includes a study to determine the effectiveness of the intervention. The course is developed and is currently open only to study participants. The course will be released to all RTs in mid-October 2015 and data dissemination from the study is expected in early 2016.

Additions to Education
Several additions to AARC University are in the works for 2015. The Adult Critical Care Specialist course (13.5 CRCE) and the Caring for the Chronically Critically Ill course (3 CRCE) were added in January 2015 and the Spirometry course (2 CRCE) was added in February 2015. The Pulmonary Function Technology: Pediatrics (4.5 CRCE) course was added in July 2015 and the Pulmonary Function Technology: Advanced Concepts (2.5 CRCE) was added in September 2015. The Congenital Heart Defects course (5 CRCE), collaboration with Duke Pediatrics, and the Clinician Training on Tobacco Dependence for Respiratory Therapists (5 CRCE) are scheduled for October. Preliminary work has begun on a comprehensive neonatal-pediatric specialist review course tentatively scheduled for launch in summer 2016.

2015 Educational Product Sales/Attendance Trends at a glance (as of 10/1/15)

	2015 to date	2014	2013	2012	Comments
Webcasts and JournalCasts	7,287	8,812	7,511	6,289	Per session attendance in 2014: 383; 2015: 432
Asthma Educator Prep Course	157	268	203	224	Slightly under budget 2014
COPD Educator Course	677	820	570	420	Well over budget 2014

Ethics	1,293	1,757	2,361	2,711	Slightly over budget 2014
RT as the VAP Expert	54	115	81	275	Under budget 2014
Alpha-1	56	125	98	330	Under budget 2014
Exam Prep	168	39	40		*F&P grant (147) + 21
Leadership Institute	51	89			Slightly under budget 2014
Asthma & the RT	341	172			Launched in July 2014
ACCS	99				Launched in January 2015
PFT: Spirometry	125				Launched in January 2015
PFT: Pediatrics	23				Launched in July 2015

Life & Breath
The Life & Breath public relations and recruitment video will be revised in 2016. AMS Studio has been contracted to begin work on reclaiming previously filmed footage and scheduling new studio dates for new footage in winter/spring 2016. The new product will have multiple types of video for various audiences and purposes.

Advertising and Marketing

Advertising
Print advertising remains to be a rollercoaster ride from quarter to quarter. Respiratory Care and AARCTimes are tracking even with 2015 projections and previous year. A strong September, October and November surrounding Congress and Respiratory Week activities is a strong contributor. We also believe that Phil Ganz, our advertising sales agent, has started to build relationships and a solid understanding of the respiratory industry after being with us for the past year.

Digital advertising on aarc.org continues to remain consistent and strong through our partner, Multiview. In fact, ***all*** of aarc.org and *AARConnect* advertising positions have been sold out for the remainder of 2015 and well into 2016. We are also seeing stable interest and sales through the AARC Respiratory Care Marketplace site. RESPIRATORY CARE JOURNAL website has been turned over to Multiview for digital advertising sales and we have seen about 30% of the ads on that site sell in the first few months. Multiview has also approach us about a new digital advertising platform that will allow our advertisers to be "transported" to other websites by our visitors. We are investigating the nuances of this as we prepare this report for a 2016 launch.

Other advertising channels through eNewsletters, ePubs and recruitment ads are also part of the digital advertising footprint. Recruitment ads continue to be highly favorable compared to prior years and budget and will exceed 6 figures in income for 2015. Changes here can be attributed to a fresh website and the biweekly Career News distribution channel. eNewsletter advertising remains less than stellar despite high readerships on 4 of those products, but has picked up in the last half of the year with most of our leaderboards sold out now through December. This projects to be very favorable to last year's revenue and our 2015 budget.

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

We will see a shifting of some partners in 2016. We will lose two Corporate Partners in 2016 as they were not able to meet the criteria, but will add a new partner. We have seen some partners step up in their activities and others step back a little changing the dynamics of our relationships with them around revenue generating activities.

2016 Partners: Carefusion, Masimo, Medtronics (Covidien), Monaghan, Philips/Respironics, Drager, Maquet, Teleflex, Boehringer Ingelheim, Astra Zeneca (Forest Pharmaceuticals), Mallinckrodt (Ikaria), and Fisher Paykel (new). Sunovion Pharmaceuticals and ResMed will no longer be partners in 2016.

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

We also redesign the AARC Store site to optimize its appearance and utility to those that visit us for our variety of products. We have also been able to develop a dashboard that allows us more real-time feedback on the products we host in the AARC store. We will continue to monitor this area, as product sales are not as strong today as historical data would show.

We are also looking at “value added” products through our Membership Affinity program that may my find highly desirable. We have reinvigorated our relationship with Geico Insurance and have continued to see a boost in revenues from that program. We also continue our relationship with the malpractice insurance group for our members.

We have also launched a new membership credit and reloadable debit card program with VISA brands. Both of these new programs will provide additional revenue streams on customized AARC and ARCF cards that are acquired and used by our membership.

We have also been approach with 3-4 other affinity membership programs on items that people utilized in their everyday lives that we will investigate further for possible membership enhancements. Those being currently evaluated include travel member discounts (Choice hotels and all Rental Cars) as well as student and debt loan consolidation programs.

Products
Benchmarking subscriptions have remained flat in 2015 as the economic reigns are tightening for hospitals with approximately 60-65 hospitals around the US and in Middle East (2). 2016 will be a make or break year for this product as the Benchmark Committee is recently concluded an assessment of the program, and are considering some upgrades and a potential new product line to insure it is a current and valued tool to its participants. We are also looking at a “view only” option based on a 2-year analysis of our program.

As you are aware, in 2012 we outsourced our Respiratory Care Week products to a third-party supplier, Jim Coleman Ltd that handle all products and the necessary shipping. 2014 was our third year outsourcing RC Week products to Coleman. We came in right about our budget target in 2014 and realized a similar royalty to last year. 2015 appears to be tracking slightly ahead of 2014 as we had an "extra week" in October this year and some more focused marketing strategies.

We have added a "new" digital publication product into the Daedalus portfolio after a year of market research and discussions with the Daedalus team. The Best of RESPIRATORY CARE ePublication series was launched about 3-4 weeks ago with the proceedings of the 2013 New Horizon Symposium edition. We are looking to really boost this program and will be working with Rich Branson to facilitate a comprehensive library.

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

RESPIRATORY CARE Journal

The Journal continues to receive more manuscripts than we're able to publish, even though this past Jan 1 we stopped accepting case report and teaching case submissions. Acceptance rate by this end of 2015 should be around 30-35%.

While most AARC members have opted to read the Journal online instead of the printed version (probably because of the lesser membership cost), the low number of active subscriptions is disturbing: 8,151 as of Sept 15.

The Journal and staff are responsible for the administration and process necessary to present the OPEN FORUM sessions at the AARC Congress. That process is now completed and we should have very exciting and informative sessions at AARC Congress 2015. Accepted abstracts will be presented in one of 3 formats:

1. Editors' Choice – Authors of this select group of abstracts will prepare a poster for prominent display on the first two days of the Congress. On the 3rd day of the Congress each author will make a 8-minute slide presentation, followed by a 5-minute discussion period. Each author is also required to submit a manuscript to RESPIRATORY CARE prior to the Congress

2. Poster Discussions – Twelve sessions grouped by topic for which authors will prepare a poster of their work. A brief oral presentation (no slides) and audience questions and discussion will allow authors to expand upon their initial findings. The majority of accepted abstracts fall into this category.

3. Posters Only – Authors will prepare a poster to be displayed in the Exhibit Hall on an assigned day and time. Authors are required to be present between 12:00 noon and 1:30 pm to discuss their work.

Submissions in 2015 and comparison to years past are:

	Submissions	Accepted	Rejected	Editors' Choice	Poster Discussions	Posters Only
2015	283	222 (78%)	61 (22%)	11	173	38
2014	361	254 (70%)	107 (30%)	6	154	94
2013	398	287 (72%)	111 (28%)	-	287	-
2012	419	328 (78%)	91 (22%)	-	328	-
2011	347	271 (78%)	79 (22%)	-	271	-
2010	387	280 (72%)	107 (28%)	-	280	-
2009	277	228 (82%)	49 (18%)	-	228	-
2008	306	269 (88%)	37 (12%)	-	269	-
2007	283	242 (86%)	41 (14%)	-	242	-

Special thanks also to Monaghan Medical for their unrestricted educational grant to enable the presentation of the FORUM.

The December 2015 issue will mark 60 years of uninterrupted publication for the Journal. The Journal throughout the years is as good of a measurement as we have on how much our profession has grown and developed. We owe greatly to the thousands of AARC members and other contributors, but most important, we are very thankful to the AARC leadership for their unwavering support of the Journal during all those years. We look forward to the challenges ahead and to continuing success for the Journal, the Association, and the profession.

Our Mission

RESPIRATORY CARE deals with the subject area of the same name, and thus publishes articles pertaining to disorders affecting the cardiorespiratory system, including their pathogenesis, pathophysiology, manifestations, diagnostic assessment, monitoring, prevention, and management. Because the practice of respiratory care prominently involves equipment and devices, the development, evaluation, and use of these things feature prominently in what the Journal publishes. However, as indicated by the word "care" in its name, the Journal also emphasizes the patient, and on improving all aspects of the care of individuals affected by respiratory disease.

In addition to the reports of original research and the other article types, an important function of RESPIRATORY CARE is the publication of state-of-the-art special issues arising from conferences convened by the Journal. These Journal Conferences have been an integral part of the Journal for 35 years.

All manuscripts submitted to RESPIRATORY CARE are subjected to peer review. The Editor relies on evaluations by members of the Editorial Board and outside experts in deciding whether submitted manuscripts should be accepted for publication, revised for further peer review, or rejected.

IT

The IT department has been working to meet the Aug 31 deadline to renew our PCI status. There were a number of changes made that were related to networking and policy. Access to the WiFi networks was one of the major issues. It had been open to any device with a password. We now will require connected devices to be registered so that we know who to talk with in the event we see attacks coming into the system.

We are converting our credit card readers to read the new chip cards. There has been a backlog of orders, since all devices were supposed to be converted by Oct 1. Since we ordered ours prior to that date, we will be covered under the new standard. It seems priority has been given to companies with hundreds of thousands of devices to update. Our need for only 4 devices seems to be low priority to the suppliers.

We have installed new desktops and are using a standard configuration that will minimize maintenance. So far the desktop change has been positive for all the people that got them.

The move to cloud-based servers has started. We have selected a vendor and will start by migrating our email services. The server migration will not start until December, primarily due concerns about a setting up and testing a new environment just prior to Congress.

Our changes to the new website have seen an increase in traffic by more than 50%. We are also seeing that people are staying on the site longer. This is generally an indication they are find more material of interest. We are continuing a review of design elements and finding interesting things. One test showed that people were more likely to click an orange button, than a green or red one. This seems trivial, but getting people to take a specified action on your page is one of the ways that we can show increase involvement with the site.




State Government Affairs Activity Report

BOD/HOD November 2015
Cheryl A. West, MHA
Director Government Affairs

Introduction

With a few exceptions, most state legislatures have adjourned for the year. Those states that have a (nearly) year round session can still enact legislation so keeping watch on them is advisable. The states with year round legislative sessions are: DC, IL, MI, NH, NJ, NY, OH, PA, Puerto Rico. CA's session ends the last day of November, and MA adjourns mid-November. Regardless of session duration, most state legislatures set firm introduction/committee passage dates. If those dates are missed new legislation cannot move forward. And keep in mind that some states are even now preparing for their next legislative session by pre-filing bills prior to their legislature officially coming back in early 2016.

This report will provide an update to the issues presented since the July 2015 Summer Report.

RT Licensure Law Sunset Recap

In 2015 the RT licensure law was up for Sunset review in **CO, NM & IL.** The RT licensure law was also up for Sunset in **NJ** however this state took a different path to RT licensure renewal (see below). By the end of the legislative sessions all of these noted states had enacted laws extending the RT licensure law. To achieve this success each state society leadership and its RT members focused intensive efforts to assure that those who were to make the final decision had all the information and data about the profession.

The sunset experiences in states can vary greatly. **CO and NM** required the RT profession to undergo an extensive written review by agencies within the state government. The leadership of these state societies was intently focused on the progress of the report and they were there to "assist" whenever the appropriate opportunity presented itself. At the conclusion, both **NM and CO** agencies wrote a final report to their respective state legislatures recommending that RT licensure be continued.

IL Unlike their colleagues in CO and NM where the possibility that those aforementioned state Agency Reports might have recommended de-licensing the profession, IL was fortunate not to have the future of RT licensure be questioned. Knowing that the legislature was required to pass a Sunset bill extending RT licensure the ISRC took the opportunity to insert needed updates and changes to their law including a RT transport exemption; revising the RT scope of practice to include cardio pulmonary disease management; and providing a more explicit and detailed DME exemption that clarifies what unlicensed personal may and may not do.

NJ was able to take an entirely different path to RT licensure continuation, bypassing the legislature altogether. The standalone RT licensing Board simply issued a 2 sentence rule: *"The Board of Respiratory Care has reviewed the rules and has determined them to be necessary,*

reasonable, and proper for the purpose for which they were originally promulgated …..Therefore, ……, these rules are readopted
and shall continue in effect for a seven-year period.".

While the **Hawaii** legislature will not officially address RT licensure Sunset until 2016, the State Audit Agency conducted its review and issued its final report in 2015. Again as with the other societies the RT leadership devoted time and effort in order to provide essential information, statistics and rationale to the state reviewers. The final report which will be sent to the HI legislature next year strongly recommends that HI licensure be continued. HI RTs are very optimistic (but not complacent) that the legislature will enact a bill to continue their licensure.

In the next several years we should anticipate that other state RT licensure laws will cycle into the Sunset process. We would urge you to contact your colleagues in the aforementioned states to find out exactly what methods they used to make the successful case for licensure continuation.

RT Legislation

NC- late this summer the bill to move to the "RRT only" for NC RT licensure was voted unanimously out of the NC House and was sent over to the Senate to the Senate Rules Committee. The legislature adjourned without further action, but the bill will be re-introduced again in the 2016 April session. Legislative support appears to be strong but other legislative issues took precedence. As with **CA** and **OH** which have moved to the "RRT only" the provisions of the NC legislation as currently drafted provides an important grandfather clause allowing currently licensed CRTs to continue to be licensed. After the implementation date the new RRT only requirement there would a provision allowing new CRTs to obtain a provisional license renewable for up to 5 years while working towards obtaining their RRT credential.

OH (enacted) a bill that permits physician assistants to write RC orders

CA (enacted) a bill that that updates the RT scope of practice including specifying that respiratory care would include caring/treating patients with "deficiencies and abnormalities affecting the heart and cardiovascular system". The new changes also include the administration of medical gases and pharmacological agents for the purpose of inducing conscious or deep sedation under specified supervision and direct orders.

(While noted in previous Reports these two bills are worth noting again.)

AZ (enacted) repeals the issuing of temporary RT licenses

NJ (not yet enacted) extensive bill revises RT law by adding disease management to the scope of practice, specifically permitting RTs to execute protocols, allowing NPs and PAs to give RT orders and deleting temporary RT licenses

Legislation that includes RT

AL (enacted) adds Hepatitis C to the list of conditions (HIV, Hepatitis B) that health care workers must report. RTs are defined as health care workers therefore are subject to this new requirement

GA (enacted) a new law that requires that advertisements identify a health care practitioner's license; RTs are included in the list of professions

NE (enacted) authorizes a license to be issued (long list of licensed professions, including RT) based on military education and training

NV (enacted) makes changes to disciplinary aspects of the professions regulated under Board of Medical Examiners and that includes RT

TX (enacted) a new requirement for identification of certain health care providers associated with a hospital, includes RTs

VA (enacted) a technical corrections bill, included in the provisions is the removal of the term "care" in respiratory care and a substitution of "therapy" in its place

Legislation of Interest

CA (enacted) an interesting bill that allows individuals reaching the age of 22 and beyond not to "age out" of the category of *pediatric* when they have been previously diagnosed as medically fragile, or as noted in the provisions if these individuals require mechanical ventilation. Those qualifying would still be considered pediatric and would be able to continue to receive care in a pediatric day health and respite care facility

GA (enacted) permits schools to stock a supply of albuterol sulfate and make "arrangements with manufacturers" to obtain it, also allows the local board of education to authorize school personnel to administer albuterol sulfate to students who are in perceived respiratory distress

OR (enacted) a bill permits pharmacists to engage in practice of *clinical pharmacy* and provide patient care services, specifically noted is smoking cessation

MN (not enacted) a bill that has the goal of reducing asthma triggers by enhancing the asthma care services benefit under MN Medicaid

EMT/Paramedic Legislation

It's important to be aware of two separate legislative developments regarding Emergency Medical Service (EMS) personnel (paramedics and emergency medical technicians). Previous State Reports have noted legislation that expands the sites of care where EMS personnel may provide services. What follows is a recap of EMS legislation which has increased very noticeably this year. Some legislation has dealt strictly with paramedics, some only for EMTs, some only for the advanced EMT, and some for all categories defined by a state as EMS personnel.

Multi-State Compact Licenses

The first area to review and assess is the effort in multiple states to pass laws that grant multi-state licenses for EMS personnel. The term EMS Compact is being used and the meaning is the same as that being used by the nursing profession, i.e. the Nurse Compact
https://www.ncsbn.org/compacts.htm

Basically these new laws allow a licensed EMS practitioner in one state that enacts legislation to make it a Compact state, to be recognized as a licensed EMS practitioner in another state that also participates in the Compact. As an example the newly enacted Nevada multi-state EMS licensing law states:

"This compact is intended to facilitate the day-to-day movement of EMS personnel across state boundaries in the performance of their EMS duties as assigned by an appropriate authority and authorize state EMS offices to afford immediate legal recognition to EMS personnel licensed in a member state."

This type of EMS personnel Compact legislation is a very new (2014/2015) phenomenon, with enough states introducing bills and in some cases passing bills that one might conclude this is a well-organized and quite possibly a national legislative effort to push forward with this concept.

There are a number of speculative reasons why this effort has gained momentum this year. One logical explanation is to create efficiencies for EMS personnel operating in ground or air transports who frequently and routinely cross state lines (as noted in the Nevada legislation). This would be especially reasonable in state border locations. Requiring multiple licenses would be inefficient and costly, although presumably explicit "transport exemptions" should and probably have been sufficient to avoid the multiple license requirements. So the question is, if transport exemptions have worked well in the past why the need to have Compact legislation?

Another explanation is that EMS personnel holding a multiple state license can quickly respond to declared natural or manmade disasters/emergencies in other states, situations that might require extended stays in the affected community.

Another reason is that a license for multiple states can make EMS personnel more mobile in terms of employment. Employers (again thinking Border States) could "share" in the utilization/employment of EMS personnel as emergency transport personnel.

Whatever the reasons behind this legislative movement, one should expect it to continue.
The states that have Compact/Multi-state license legislation are:

CO (enacted)
NV (enacted)
TX (enacted)
KS (not passed)
OR (not passed)

WI (enacted) **–**somewhat different then the above "exempts out-of-state emergency medical services personnel from licensure requirements", which appears to be more of an exemption than a multi-state licensure Compact law.

Community Paramedic/EMTs or Emergency Medical Service Personnel EMS

The other area to note and one that has been reported in previous State Reports is the rise in legislation that "authorizes" or gives recognition to the relatively new iteration of the paramedic i.e. the Community Paramedic. This is the website for what appears to be a loose national association for community paramedics http://communityparamedic.org/

The introduction statement from the website says that access to health services is especially problematic for those who live in rural areas and who might be impoverished. Community paramedics can fill this gap in providing needed services to those in these areas. As I have reviewed 2015 legislation I have **not** noticed that there are provisions that would limit (i.e. only rural or designated underserved areas) where a Community Paramedic could render services.

According to the above site additional training will provide the paramedic expanded skills in the areas of: primary care, public health, disease management, prevention and wellness, mental health, and oral health.

The push in various states for a Community Paramedic started in earnest about 2 years ago. The concerns we have with this type of legislation focuses on the expanded scope of practice into complex non emergent care scenarios and whether the training/ education and competency testing are commiserate with what clinical services paramedics or EMTs would legally be able to provide presumably without direct supervision by another licensed health professional. Most legislation includes the authority to offer chronic disease monitoring and education and is fairly clear that these services can be provided in a variety of settings including the home.

We can speculate on the possible reasons for the continued state by state effort to legally authorize a specialized and "expanded" category of paramedic/EMT.

Perhaps with the years of predicting the impending physician shortage and current nursing shortage that building on the already wide "scope" of practice that paramedics/EMTs already have would make sense in order to provide health care services to those who need it when there are not an adequate number of "traditional health care professionals" available.

Perhaps another reason is, with the implementation of the ACA's requirement for individuals to hold health insurance and the number of states that have expanded their Medicaid program to include more recipients; this simply increases the number of people entering the health care system who will need health services. Again there simply may not be adequate numbers of traditional personnel to fill the demand.

Then of course there is recognition of the increasing numbers of patients with chronic conditions that can often be managed outside of the hospital. As we all are aware, there is a shift in how and where health care services are provided, not to mention the focused effort to avoid costly hospital readmissions or even admissions.

And looking at the purely financial aspect, a health care entity, such as a clinic or other care site employer might view utilizing paramedic/EMT personnel in the community would more than likely cost less than a nurse. Then there are hospitals that might see the efficiencies in employing a Community paramedic or EMT, one who had both the knowledge and skills to provide emergency services as well as being able to go out into the community and provide nonemergency services.

Whatever the reasons it is very clear that Community paramedic/EMTs legislation is moving forward.

ID (enacted) creates both a community paramedic and community emergency technician who would work "… under local medical control as part of a community based team of health and social service providers"

MN (enacted) FYI about three years ago MN enacted a community paramedic law. This legislative session MN passed a new law that would add Advanced EMTS to the community paramedic provisions

NV (enacted) in addition to enacting an EMT Compact law NV also passed a law that allows "ambulance based air ambulance services or fire-fighting to provide community para-medicine

services in certain cases”

ND (enacted) clarifies the state payment for community paramedic services and the Advanced EMT under the definition of community paramedic

WA (enacted) slightly different than other laws/bills as it allows “….emergency medical services to develop community assistance referral and education services programs…”

NE (not enacted) a bill that recognizes the community paramedic designation, under State Medicaid and permits and allows them to provide a number of new services, including “chronic disease monitoring and education and medication compliance” in a number of non-hospital care sites including the patients home

I would anticipate that the 2016 legislative session will continue to have both EMS personnel Compact and Community Paramedic legislation being introduced and more than likely many of the bills will pass.

For any new updates and developments that have occurred after submission of this Report I will provide a verbal update at the November Meeting.

Federal Government Affairs
Activity Report – Congress 2015

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The Congress

As this Report is written Congress has approximately 30 working days left in the first session of the 114th Congress. Earlier this year, Congress was finally able to address the perineal "physician fee fix" dilemma and passed legislation the sets in motion a final "fix". The key component will be a rollout of a new reimbursement formula for physicians targeted to begin in 2019. For well over a decade the annual "doc fix" was the legislative vehicle to attach Medicare revisions. Now that the "doc fix" has been "fixed" there is intense discussion as to what if anything will be the "replacement" legislative vehicle.

What health issues the Republican majority in Congress will pursue in 2016 remains a mystery. The fact that 2016 is not only an election year (all of the House of Representatives, one-third of the Senate) but a Presidential election year as well will have a major impact on the issues Congress will choose to address

Legislation

HR 2948– Medicare Telehealth Parity Act

By now, everyone is familiar with HR 2948, the Medicare Telehealth Parity bill that was re-introduced in early July by Reps. Mike Thompson [D-CA] and Gregg Harper [R-MS]. To recap the highlights, the bill is to be implemented in 3 phases, each 2 years apart. It expands telehealth sites to incorporate certain metropolitan areas, adds an inpidual's home as a telehealth site with respect to certain home health benefits, adds respiratory therapists as telehealth providers, adds respiratory therapy as a covered telehealth service, and covers remote patient monitoring (RPM) for certain chronic conditions that include COPD and heart disease (covered in first phase).

The new bill contained several revisions from the one that we saw in the last Congress. Mindful of cost issues, it covers RPM for a 90-day period (extensions are permissible if medically necessary) as long as it is included as part of Medicare's chronic care management services (in other words, a bundled payment). The revised bill covers RPM in incremental stages, with diabetes in the second phase and other conditions as determined by the Secretary in the third phase. It also adds store-and-forward technologies not currently covered by Medicare, expands access to evaluate/treat stroke patients, and allows telehealth to meet the home dialysis face-to-face requirement.

Kim Turner, AARC's new Legislative Director, has developed a strategic plan to advocate for HR 2948 over the coming year. Key goals include securing 50 House bill co-sponsors by June 2016, identifying key health care opinion leaders with experience in telemedicine to advocate for the bill, to work with House sponsors to seek Senate companion legislation, to organize a Hill briefing with a focus on telehealth, and to build a coalition of patient, provider and other interested groups to endorse the bill. We are excited to have her as part of the Government Affairs team and look forward to expanding our efforts to engage Congressional leaders in dialogue on the important role respiratory therapists play in the care of patients with chronic respiratory diseases.

Virtual Lobby Week and Virtual Lobby Week Reboot 2015

As we have done in years past, we launched our Virtual Lobby (VL) Week just prior to Hill Day. As you know, VL Week is a critical part of our run-up to Capitol Hill Advocacy Day and is designed to send as many e-mails as possible to the Hill to support our PACT representatives' Hill efforts and our legislative agenda. We had over 22,000 emails from supporters prior to our 2015 Hill Lobby Day. However at the time of our Hill Day, the Medicare Telehealth Parity bill had not yet been re-introduced in Congress. When it was re-introduced in mid-summer as HR 2948, AARC leadership decided to re-launch our VL Week in mid-July as a way to boost support for the bill and keep the RTs hand "visible" on the Hill. Between July 1 and this October we generated an additional 27, 000 messages to the Hill asking for support and co-sponsorship of the Telehealth Parity bill.

AARC Capitol Hill Lobby Day

The AARC held its 17th annual Capitol Hill Advocacy Day on March 18th. In addition to 120 respiratory therapists represented by 44 states and the District of Columbia, DC area RT students and patient advocates also joined in to lobby Congress on the importance of the Telehealth Parity bill. Members of the Allergy and Asthma Network and the COPD Foundation also attended our briefing day and supported AARC on Hill Day. The PACT reps scheduled over 300 Hill visits.

Plans for the 2016 are also well underway. Our Hill Day will be in April rather than March next year (date to be determined) and we will be advocating again for the Telehealth bill.

Other Legislative Initiatives

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

As noted earlier, the "doc fix" bill was signed into law by President Obama on April 16, 2015. In addition to repealing the Medicare sustainable growth rate, it strengthens Medicare access by establishing a new pay-for-performance payment system under Medicare's fee-for-service program called the Merit-based Incentive Payment System (MIPS). The new payment methodology will basically consolidate the existing quality reporting programs into one system that will be based on four categories: quality, resource use, meaningful use, and clinical practice improvement activities. It also provides a bonus payment to physicians if they derive a significant share of their revenue from an Alternative Payment Model (APM) such as Accountable Care Organizations.

During the June 2015 BOMA conference call, several physicians on the call asked that we provide additional written information about the new payment system so they could be better informed prior to our face-to-face meeting in Tampa. The American Medical Association has developed a list of Frequently Asked Questions and a discussion of myths and facts about the legislation. Rather than reinvent the wheel, we have attached the AMA's paper as part of our report.

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

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

Security Income (SSI) and Medicaid. It would make permanent a law enacted in 2010 and scheduled to sunset in October this year.

We are pleased to report that the bill was passed by the House on September 28, 2015 under suspension of the rules and at the time of this report the bill was headed to the President's desk for his signature.

21st Century Cures Act: HR 6

The full House passed this bill spearheaded by Reps. Fred Upton (R-MI) and Diana DeGette (D-CO) on July 10 by a vote of 344-77. It is now with the Senate committee of jurisdiction and has the support of 230 bipartisan co-sponsors (121D/109R) and over 700 groups. Although the bill provides for offsets, cost will remain a factor. As it is currently drafted, the Congressional Budget Office estimates it will increase expenditures over a 10-year period by approximately $100 billion.

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

Telehealth Enhancement Act: HR 2066

This bill, sponsored by Rep. Gregg Harper (R-MS) was reintroduced in the 114th Congress on April 28, 2015. To date it only has 5 co-sponsors. With all the other activities on the Hill that address telehealth issues, whether this bill moves forward remains to be seen. In addition to including coverage of telehealth and remote patient monitoring services as part of a national pilot program for bundled payments and as supplemental health benefits in Accountable Care Organizations, it also covers certain telehealth services for pregnant women under Medicaid. It does not contain language that would include respiratory therapists and other health care professionals as qualified telehealth practitioners.

Senate Bill to Address Telehealth Issues (Not Yet Introduced)

We received a copy of this bill (leaked to Politico – no name as yet) through the multi-stakeholder group of which AARC is one of many participates. The bill has been introduced at the time of this report. Co-sponsors include Senators Wicker (R-MS), Cochran (R-MS), Schatz (D-HI), and Thune (R-SD). Among other things, the bill would create a bridge payment to physicians for telehealth and RPM while they are in transition from the current payment system to value-based care, or MIPS. The bill was spearheaded by the Alliance for Connected Care. The American Medical Association also participated in discussions with Senate members during the drafting of the bill.

Senate Chronic Conditions Working Group

Senators Hatch (R-UT) and Wyden (D-OR) have established a bi-partisan Senate Finance Committee Working Group to explore solutions to improve the health outcomes of Medicare beneficiaries living with chronic conditions. The Working Group headed by Senators Isakson (R-GA) and Warner (D-VA) sought public input on a number of issues. Those of interest to AARC included ideas on how to effectively use telehealth and RPM technologies and options for empowering Medicare patients to play a great role in management their health and engaging their health care providers.

AARC submitted extensive comments supporting the Medicare Telehealth Parity Act and inclusion of respiratory therapists as telehealth providers and respiratory services as covered telehealth services. In addition, we advocated for separate payment for self-management education and training when furnished by respiratory therapists to pulmonary patients who often present with multiple chronic conditions. We understand that the Group plans to meet with those who have provided comments as they further investigate options for future legislation.

Regulations and Other Issues of Interest

Reform of Long-Term Care Facilities

As reported during the Joint BOD/HOD Session in July, CMS has proposed to add respiratory services as specialized rehabilitation services as part of its extensive reform of long-term care facilities. The facility would be able to furnish the services directly, or it could obtain the services from outside as long as the provider is a qualified Medicare/Medicaid provider of specialized services. The latter restriction is not new. A concern of AARC is whether respiratory therapists would be considered qualified providers if the service were contracted out. The question was raised to CMS staff during an open forum conference call who advised to put the question in writing to be addressed as part of the formal comment period. Comments were submitted to CMS in late August with the specific request that CMS address the issue and provide an answer in the final rule.

FDAs Proposal to Regulate E-Cigarettes and Other Tobacco Products

FDA's final rule to "deem" all categories of products that meet the statutory definition of "tobacco product" subject to its regulatory authority seems to be languishing in "Neverland." A discussion at the October Tobacco Partners meeting revealed that it has not made its way to the Office of Management and Budget and that it could be held up in the Secretary's office. Action before the end of the year is unlikely.

Ventilators

As discussed at the July meeting, Government Affairs is involved in ongoing issues regarding Medicare coverage of respiratory assist devices and noninvasive mechanical ventilation (NMV). To recap, the current local coverage determination is out of date and does not reflect changes in technologies that have taken place over the past decade. ICUs now use NMV in certain forms of acute respiratory failure; it is a relatively common component of post-acute care and techniques have gravitated to SNFs, long term care hospitals and the home.

Subsequent to the summer Board meeting, AARC and other pulmonary organizations (NAMDRC, ATS, and ACCP) met with CMS on July 21 to lay out current problems and to determine if a national coverage determination (NDC) was necessary. Payment classification categories and coding changes to take effect January 1, 2016 complicate matters. At the conclusion of the meeting, the pulmonary organizations agreed to develop a more comprehensive paper with a list of scientific studies to support changes in policy. The paper is expected to offer definitions of respiratory insufficiency/failure, mechanical ventilator and mechanical ventilation as these are not defined in current policy. The paper also will make specific coverage criteria recommendations for three distinct categories of mechanically ventilated patients. Additional verbal details will be provided at the November Board meeting.

Removal of National Coverage Decision (NCD) on Smoking Cessation

In 2013 CMS revised its process for removing NCDs that were older than 10 years from their most recent review. On September 30, 2013, CMS removed the national coverage decision (NCD) on Smoking and Tobacco-use Cessation Counseling that dates back to 2005. Not to be alarmed, the policy was subsequently revised in 2010 to provide counseling for inpiduals who use tobacco, regardless of whether they have signs or symptoms of a tobacco-related disease. The more recent preventive service policy remains and according to CMS better serves the needs of Medicare beneficiaries because it does not impose cost-sharing obligations.

Conclusion

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

Medicare Access and CHIP Reauthorization Act of 2015—H.R. 2

The American Medical Association and over 750 national and state-based physician and specialty organizations have gone on record in support of H.R. 2, the "Medicare Access and CHIP Reauthorization Act." Many physicians have questions about the major provisions of the legislation, and others have been disturbed by incomplete or incorrect interpretations of the bill's legislative language. Below are responses to frequently asked questions about the major provisions of H.R. 2 that will affect Medicare physician payments; following these FAQs are Myth-Fact clarifications to incorrect interpretations of the bill that have been widely circulated.

Frequently Asked Questions about H.R. 2

What are some of the key features of H.R. 2?

Many features of this bill represent improvements over current law. Some of the most important include the following:

• The sustainable growth rate (SGR) is permanently repealed, effective immediately.

• Positive payment updates of 0.5 percent are provided for four and a half years, through 2019.

• Physicians in alternative payment models (APMs) receive a 5 percent bonus from 2019 to 2024.

• In 2026 and beyond, physicians in APMs qualify for a 0.75 percent update; all others will receive a 0.25 percent annual update.

• The fee-for-service payment model is retained, and physician participation in APMs is entirely voluntary.

• Technical support is provided for smaller practices, funded at $20 million per year from 2016 to 2020, to help them participate in APMs or the new fee-for-service incentive program.

• Funding is provided for quality measure development, at $15 million per year from 2015 to 2019. Physicians retain their preeminent role in developing quality standards.

• Current quality incentive and payment programs are consolidated and streamlined, and the aggregate level of financial risk to practices from penalties has been mitigated in comparison to current law.

Are there provisions that the AMA opposes?

This is not the bill we would have written ourselves. There are still some things about the quality programs, for example, that we will continue working to improve. Nothing in this bill prevents us from advocating for future legislation. In fact, because the SGR and its accumulated debt are eliminated, future modifications will not face the same budgetary obstacles.

How does the legislation support transitions to APMs?

The bill provides incentives and a pathway for physicians to develop and participate in new models of health care delivery and payment. Physicians participating in patient-centered medical homes, widely recognized to lower costs of care, would not be required to assume downside financial risk. Other models would require some degree of downside risk in addition to the opportunities for increased revenues that many APMs provide if the physician practice generates savings. To encourage physicians to assume this risk, and to provide a financial cushion, the legislation provides 5 percent bonus payments from 2019 to 2024 for those who join new models. This provides a transition period to support successful implementation of new models. Another advantage is that physicians would only be subject to the quality reporting requirements for their APM; they would be exempt from the new Merit-based Incentive Payment System (MIPS) quality program described below. The bill also supports the use of telemedicine in new models of care and creates an advisory panel to consider physicians' proposals for new models.

What is the Merit-based Incentive Payment System or MIPS?

Beginning in 2019, H.R. 2 provides for bonuses ranging from 4 to 9 percent for physicians who score well in the MIPS, a new pay-for-performance program under the current Medicare fee-for-service payment system. The current matrix of penalties under the Physician Quality Reporting System (PQRS), Electronic Health Records/Meaningful Use (MU), and the value-based payment modifier (VBM), would end at the close of 2018. In 2019, the MIPS program would become the only Medicare quality reporting program. Performance under the MIPS would be based upon four categories: quality, resource use, meaningful use, and clinical practice improvement activities. These would build and improve upon the current quality measures and concepts in PQRS, MU, and VBM. Physicians are specifically encouraged to report quality measures through certified EHR Technology or qualified clinical data registries. Participation in a qualified clinical data registry would also count as a clinical practice improvement activity.

In many respects, the MIPS program would be more attainable for physicians than current quality programs. The MIPS program presents the first real opportunity for high-performing physicians to earn substantial bonuses, and for all physicians to avoid penalties if they meet prospectively-established quality thresholds. Several new aspects of the MIPS program support physicians scoring better, and receiving more credit for their efforts, than under current programs.

Would the MIPS do a better job of rewarding physicians for high quality performance than current programs?

Performance scoring under the MIPS program has several advantages over current quality programs:

• The MIPS does not employ the VBM's "tournament model" which requires both winners and losers, thereby potentially penalizing even-high performing physicians since someone has to be a loser. In the MIPS, if all physicians perform at or above the performance threshold, no one would get a penalty.

• Performance assessment under the MIPS program would be according to a "sliding scale"—versus the current "all or nothing" approaches used in PQRS and MU. Credit would be provided to those who partially meet the performance metrics.

• The bill has guidelines for the weighting of the four performance categories, yet specifically allows administrative flexibility for those in practices or specialties that are at a disadvantage in meeting quality or MU requirements.

• At the start of each performance period, physicians would know the threshold score for successful performance, and they would receive timely (such as quarterly) feedback on their individual performance.

• Physicians could receive substantial credit for clinical practice improvement activities and for improving (and achieving) quality of care.

• Physicians with a low level of Medicare claims, and those who are in APMs, would be exempt from the MIPS requirements and payment adjustments.

The MIPS also presents the first real opportunity for physicians to earn substantial bonuses for providing high quality of care. For exceeding the performance threshold, physicians could earn bonuses of up to: 4 percent in 2019; 5 percent in 2020; 7 percent in 2021; and 9 percent in 2022 and beyond. Additional funding is provided for exceptional performance, up to $500 million per year, from 2019 through 2024. So even if all physicians score above the threshold, some will still receive incentive payments. Unlike current law, the MIPS penalties provide greater certainty, and have a maximum range in future years.

Is H.R. 2 consistent with AMA policy on pay-for-performance?

The AMA has worked throughout the negotiations on this legislation to bring it more closely in line with our extensive policy on pay-for-performance. As a result of AMA advocacy, the pending legislation more closely aligns with our P4P policy than previous legislative proposals and is an improvement over current law.

Does the bill include any liability protection for physicians?

Yes, the bill contains a provision similar to the Standard of Care Protection Act. This will protect physicians by preventing quality program standards and measures (such as PQRS/MIPS) from being used as a standard or duty of care in medical liability cases.

How does the bill support chronic care management services?

H.R. 2 would require Medicare to reimburse, under at least one payment code, monthly care management services for inpiduals with chronic care needs. Payment would go to one professional practicing in a patient-centered medical home or comparable specialty practice certified by a recognized organization. No linkage is required to an annual wellness visit or initial preventive physician examination.

What does the bill say about the release of physician claims data?

Starting in 2014, CMS began to publicly release physician-identified Medicare claims data on an annual basis. The bill would continue to allow the public release of these data. The bill retains provisions that the AMA has supported that allow the sale of non-public data and analyses by Qualified Entities, with certain safeguards.

Does the bill address private contracting?

Physicians who choose to opt out of Medicare to engage in private contracting could elect to automatically renew their status; they would no longer be required to renew their opt-out status every two years. The bill also requires regular reporting about physicians who choose to opt out of Medicare.

Does H.R. 2 make any positive changes to the EHR Meaningful Use program?

The bill sets a target of achieving interoperability of electronic health records by the end of 2018. It also prohibits the deliberate blocking of information sharing.

Will Medicare's plans to eliminate the 10-day and 90-day global surgical service bundles be addressed?

The decision by the Centers for Medicare & Medicaid Services (CMS) to eliminate bundled payments for 10-day and 90-day global surgical services has been reversed; instead, CMS will collect data on these services beginning in 2017 to determine the accuracy of payment rates. These data will be collected from a sample of physicians, rather than from all who bill global surgical services. To encourage participation, a 5 percent payment withhold may be applied until the required data are submitted.

Myths and Facts about H.R. 2

Myth: H.R. 2 mandates physician participation in Maintenance of Certification (MOC).

False. Nothing in H.R. 2 mandates maintenance of certification, nor does it penalize physicians for not participating in MOC.

Myth: H.R. 2 requires MIPS quality standards to be based only on input from certification boards, such as the American Board of Internal Medicine (ABIM) or the American Board of Medical Specialties (ABMS).

False. Professional organizations defined by certification boards are only one of many stakeholders—including other physicians and physician groups—that can provide input on quality measures under the MIPS program. Under H.R. 2, the existing PQRS, MU, and VBM programs are streamlined into the MIPS program. Many of the MIPS quality measures will be based upon existing measures that are still considered valid and are currently used for PQRS, MU, VBM, and qualified clinical data registries. The bill would require the Secretary of Health and Human Services (HHS) to get input from a wide variety of stakeholders on the selection of quality measures, including "relevant eligible professional organizations and other relevant stakeholders, including State and national medical societies."

Furthermore, H.R. 2 lists "clinical or surgical checklists and practice assessments related to maintaining certification" (not the maintenance of certification itself) as just one of the examples of the type of clinical practice improvement activities for the required category of "patient safety and practice assessment" activities. However, there are five other categories to choose from, and the Secretary can add more categories, in consultation with "stakeholders."

Myth: H.R. 2 would eliminate fee-for-service completely.

False. Under H.R. 2, fee-for-service remains the basic, fundamental payment system for Medicare Part B services under the Physician Fee Schedule. H.R. 2 includes incentives and support for physicians to participate in new payment and delivery models, including $20 million per year

(from 2016-2020) in technical assistance funds for small practices to transition to new payment models or participate in the MIPS. But participation in these models is completely optional.

Myth: H.R. 2 sets a new requirement that the quality of physicians' care must be compared with the quality of care by non-physicians.

False. PQRS currently does not differentiate in its assessment of physicians and non-physicians, although all eligible professionals (EPs) are allowed to select their own quality measures. The same will be true for the MIPS program. The MIPS requirements will apply to a wide array of non-physicians—dentists, podiatrists, optometrists, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists—who are not currently subject to MU and VBM requirements. Both physician and non-physician EPs will be assessed against the same MIPS "performance threshold."

Myth: Section 507 of H.R. 2 allows the Secretary of Health and Human Services to punish physicians who opt out of Medicare.

False. The Secretary of HHS cannot selectively punish a physician because of his/her opt-out status.

Myth: Section 507 of H.R. 2 bans physicians who opt out of Medicare from writing prescriptions under the Part D program.

False. Under current regulations, physicians who opt out of the Medicare program can still write prescriptions under the Medicare Part D program for covered beneficiaries, assuming they have filed an opt-out affidavit as required under existing law. In general, most practicing physicians are required to have a valid National Provider Identifier (NPI)—a requirement that is not limited to those who participate in the Medicare program, but includes those who opt out as well.

The purpose of the NPI is to uniquely identify a health care provider in standard transactions, such as health care claims. NPIs may also be used to identify health care providers on prescriptions, in coordination of benefits between health plans, in patient medical record systems, in program integrity files, and in other ways. The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities, including physicians, use NPIs in standard transactions. There has been an ongoing concern that the NPIs placed on Part D pharmacy claims have included invalid NPI claims—these could include NPIs that do not actually correspond to the prescriber, are expired NPIs, or are NPIs for deceased physicians, for example. Section 507 is designed to ensure that NPIs are correct to prevent fraudulent use of an NPI in the case of identity theft or where a prescriber's other identification (DEA number, for example) does not correspond to the NPI.

Myth: H.R. 2 creates new authority for the government to place a levy on Medicare payments if providers are delinquent on their taxes.

False. The Federal Payment Levy Program (FPLP) was first authorized under the Taxpayer Relief Act of 1997. This law allows the government to collect overdue taxes through a levy on certain federal payments (e.g., federal employee retirement annuities, contractors/vendors doing business with the government, certain Social Security benefits), including Medicare provider and supplier payments. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 expanded the FPLP to include a levy against Medicare payments for non-tax debt. Under MIPPA, CMS could have reduced federal payments subject to the levy by 15 percent until the overdue taxes were paid in full, and could have reduced federal payments subject to a non-tax levy by 100 percent or the amount of the non-tax debt owed. The Tax Increase Prevention Act of 2014 made further

amendments to increase the levy rate from 15 percent to 30 percent on payments due to a Medicare provider or supplier for overdue taxes. H.R. 2 would increase the existing levy rate from 30 percent to 100 percent.

Visit www.ama-assn.org/go/medicarepayment for additional information and resources.

House of Delegates Report

Submitted by John Wilgis – Congress 2015

Recommendations

None

Report

- Continued working with the Executive Office, House Officers, House Committee Co-Chairs and Delegates to on house business.
- Revised House objectives, goals, strategies and charges document and committee calendar and disseminated documents to the House via AARConnect.
- Continued monthly conference calls with House Officers to share information and in support of House objectives, goals, strategies and charges.
- Held 3rd quarter conference call with House Committee Co-Chairs to share information and in support of House objectives, goals, strategies and charges.
- Participated in conference calls with President Salvatore, AARC leadership and liaisons to share information and collaborate House activity with AARC and AARC Board actions and plans.
- Represented the House at Daedalus meetings.
- Continued working with Immediate Past Speaker Skees on Military Liaison program and House recognition and participation.
- Worked with Immediate Speaker Elect Grimball to assist in determining Speaker Goals for 2016.
- Worked with the House Officers and the House Liaisons to determine Officer obligations and expectations for spring Board of Directors, summer and winter meetings.
- Continued serving as co-chair on the Ad Hoc Committee on Advanced RT Practices, Credentialing and Education.
- Continued working with the Executive Office, House Officers and the Delegate Assistance Committee to refine affiliate information sharing requirements, affiliate responsibilities as a non-profit organization and create a mechanism of assistance and resource information for affiliate use.
- Shared House approved Bylaws Amendments from summer meeting with President Salvatore and the AARC Bylaws Committee Co-Chairs.
- Shared House recommended Bylaws Amendments from the summer meeting with President Salvatore and the AARC Bylaws Committee Co-Chairs.
- Reviewed information for the selection of students participating in the winter House and Board of Directors meetings.

- Reviewed information for delegate assistance and attendance at the winter House meeting.
- Reviewed information from the Chartered Affiliate / Special Recognition and Volunteering and Mentoring Committees as related to awards presented by the House.
- Selected Delegate of the Year candidate.
- Continued serving as a work group member with AARC Board Members Diane Lewis, Bill Lamb and Garry Wickman to review AARC Strategic Goal # 8 “Assure the Association has the resources to meet the mission and strategic goals of the organization” and make recommendations to each strategy under the goal for effectiveness.
- Advised and assisted House Committees as requested.
- Provided quarterly progress reports to the House.

I owe a debt of gratitude to the Executive Office, Board of Directors and other House Officers who have all been a tremendous resource and network of support over the past year. I also want to acknowledge all of the House Committee Co-Chairs for their on-going hard work and dedication to their responsibilities. We have accomplished a lot this year! Thanks also to the members of the House for the support, collaboration, and teamwork. You all have made my role as Speaker a rewarding experience. Thanks to all!

Board of Medical Advisors Report

Submitted by Dr. Steve Boas – Congress 2015

A verbal report will be given by Dr. Boas at the meeting.

President`s Council

Submitted by Dianne Lewis – Congress 2015

Recommendations

That the AARC BOD approves the revisions to BOD Policy.001. (see attached and below)

That the AARC BOD approves the revisions to Attachment D-AARC Awards Guidelines.

Justification: All three awards that the Presidents Council oversees are setup in a similar format. All identify who can nominate, criteria for each and how the selection occurs, and how winners are notified.

That the AARC BOD approves the revisions to AARC Bylaws Article IX-Presidents Council.

Justification: There are members of the Presidents Council who have not served as AARC President. There is no mechanism in place in the event of a vacancy in the Chair of the Council.

Report

I am happy to announce the new Life and Honorary members of the AARC. The new Life member is Fred Hill, MA, RRT, CPRT and the new Honorary member is Kris Kuykendall.

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Awards**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: April 2010

DATE REVISED: 2015

REFERENCES: AARC Bylaws

Policy Statement:

Policy Amplification:

1. The AARC Executive Committee shall serve as the central clearinghouse and review body for newly established AARC awards and/or major revision of currently existing awards.

2. The Board of Directors shall be responsible for:

   A. Submitting nominations for AARC Life and Honorary membership awards to the Presidents Council.

   B. Submitting nominations for certain awards for related organizations such as the American Respiratory Care Foundation (ARCF)

   C. Submitting nominations for the Legends of Respiratory Care award.

DEFINITIONS:

ATTACHMENT D - AARC AWARD GUIDELINES

Life Membership

1. Nominations for Life Membership are solicited from the AARC BOD and HOD.
2. The HOD and the BOD may each submit one (1) nominee for Life membership.
3. Candidates for Life membership must:
   - be and have been an active member (one who has the right to vote and hold office) of the AARC for a period of at least fifteen (15) years.
   - have served in the AARC in an official capacity, i.e., national officer, Board member, committee chair or member, House of Delegates, etc., for at least seven (7) years, not necessarily consecutively.
   - have made an extraordinary contribution to the AARC and its affiliates.
   - have been active in affiliate operations and have served in an official capacity at the affiliate level.
4. By the established deadline, each nomination must be accompanied by a summary detailing the nominee's service and contributions to the AARC and its affiliates.
5. The materials will be distributed electronically to the members of the Presidents Council for their review and vote.
6. The individual receiving the highest number of votes cast for Life membership will be awarded Life Membership. In the event of a tie, the Chair of the Presidents Council will cast the deciding vote.
7. The Chair of the Presidents Council will notify the individual of his/her selection.
8. Life membership will automatically be awarded to the AARC Past President upon completion of his/her term.
9. The new Life Member(s) will be recognized during the Awards Ceremony at the AARC Congress and invited to attend the Presidents Council Luncheon.
10. Registration fees are waived for Life Members for the AARC Congress, Summer Forum, and live webcasts.

Honorary Membership

1. Nominations for Honorary Membership are solicited from the AARC BOD and HOD.
2. The HOD and BOD may each submit one (1) nominee for Honorary Membership.
3. Candidates for Honorary Membership must:
   - have been active in AARC affairs for a period of at least ten (10) years or worked in a field related to the goals of the Association for at least ten (10) years.
   - otherwise be eligible for associate membership in the AARC at the time of consideration.
   - have made a special achievement or contribution to the AARC, its affiliates, or the profession of respiratory care.

4. By the established deadline, each nomination must be accompanied by a summary detailing the nominee's service and contributions to the AARC.
5. The materials will be distributed electronically to the members of the Presidents Council for their review and vote.
6. The individual receiving the highest number of votes cast will be selected to receive honorary membership that year. In the event of a tie, the Chair of the Presidents Council will cast the deciding vote.
7. The Chair of the Presidents Council will notify the individual of his/her selection.

8. The new Honorary Member will be recognized during the Awards Ceremony at the AARC Congress and invited to attend the Presidents Council Luncheon.
9. Registration fees are waived for Honorary Members for the AARC Congress, Summer Forum, and live webcasts.

Jimmy A. Young Medal

1. The Jimmy A Young Medal is the highest award bestowed by the AARC.
2. Immediately following the annual meeting of the Presidents Council, the Chair of the Council shall issue an electronic call to the council for nominations for the Jimmy A Young Medal (JAY), inclusive of the selection criteria and a roster of past recipients.
3. Candidates for the Jimmy A. Young Medal must:
    - have an outstanding record of contributions to the AARC vision of professional excellence, advancement of the science and practice of respiratory care, and service as an advocate for patients, their families, the public, the profession and the respiratory therapist that are well above the usual commitment of time, efforts, or material goods.
4. Members of the Presidents Council will have ninety (90) days from the date of the call for nominations to submit nominations for the JAY Medal for the coming year. Each nomination must be submitted in a formal letter/memorandum detailing the nominee's achievements and contributions. A current C-V of the nominee must accompany each nomination and be submitted electronically to the Chair of the JAY Selection Committee within the ninety (90) day period.
5. The Chair of the Presidents Council shall appoint the JAY Selection Committee. The Selection Committee shall be comprised of five (5) members of the Presidents Council who are also past recipients of the JAY Medal. The chair of the JAY Selection Committee will be elected by members of the Selection Committee and shall serve a two (2) year term. Subsequent terms of both members and chair of the Selection Committee shall serve at the pleasure of the Chair of the Presidents Council.
6. Upon the close of receipt of nominations, all nominations and supporting documents will be distributed to each member of the JAY Selection Committee for review and full consideration. Within seven (7) days of distribution of all documents, the Chair of the JAY Selection Committee will conduct a conference call with members of the Selection Committee to discuss and determine the best-qualified nominee
7. Once a recipient has been selected, the Chair of the Selection Committee will then notify the full Presidents Council electronically of the recommendation of the Selection Committee and ask for consent for the nominee so selected. Members of the Council will have five (5) days to notify the Chair of their support for the recommended nominee.
8. Once majority consent is received, the Chair of the Selection Committee will notify the Chair of the Presidents Council who, in turn, will contact the selected nominee via telephone and inform the individual of his/her selection.
9. Once the recipient has been notified, the Chair of the Selection Committee will then notify the Editor of ***AARCTimes*** and the AARC Director of Membership of the new JAY Medal recipient to facilitate proper publicity and inclusion into the Award Ceremony to be held during the AARC's next Annual Congress.
10. The recipient of the JAY Medal will be invited to the next Presidents Council meeting for acknowledgement and congratulatory sentiments.

Current Bylaws
ARTICLE IX- PRESIDENTS COUNCIL

a. The Presidents Council shall be composed of Past Presidents of the Association who have been elected to membership in the Council.
b. The Presidents Council shall serve as an advisory body to the Board of Directors and perform other duties assigned by the Board of Directors.
c. The Presidents Council shall elect a Chair from its membership to serve a one-year term beginning immediately following the Annual Business Meeting.
d. The Chair of the Presidents Council shall serve as a non-voting member of the Board of Directors and preside at meetings of the Presidents Council.
e. The Presidents Council shall meet annually following the Annual Business meeting of the Association.
f. The Presidents Council may appoint committees as necessary to complete its duties.
g. In the event of a vacancy in the Chair, the vacancy shall be filled according to the procedure defined by the Association.

Proposed Revisions
ARTICLE IX- PRESIDENTS COUNCIL

a. The Presidents Council shall be composed of Past Presidents of the Association and individuals who have been elected to membership in the Council.
b. The Presidents Council shall serve as an advisory body to the Board of Directors and perform other duties assigned by the Board of Directors, including, but not limited to selection of the Jimmy A. Young Medalists, life membership, and honorary membership.
c. The Presidents Council shall elect a Chair from its membership to serve a one-year term beginning immediately following the Annual Business Meeting.
d. The Chair of the Presidents Council shall serve as a non-voting member of the Board of Directors and preside at meetings of the Presidents Council.
e. The Presidents Council shall meet annually following the Annual Business meeting of the Association.
f. The Presidents Council may appoint committees as necessary to complete its duties.
g. In the event of a vacancy in the Chair, the ~~vacancy shall be filled according to the procedure defined by the Association~~ AARC President will appoint a Council member to serve the duration of the term.

Standing Committee Reports

Audit Sub-Committee

Submitted by Jakki Grimball– Congress 2015

Recommendations

None

Report

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

The Audit Sub-Committee is prepared to participate in the Finance Committee meeting in November in Tampa, Florida.

Bylaws Committee

Submitted by Troy Whitaker – Congress 2015

Recommendations

That the AARC Board of Directors find that the Texas Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (see attachment "TSRC Bylaws Proposed Change 2 Year Term")

That the AARC Board of Directors find that the Connecticut Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (see attachment "Bylaws of the Connecticut Society for Respiratory Care Final Revision February 2015")

That the AARC Board of Directors considers developing a more formal onboarding/orientation program for new committee chairs.

Justification: The main purpose of this onboarding program would be to help these new leaders make the most out of their new roles by not only informing them of their expected responsibilities, but also engaging them early on in their tenure to make them aware of the resources and support available to help them hit the ground running and to be successful. This more formal orientation program should not only help the individual, but also the AARC be more cohesive and successful as an organization.

That the AARC Board of Directors considers a future amendment to the Bylaws that will prevent conflicting versions of Bylaws revisions to be under consideration at the same time.
(For example, we should not have one version of a proposed Bylaw amendment under consideration in a first reading, while another version of a proposed amendment to the same Bylaw is being considered in a second reading at the same meeting.)

Report

Throughout the review process, the AARC Bylaws Committee considered the implications of all recommended Bylaws changes to both the respective affiliates and the AARC and has determined that the changes to the Texas and Connecticut Bylaws are appropriate and are not in conflict. Potential conflicts with affiliates Bylaws changes were considered and were determined to be consistent with the AARC Bylaws and established requirements. The AARC Bylaws Committee has therefore approved and submitted the Connecticut and Texas Bylaws amendments for review by the Board of Directors.

There are three (3) remaining state affiliates that are due for Bylaws review this year that have yet to submit their Bylaws to the Bylaws Committee as follows: Idaho, Maryland-DC and Oregon. The Bylaws Committee has previously reached out to those states to inform them. As the chair, I personally will reach out to their state delegations at the meetings in Tampa next month and will encourage them to get their bylaws submitted for review as soon as possible. As for next year

(2016), there are several states – fourteen - that are due for bylaws review. The Bylaws Committee has contacted those states as well to give them early notice with a suggestion to consider submitting their bylaws as early as possible. I will also personally remind each of these state delegations in person in Tampa next month. As states affiliates are due for Bylaws review each 5 years, I have maintained an updated list of which states are due and at what interval (see chart below).

There are six (6) proposed bylaws amendments that are due for their second reading in Tampa next month. I am planning to conduct the second reading during a Joint Session at the House of Delegates (HOD) meeting on November 5th in Tampa. These were sent out for public comment and I received back five (5) emailed responses from AARC members. I have included those responses for review in a separate document (see below)

The AARC Bylaws Committee has also received back revisions of three (3) proposed amendments submitted from the HOD Bylaws Committee / House Leadership for revision. These are amendments that were approved by the Bylaws Committee and BOD, but that the HOD has revised and sent back to the Bylaws Committee for review and approval. While the Bylaws Committee members have individually reviewed these latest revisions, we have not yet had the opportunity to meet and discuss and vote on these revised amendments. We have attempted to meet via conference call twice already on this, but have not had enough participation to warrant a discussion and vote. I am attempting to schedule another Bylaws Committee meeting to discuss this before we meet in Tampa next month. Therefore, I have not included the aforementioned three (3) Bylaws amendments in this report to the BOD and these will likely be held over until at least the next report in April 2016. (NOTE: There is a potential Bylaws versioning issue here that I allude to in Recommendation #4 above.) We are currently in the process of attempting to reschedule a conference call to deliberate over these three (3) revised amendments as a committee before these can be voted on, and if approved, submitted the BOD for review and approval as the Bylaws require. If this occurs, I will be available to give a verbal update at the next BOD meeting in Tampa.

Other

We had a challenging year. I would like to thank the AARC Bylaws Committee members for their input and involvement in the committee this year.

State	AARC BOD approves	Next review due
Alabama	Approved Nov-12	2017
Alaska	Approved Apr-12	2017
Arizona	Approved Apr-14	2019
Arkansas	Approved Dec-14	2019
California	Approved Nov-13	2018
Colorado	Approved Apr-11	2016
Connecticut	Pending Approval Nov-15	2020
Delaware	Approved Jul-11	2016
Florida	Approved Dec-14	2019
Georgia	Approved Jul-13	2018
Hawaii	Approved Nov-11	2016
Idaho	Approved Dec-10	2015
Illinois	Approved Nov-11	2016
Indiana	Approved Apr-15	2020
Iowa	Approved Nov-12	2017
Kansas	Aproved Jul-11	2016
Kentucky	Approved Jul-11	2016
Louisiana	Aproved Jul-14	2019
Maine	Approved Nov-12	2017
Maryland-DC	Approved Dec-10	2015
Massachusetts	Approved Apr-14	2019
Michigan	Approved Apr-12	2017
Minnesota	Approved	2017

	Jul-12	
Mississippi	Approved Nov-12	2017
Missouri	Approved Nov-11	2016
Montana	Approved Apr-11	2016
Nebraska	Approved Nov-12	2017
Nevada	Approved Jul-12	2017
New Jersey	Approved Nov-11	2016
New Mexico	Approved Apr-11	2016
New York	Approved Jul-13	2018
North Carolina	Approved Apr-11	2016
North Dakota	Approved Jul-13	2018
Ohio	Approved Apr-11	2016
Oklahoma	Approved Nov-11	2016
Oregon	Approved Dec-10	2015
Pennsylvania	Approved Jul-15	2020
Puerto Rico	Approved Nov-12	2017
Rhode Island	Approved Nov-12	2017
South Carolina	Approved Nov-12	2017
South Dakota	Approved Jul-14	2019
Tennessee	Approved Nov-12	2017
Texas	Pending Approval Nov-15	2020
Utah	Approved Nov-12	2017
Vermont-NH	Approved Nov-11	2016
Virginia	Approved Jul-12	2017

Washington	Approved Jul-12	2017
West Virginia	Approved Jul-15	2020
Wisconsin	Approved Apr-14	2019
Wyoming	Approved Nov-12	2017

Overdue or Due in 2015
Due in 2016
BOD Approved/Pending Approval in 2015

Responses from AARC Members on proposed Bylaws Changes

Below are a handful of emailed responses from AARC Members regarding some of the (6) proposed Bylaws Changes that are due for a second reading in Tampa in November 2015. I have referenced these responses in my report to the AARC Board of Directors (BOD), which are copied below for consideration.

RESPONSE 1

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

1. The committee shall be composed of five (5) Active Members; three (3) elected by the House of

Delegates and two one (1) elected by the Board of Directors, and the seated Past President. The

Chair shall be selected by the House of Delegates.

Picky I know, but I would place a comma after the Board of Directors to prevent confusion that both the Board of Directors and the seated Past President are not doing the election of one member of the committee.

RESPONSE 2

Good morning Troy,

In the proposed amendments to the AARC bylaws I noticed the following:

The Vice President for Internal Affairs shall serve as a liaison to the ~~Chartered Affiliates~~, …

This made me wonder who would actually be considered a liaison to the Chartered Affiliates? Thanks!

RESPONSE 3

So how does BOMA feel about the change in their oversight and approval duties? Apparently, this simply makes them an advisory board with little more than voice. I agree with the change but just want to know how this is seen by BOMA.

As to the Internal and External VPs roles, except for the IVP taking the role of the PE, they are the same. Was any thought given to renaming the positions and have one as VP and the other Executive VP? The original vision, as I saw it when we developed these roles, was the EVP was a role where the person could track to the IVP hopefully on the way to PE. I know it hasn't necessarily worked that way from what I have seen. I would rather see a title difference. There seems to be no reason that one or the other shouldn't take the PE slot if the PE could not perform their duties.

RESPONSE 4

Number one should say " …three (3) elected by the House of Delegates, ~~and two~~ one (1) elected by the Board of Directors and the seated Past President. "

Get rid of that and. :)

RESPONSE 5

Thanks for the opportunity to review and comment on the proposed amendments. I believe the changes make sense and support them.

Elections Committee

Submitted by: Jim Lanoha – Congress 2015

Recommendations

None

Report

The slate of nominees approved by the BOD at the Summer meeting was submitted to the membership for vote. The ballot count was made, and the results were certified by Jim Lanoha, AARC Elections Chair, verified by Frank Salvatore, AARC President, George Gaebler, AARC Past President, and attested by Sherry Milligan, AARC Elections Liaison.

THIS IS TO CERTIFY that a count was made of the 2016 general election ballots for AARC Officers and Directors at Large on October 1, 2015. The following is certified as the official count:

OFFICERS	VOTES / %
President-Elect	
Sheri Tooley, BSRT, RRT-NPS,CPFT,AE-C, FAARC	1096/33.85%
Brian Walsh, MBA, RRT-NPS,RRT-ACCS, AE-C, RPFT, FAARC	2120/65.47%

Write-in candidates for Officers received no more than _2_ vote(s) each.

Brian Walsh was elected President-Elect with 2120 votes

DIRECTORS AT LARGE	VOTES / %
Carl Hinkson, MS, RRT-ACCS, NPS, FAARC	1272/39.86%
John Lindsey, MEd, RRT-NPS, FAARC	1370/42.93%
Thomas Malinowski, MSc, RRT, FAARC	1161/36.38%
Doug McIntyre, MS, RRT, FAARC	1666/52.21%
Raymond Pisani, BS, RRT-NPS, FAARC	831/26.04%
Debra Skees, MBA, RRT, CPFT	1696/53.15%
Pattie Stefans, BS, RRT	1275/39.96%
Gary Wickman, BA, RRT, FAARC	1152/36.10%

Write-in candidates for Directors received no more than _4_ vote(s) each

The following were elected Director at Large for a 3 year term

John Lindsey was elected with 1370 votes

Doug McIntyre was elected with 1666 votes

Debra Skees was elected with 1696 votes

Pattie Stefans was elected with 1275 votes

Home Care Section	VOTES/%
Zachary Gantt, RRT	64/59.26%
Debra Schuessler, CRT	43/39.81%

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

Zachary Gantt was elected as Chair Elect for Home Care Section with 64 votes

Neonatal/Pediatrics Section

Bradley Kuch, MHA, RRT-NPS, FAARC	111/41.73%
Steve Sittig, RRT-NPS, C-NPT, FAARC	148/55.64%

Write-in candidates for Neonatal/Pediatrics Section received no more than _1_ vote(s) each

Steve Sittig was elected Chair Elect for Neonatal/Pediatrics Section with 148 votes

Sleep Section

Marilyn Barclay, BSRC, RRT, CPFT, RPSGT	93/80.87%
Jessica Schweller, MS, RRT, RN, CNP	22/19.13%.

Write-in candidates for Sleep Section received no more than _No_ vote(s) each

Marilyn Barclay was elected Chair-Elect for Sleep Section with 93 votes

Other:

I would like to thank the members of the Elections Committee for their hard work and due diligence in considering this year's nominees. Committee members include Dan Rowley, Mary Roth, John Hiser and George Gaebler. I would like to also give special thanks to Sherry Milligan, Tim Myers, and Beth Binkley at the Executive office for their assistance and guidance.

Executive Committee Report

Submitted by: Frank Salvatore – Congress 2015

Verbal report at meeting.

Finance Committee Report

Submitted by: Frank Salvatore – Congress 2015

Verbal report at meeting.

Judicial Committee

Submitted by Anthony DeWitt – Congress 2015

Recommendations

None

Report

The committee has been tasked to provide some policy guidance. At present the interim guidance provided has been requested to be clarified. That process is ongoing and will be formalized upon completion.

No disciplinary matters have been reported, and none are pending.

Program Committee

Submitted by Ira Cheifetz – Congress 2015

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 2015: The 61st International Respiratory Convention & Exhibition will take place Nov. 7-10, 2015 in Tampa, FL. The Program is currently posted on-line and in hard copy in the Sept. edition of the AARC Times.

• Mr. Patrick Reynolds (of the RJ Reynolds family), a tobacco-free advocate will deliver the keynote address.

• We will offer more than 220 presentations covering all aspects of Respiratory Care and other healthcare related topics.

CRCE by Content Category

- Adult Acute Care: 22.62
- Management: 16.24
- Neo/Peds: 21.46
- Sleep: 13.34
- Education: 8.7
- Clinical Practice: 43.0
- Pulmonary Function: 9.86
- Patient Safety: 4.06
- BioTerrorism/Emergency Preparedness: 1.74
- Ethics: 2.9

OPEN FORUM

More than 275 abstracts are scheduled for presentation during 12 Open Forum sessions.

Three presentation methodologies will be incorporates in the Open Forum - Posters Only, Traditional Format and Editor's Choice. Posters only will **not** include an oral presentation of the study design. Authors will stand by their posters in the Exhibit Hall and answer questions to attendees. The Editorial Board from RESPIRATORY CARE has selected what they believe to be the 11 best abstracts submitted. These will be prominently displayed at the entrance of the exhibit hall, after which the 11 selected authors will present their findings with a 8-minute Q&A session and slide deck.

• Expounding upon the success of the previous two year's 30-minute presentations, this year's delivery model will also be 30-minute (for most all sessions) followed by a mandatory 5-minute Q&A session.

• AARC Congress 2015 will conclude with a closing ceremony featuring United States' Olympian; Amy Van Dyken. Ms. Van Dyken has suffered from asthma her entire life and she will discuss the role of the respiratory therapist in her care. She will also share her favorite Olympic stories and her horrific ATV accident last year that severed her spinal cord.

• 3 Pre-courses: Mechanical Ventilation (Adult & Pediatric), Vascular Access Workshop and Chronic Hypoxemia; Managing the Patient Across the Continuum.

• Dale Needham MD will deliver this year's Thomas L. Petty Memorial Lecture titled; "Surviving the ICU: Taking a Step Back into the Future". This presentation will discuss the importance of early ambulation in the ICU…even for mechanically ventilated patients.

• Charles Durbin MD will deliver the Donald F. Egan Scientific Memorial Lecture titled; "Monitors: Improving Safety or Increasing Risk?" This presentation will discuss the importance of physiologic monitoring (and its limitations) as well as the understanding of knowing what the monitor is telling us (and how to react).

• Nathan Cobb MD will present the Phil Kittredge Memorial Lecture. This lecture will discuss the evidence (and potential role) of using eCigarettes in the treatment of tobacco cessation.

Exhibit Hall hours

Tuesday: 11:00 am – 4:00 pm

Wednesday: 9:30 am – 3:00 pm

Thursday: 9:30 am – 2:00 pm

The AARC will continue to sell exhibit space to participating exhibitors for AARC Congress 2016 as well as allow them to select preferred locations. Exhibits Coordinator; Annette Phillips will meet privately with more than half of this year's exhibitors to transact booth purchases and space locations for next year's show.

Sputum Bowl (sponsored by Medtronic)

• 12 Practitioner Teams and 25 Student Teams will compete. We are noticing a concerning trend that Practitioner Teams are decreasing in size year after year (despite the addition of "Renegade" teams for 2014). The number of participating teams remains static from 2014, however this is a concern the Program Committee will closely evaluate this during our 206 meeting in Jan. and make appropriate recommendations to the BOD as necessary.

• In an effort to maximize attendance, this year's competition will begin at 5:15pm. We saw success in doing this in 2014 and hope for the same results in 2015. Complimentary light appetizers will be served in addition to an open bar during the Finals' matches. It is the hope that the earlier start time will increase attendance so that attendees may still have time for dinner afterwards.

• A comedian will entertain attendees during halftime as has been customarily been done in the past.

2016 Meetings

• Proposals are currently being accepted for the 2016 Summer Forum and AARC Congress 2016.

• OPEN FORUM proposals will still be submitted through Easy Street.

• Ira Cheifetz, MD will serve as the Chair of the Program Committee again in 2016 with a succession plan of Tom Lamphere as chair-elect. New committee members are still being identified at the time of this writing, but a submission of candidates will be made available for ratification for the BOD meeting on Nov. 10.

• The Program Committee will meet in late January/early February in Dallas, TX to begin planning for next year's SF and AARC Congress

• The 2016 Summer Forum will be held in Ponte Vedra Beach, FL from June 26-28, 2016

•AARC Congress 2016 which will take place in San Antonio, TX from Oct. 15 – 18, 2016

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

Strategic Planning Committee

Submitted by George Gaebler – Congress 2015

Recommendations

None

Report

The Strategic Planning Committee will continue in our group activities at the AARC BOD Meetings. It is fully expected that more recommendations will occur with enhancements and strategic plan changes adopted during the meeting.

The strategic workgroups will give updates during the meeting.

Specialty Section Reports

Adult Acute Care Section

Submitted by Keith Lamb – Congress 2015

Recommendations

None

Report

The section continues to use Connect to discuss case reports, imaging and current trends in patient care and science

Continue to produce bulletins and newsletters.

Continuing Care-Rehabilitation Section

Submitted by Gerilynn Connors – Congress 2015

No report submitted as of October 21.

Diagnostics Section

Submitted by Katrina Hynes – Congress 2015

Recommendations

None

Report

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section's members. Proposals must be received by the deadline in Jan 2015.
    a. *Charge met; details reported in last quarter's report.*

2. In cooperation with Executive Office staff, plan and produce four section bulletins, at least one Section Specific thematic web cast/chat, and 1-2 web-based section meetings. Documentation of such a meeting shall be reported in the April 2015 Board Report.
    a. *Section Bulletin – the 2015 fall bulletin has been completed and is available to the membership. Authors for the winter bulletin have been recruited. Quarterly Bulletin deadlines: Winter Issue: December 1; Spring Issue: March 1; Summer Issue: June 1; Fall Issue: September 1.*
    b. *Section Specific web cast/chat – webcast topics and prospective speakers have been discussed with Ms. Strickland, Associate Executive Director - Education. Efforts are being made to coordinate a webcast for January 2016.*
    c. *1-2 web-based Section meetings – communication has been made by the Chair with Ms. Shawna Strickland, Associate Executive Director – Education regarding the logistics of setting up a web-based meeting. An official web-based meeting agenda and date has not been determined.*

3. Undertake efforts to demonstrate value of section membership, thus encouraging membership growth.
    a. *2015 Pulmonary Function Laboratory: Advanced Concepts (part 1) course presented September 22, 2015 by Gregg Ruppel, Renato Galindo and Jeff Haynes – 2.5 continuing respiratory care education hours. Part II course seminar date is to be determined. The speakers and topics have been identified. Recordings are in progress.*
    b. *2015 Pulmonary Function Technology: Pediatrics course presented July 8, 2015 by Deborah White, RRT, RPFT, AE-C – 4.5 continuing respiratory care education hours.*
    c. *AARC Blood Gas Survey posted to the membership June 2015 in response to active communication regarding laboratory surveyors who are citing labs due to a new interpretation of the personnel qualifications via the CLIA 88 regulations. 180 members participated in the survey.*
    d. *Ongoing communication by the Section Chair with Section membership and recruit prospects is made to promote and advocate the value of the AARC membership as a tool to share knowledge, professional growth and development, and keep abreast of up-to-date technology, standards and guidelines.*

e. *As a team, the Section Chair and Bulletin Editor are relentless in seeking out new talents through AARConnect List Serve interactions, or via warm-chatter during the International Congress, to author quarterly Section Bulletin articles. These efforts engage our membership and encourage future professional interactions.*

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

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

6. Review all materials posted in the AARC Connect library or swap shops for their continued relevance. Provide a calendar of when the reviews will occur to be reported in the April 2015 Board Report and updated for each Board report.
    a. *Pages 1-5 of materials posted in the AARC Connect library and swap shops were reviewed. Recommendations to remove several old posts were communicated to Mr. Steve Nelson, Diagnostic Section Liaison. An update on progress made has not been received by the Chair.*
    b. *Pages 6-8 have been reviewed; posted materials remain appropriate and relevant resources for the membership.*

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

Other

Action Item:

1. Upon review of the resources and links provided on the Diagnostic Section webpage, great strides have been made. The following webpage deficiencies have been noted and brought to the attention of Mr. Steve Nelson, Diagnostic Section Liaison.
    a. *Updates to the "Diagnostic Section Resource List" are in progress. All updated information will be communicated to the appropriate personnel to be uploaded to the site.*
    b. *The following links are inaccessible under the Respiratory Diagnostics Online Resources: Kansas University Medical Center Physiology Page, National Committee for Clinical Laboratory Standards and Respiratory Therapy Encyclopedia.*
    c. *The last Section Newsletter, found under the Respiratory Diagnostics Section Newsletter, is June 2014; 2015 archived files have not been uploaded and available to the membership.*

Diagnostic Professional Representation:

1. Mrs. Katrina Hynes was nominated for AARC Alternate Representative to the Joint Commission Professional and Technical Advisory Committee (PTAC) for laboratory and ambulatory services by Mr. Frank R. Salvatore Jr., RRT, MBA, FAARC.
2. Mr. Matthew O'Brien MS RRT RPFT is awarded 2015 SPOY to be announced at the 2015 AARC International Congress in Tampa, FL.
3. Mr. Carl Mottram RRT FAARC, Director of the Pulmonary Function Laboratories and Associate Professor of Medicine at the Mayo Clinic was elected as Treasurer and Executive Committee Member of the Board for the Clinical and Laboratory Standards Institute for an additional term.
4. Mr. Carl Mottram RRT FAARC, Director of the Pulmonary Function Laboratories and Associate Professor of Medicine at the Mayo Clinic was nominated President – Elect of the Clinical and Laboratory Standards Institute
5. Mr. Carl Mottram RRT RPFT FAARC and Mr. Greg Ruppel RRT RPFT FAARC have been requested to serve on the newly formed ATS – PF Laboratory Accreditation Committee.
6. Mr. Jack Wanger MS RRT, Independent Consult continues to serve on the ATS Pulmonary Function Standards Committee and is currently working on their updated guideline on Bronchoprovocation Testing.

Education Section

Submitted by Ellen Becker – Congress 2015

Recommendations

None

Report

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

2. In cooperation with Executive Office staff, plan and produce four section bulletins, at least one Section Specific thematic web cast/chat, and 1-2 web-based section meetings. Documentation of such a meeting shall be reported in the April 2015 Board Report
   Status: As reported at the Board of Directors meeting in July 2015, the section chairs will be responsible for arranging or leading a quarterly engagement activity for their section membership rather than publish quarterly section bulletins. On September 1, there was a webcast directed towards hospital-based educators, *"Applying Simulation to Stay on the Leading Edge*." A web-based section meeting was held in March 2015. To enhance engagement, a second round of the Education Book Club was initiated in September. Survey results indicated that 23 individuals participated in the original book club and another 29 individuals provided survey feedback. Ninety three percent of participants felt that the original book was appropriate for their needs and gained new ideas for their teaching. The survey participants recommended, "*Making it Stick"* for the fall book club. Eight chapter discussion leaders for fall have been recruited, of which five are new.
   A second engagement activity involved initiating research networking opportunities for educators within the Research Roundtable. The increased number of educators with graduate degrees and those holding academic positions prompted greater interest in educational research mentorship. The results of a survey were used to develop a program in partnership with the Research Roundtable that supports education researchers.

3. Undertake efforts to demonstrate the value of section membership, thus encouraging membership growth.
   Status: As stated above, initiatives to share education strategies and develop research skills were initiated in the last quarter.

4. Identify, cultivate, and mentor new section leadership.
   Status: No work on this goal was initiated. Emerging leaders will be approached at the International Congress to encourage interest.

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

Status: Education section members have been regularly posting on the section's listserve. Updated information for the Education Section webpage was posted for the Resource Directory, Education Scholarship papers, Education Section Newsletters, and Specialty Practitioner of the Year.

6. Review all materials posted in the AARC Connect library or swap shops for their continued relevance. Provide a calendar of when the reviews will occur to be reported in the April 2015 Board Report and updated for each Board report.
Status: Two teams of section volunteers who were recruited at the Summer Forum meeting to update the AARC Connect library and the Swap Shop on the Education Section webpage. Brian Cayko is chairing the sub-committee for the AARC Connect library and David Zobeck is chairing the sub-committee on reorganizing the Swap Shop.

7. Review the membership and the offering of the sections and make recommendations to the Board for areas of improvement. If any of the sections fall below the threshold of maintaining that section please make recommendation as to what should be done with that section.
Status: The current Education Section membership is 1064. Through the generosity of Drager, a total of 10 Drager ventilators were raffled off at the Education Section meeting at the Summer Forum in Phoenix. A criteria for winning was that individuals were a member of the Education Section. Several individuals joined the education section to be eligible for the raffle. Karen Schell is co-chairing a membership sub-committee to engage more education section members. Of interest, the Summer Forum pre-conference session was fully enrolled with only 60% of the individuals being enrolled in the Education Specialty Section. The value of the Education Section was promoted to this targeted audience.

8. Work to develop more programming directed at hospital educators and all therapists whose position requires some sort type of education process.
Status: Numerous presentations for both the Summer Forum and International Congress were selected based upon the need to serve this important education constituency. The section-specific thematic webcast in September was directed towards hospital-based educators.

Home Care Section

Submitted by Kim Wiles – Congress 2015

Recommendations

None

Report

- Refinement of information on the Home Care Section web page completed and changes submitted to Shawna Strickland.
- Quarterly bulletin completed with another new author. Continue to cultivate new authors by utilizing their expertise by contributing an article to the bulletin.
- An official web based meeting agenda and date has not been determined, but will be scheduled in first quarter 2016
- Ongoing work continues on the development of the home care RT competencies
- Key competencies developed by work group, followed by a survey to section membership. Objectives for key competencies are being developed and will be discussed in depth with Shawna Strickland to determine educational needs for 2016 and beyond.
- Working with a home care ventilator focus group to provide input to CMS regarding national ventilator coverage criteria.

Long Term Care

Submitted by: Lorraine Bertuola– Congress 2015

No report submitted as of October 21.

Management Section

Submitted by: Cheryl Hoerr – Congress 2015

Recommendations

None

Report

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

Status: Members of the Management Specialty Section will be provided with information regarding proposal submission for 2016 programs. Section Chair will collaborate with the Program Committee Liaison to ensure that current topics of interest to RT leadership are selected for presentation at the 2016 Summer Forum and/or the International Convention and Exhibition.

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

Status: The summer 2015 Bulletin was published as scheduled and included articles on motivational dynamics, healthcare reform, and professionalism. These articles were submitted after a plea to membership via the management list serve, and much encouragement to members attending the Summer Forum. In addition to these articles we received enough additional articles to round out the fall bulletin that will be published this month. A management section meeting was held on Monday, July 13 as part of the Summer Forum program and was well attended; there will also be a management section meeting on Monday, Novermber 9 during the International Convention and Exhibition. Since the web-based meeting earlier in the year was so well received, another one will be planned for early 2016 to keep members who couldn't attend the International Convention up-to-date with current initiaves.

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

Status: Information on AARC membership numbers as well as management section membership is always shared during section meetings. Information on current AARC initiatives and advocacy efforts are also discussed with input solicited from members. Posts on the AARC management list serve emphasize the drastic changes affecting healthcare and encourage RT leaders to transform their practice to add value in the forming healthcare environment including: patient safety, CMS changes to PPS, patient access, competitive bidding, care transitions, etc. Three nominations for Management Specialty Practitioner of the Year were received; the chosen recipient will be announced at the Awards Ceremony on Saturday, November 7th.

4. Identify, cultivate, and mentor new section leadership

Status: The Summer Forum was fairly well attended with slightly more than 90 managers and RT leaders from around the country at those initial meetings. Although participation dropped off into the mid-60s for later sessions we did see many new faces in the crowd. I networked and took this opportunity to meet with as many attendees as I could and discuss the opportunities available through the AARC. Business cards were collected from 6 leaders who expressed interest in getting more involved and possibly speaking or writing an article for the section newsletter. A follow up with these RT leaders has been done twice: first to encourage each of them to

participate in the Leadership Book Club, and second to solicit submissions for the conferences in 2016. Both Garry Kauffman and I encouraged attendees several times each day during the Summer Forum to write articles for the newsletter and submit them to our editor Roger Berg.

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

Status: Daily review of management section list serve postings and reply as necessary. 53 threads were started in July, 56 in August, 43 in September, and 45 in October yielding an average of 49 unique threads per month. Hot topics included:

· Discharge planning issues related to 1) allowing patients to "borrow" oxygen tanks for transport home, and 2) the question of whether or not to send hospital inhalers home with patients

· Challenges The Joint Commission interpretation of standards impacting use of TDPs, storage of ventilators with circuits attached, and oxygen cylinder segregation

· Discussions related to maintaining active NBRC credentials, specifically questioning if individual departments require active status as a condition of employment, and if any state licensure boards are doing any checking to verify active credentials during the renewal process

· Several discussions on new opportunities as a result of the ACA that RTs should capitalize upon

· Various clinical discussions: treatment of inhaled chlorine injury, reporting of ventilator days, RVUs vs other weight-based measurements for staffing, and HCAHPS improvement efforts

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

Status: There are currently 718 documents in the Management Specialty Library. No reviews were able to be accomplished prior to this meeting.

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

Status: There are currently 1,512 total management specialty section members. This is a 5% decrease in membership numbers reported at the July BOD meeting and an 8% decrease since the beginning of the year. No action is currently planned for the management specialty section as of this posting.

Neonatal-Pediatrics Section

Submitted by Natalie Napolitano – Congress 2015

Recommendations

None

Report

- Working with Shawna Strickland to produce Neonatal/Pediatric Specialty Course, to be used not solely as a prep for the NPS exam, but mostly to be marketed as a refresher/introduction to neonatal and pediatric respiratory care for individuals coming from adult care into neo/peds or new graduates looking to enter this specialty.

- Spoke at 2 conferences in Florida and Missouri.

- Helped virtual meeting on September 4th – 28 participants joined for the live meeting and it has been archived and sent to the group.
    - During this meeting reminders were made to vote and updates on strategic plan.

- Working with strategic planning groups: attended several conference calls for the Research committee.

Sleep Section

Submitted by Peter Allen – Congress 2015

Recommendations

None

Report

Sleep Section has continued to facilitate section membership communication, updates and digests since the last report in July

Sleep Surveys Completed:

- Section Survey launched polling sleep section members regarding demographics and to also gain insight into their needs and concerns.
- Sleep Survey also conducted with AARC general membership regarding sleep technology and patient cross-over between all areas of respiratory care.
- Results of those surveys will be available to members in the November Bulletin
- Continuing promotion of the AARC World Congress with section membership.
- Members being contacted for articles and one appearing in November Bulletin.
- Our goal here continues to increase sleep section membership by survey response, interaction, touching membership at large, and continuing to build section offerings.
- Peter did not have the time to contact AARC leadership across the country to increase both value and awareness of sleep section support for their regional efforts.

Sleep Section membership is currently between 600 to 700 members.

AARC staff has continued their help and support throughout my time as Interim Chair

Increasing section membership as a goal has not occurred during my tenure.

I will be contacting the new incoming Sleep Section Chair as we work towards Tampa.

Looking forward to an exciting program and exchange of ideas at the Congress.

Surface to Air Transport Section

Submitted by Billy Hutchison - Congress 2015

Recommendations

None

Report

The year has flown by and the number of transport therapists is showing some improvement across the country.

Our membership is still lacking and we are developing new ideas and ways to improve that will be discussed at the Congress.

We will finalize our plan at our section meeting to develop a weekly question to stimulate conversation and participation with our section.

I am excited to introduce Joe Hylton RRT as our Transport Section Therapist of the year. Joe is a team leader, excellent presenter, and a world class educator for his team and many other programs around the country that reach out to him for assistance.

Special Committee Reports

Benchmarking

Submitted by Chuck Menders – Congress 2015

Recommendations

None

Report

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

2. Stan Holland was promoted into a new position and resigned from the committee. His coverage area was reassigned, and new client support coverage map created. His replacement on the committee is on hold for now, and will be reassessed as additional subscribers are added.

3. A customer survey was developed and sent to members of the management section to gain feedback on potential enhancements, as well as the types of quality indicators that should be added to benchmarking, and barriers for becoming a benchmarking subscriber.

4. Received 124 responses from the customer survey and have started analyzing responses to determine VOC needs and desires and best course of action.

5. BOD moved to table Recommendation 15-2-17.1 "That the AARC Executive Office explore database revisions with the vendor who manages the benchmarking database as recommended by the Committee and explore the cost for enhancements and revisions." Committee is continuing to explore options to move forward.

6. Held conference calls and committee members met in Phoenix to discuss current state of benchmarking program, issues, and upcoming actions and needs.

7. Worked with database vendor, Devore, to be able to obtain subscriber information, including active and expired subscriber lists.

8. Membership in AARC Benchmarking has increased from 52 in May to 67 as of September 24, 2015. A new pricing structure is in place to make the program more affordable for both current and new subscribers.

Billing Codes Committee

Submitted by: Susan Rinaldo Gallo – Congress 2015

Recommendations

None

Report

I continue to monitor and respond to list serve activity. Will communicate changes occurring in 2016:

Pressurized or non-pressurized inhalation treatment for acute airway obstruction ~~or~~ for ~~sputum induction~~ therapeutic purposes and/or for diagnostic purposes ~~(eg,~~such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing ~~[IPPB]~~(IPPB) device~~)~~

(Do not report 94640 in conjunction with 94060, 94070, or 94400)

(For more than 1 inhalation treatment performed on the same date, append modifier 76)

Rationale:

Code 94640 has been revised to clarify the intent that this is a bundled code, representing both diagnostic and therapeutic services. In addition, exclusionary parenthetical notes have been added to clarify that this code may not be reported together with 94060 (bronchodilator responsiveness), 94070 (bronchospasm provocation evaluation), or 94400 (breathing response to CO2).
The Coding Guidelines on AARC.org has been updated a few times this past year. I would like to thank Ann Marie Hummel for her assistance.

Federal Government Affairs Committee

Submitted by John Lindsey – Congress 2015

Recommendations

None

Report

The AARC held its Capitol Hill Day on March 18, 2015. 44 states and the District-of-Columbia were represented by 120 Respiratory Therapists. Respiratory Therapy students and patient advocates also joined in. At this writing the dates for Hill Day 2016 have not been fully finalized. We are however looking for a mid-March or mid-April date.

We will continue to support HR-2948 – the Medicare Telehealth Parity Act. As you recall, this bill will include among other provisions respiratory therapists as Medicare recognized telehealth providers. More detailed information on the bill can be found in the Federal Government Affairs Report submitted by Cheryl West and Anne Marie Hummel.

As this Report is submitted there are currently 21 co-sponsors of HR 2948 an increase from 12 co-sponsors at the beginning of August. The list of co-sponsors is at the end of this report.

We had a Virtual Lobby Re-Boot in July-2015 and nearly 26, 000 messages were sent to our representative in Congress. We believe our efforts in sending more messages to the Hill in August was in some part responsible for the increase in the number of co-sponsors that signed on to the bill.

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

Respectfully submitted,

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

House Co-sponsors HR 2948 as of October 5, 2015

Cosponsor	Date Cosponsored
Rep. Harper, Gregg [R-MS-3]*	07/07/2015
Rep. Black, Diane [R-TN-6]*	07/07/2015
Rep. Welch, Peter [D-VT-At Large]*	07/07/2015

Cosponsor	Date Cosponsored
Rep. Esty, Elizabeth H. [D-CT-5]	07/14/2015
Rep. Eshoo, Anna G. [D-CA-18]	07/15/2015
Rep. Jolly, David W. [R-FL-13]	07/15/2015
Rep. DeSaulnier, Mark [D-CA-11]	07/23/2015
Rep. Lofgren, Zoe [D-CA-19]	07/23/2015
Rep. Polis, Jared [D-CO-2]	07/28/2015
Rep. Zinke, Ryan K. [R-MT-At Large]	07/29/2015
Rep. Kirkpatrick, Ann [D-AZ-1]	07/29/2015
Rep. Palazzo, Steven M. [R-MS-4]	07/29/2015
Rep. Nugent, Richard B. [R-FL-11]	09/08/2015
Rep. Hastings, Alcee L. [D-FL-20]	09/08/2015
Rep. Marchant, Kenny [R-TX-24]	09/08/2015
Rep. Ribble, Reid J. [R-WI-8]	09/09/2015
Rep. Norton, Eleanor Holmes [D-DC-At Large]	09/09/2015
Rep. Cartwright, Matt [D-PA-17]	09/10/2015
Rep. Rush, Bobby L. [D-IL-1]	09/16/2015
Rep. Bishop, Sanford D., Jr. [D-GA-2]	09/17/2015
Rep. Graham, Gwen [D-FL-2]	09/22/2015

Fellowship Committee

Submitted by: Patrick Dunne – Congress 2015

Recommendations

None

Report

The Committee completed its charge of reviewing the nominations of 23 worthy individuals received by the August deadline. Accordingly, the Committee is pleased to announce that 13 AARC members have been unanimously selected for induction as 2015 Fellows of the AARC. All of these high-performing professionals have been so notified and invited for formal induction at the Awards ceremony, to be held in conjunction with AARC's 61st International Congress in Tampa, FL.

International Committee Report

Submitted by John Hiser – Congress 2015

Recommendations

None

Report

1. Administer the International Fellowship Program.

This year we will welcome four new international fellows. We have invited two physicians, one from China and one from Egypt. We also invited two physio/respiratory therapists, one from Argentina and one from Thailand. We are now at 160 fellows from 65 countries over the last 26 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.

2015
13 applicants
9 different countries
4 applicants from 4 countries without past fellows
(Bahrain, Bosnia, Cyprus, Guatemala)
6 MD
5 RT
2 PT/RT

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

- 2014 17
- 2015 13

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
- 2014 17
- 2015 10

2015 Program Schedule

Event	Date
Arrive in the First City	Saturday, October 24
First City Rotation	Monday, October 25-Friday, October 30
Arrive in Second City	Saturday, October 31
Second City Rotation	Monday, November 2- Friday, November 6
Arrive in Tampa, FL	Friday, November 6
AARC Congress 2015	Saturday, November 7–Tuesday, November 10
Fellowship Program Ends	Wednesday, November 11

2015 AARC
International Fellows

Husain Khatam, RRT

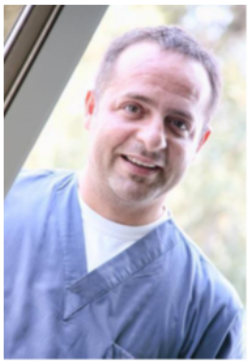
- Senior Respiratory Therapist
  - Salmanyia Medical Complex
  - Manama, Bahrain
  - Acting Head Respiratory Therapy Unit
  - BS & MS in Respiratory Care–Boise State University
  - Top Ten Scholars' at Boise State University for the year 2005
  - 1st Bahraini with degree in RC
  - established policies and protocols for the RT Unit →earning Canadian Accreditation in 2010
  - Chairman Organizing Committee First RT Scientific Symposium
- Hosts
  - Winston Salem, NC – Garry Kauffman
  - Chicago, Il – Edita Mekstraityte

Peifeng Xu, RT

- Clinical Trainer RT Department
  - Sir Run Run Shaw Hospital
  - Zhejiang Province,Hangzhou,China
  - Provides ICRC, IERS Level II approved training courses to medical staff
  - Chief Editor & Operations Manager Chinese Association of RC
  - Deputy Editor & Deputy Translator
    - *Essentials of Respiratory Care* – Kacmarek
    - *Equipment for Respiratory Care* – for Zhengzhou Railway Vocational & Technical College RT program
    - Published several articles & spoke at numerous meetings
  - Hosts
  - Honolulu, HI – Ron Sanderson
  - Charlottesville, VA – Dan Rowley

Musa Muhtaroglu, PT

- Physical Therapist Specializing in RC
  - Dr. Burhan Nalbantoglu State Hospital
  - Nicosia, Cyprus
    - responsible for all the ICU's in the hospital
    - assessment/treatment/education/intubations/ trache care/ventilator care
    - Teaches at European University of Lefke
    - President – Cyprus Turkish Physiotherapy Association
    - Organized – Patient Assessment & Clinical Applications of RT Ed Program– IERS approved
  - Hosts
  - Ogden, UT – Lisa Trujillo
  - Greenville, NC – Charles Bandley



Ramesh Unnikrishnan, RRT

- Assistant Professor–Senior Scale
- Manipal University
- Karnatakia, India
  - academic & clinical education, administration and clinical research
  - Mentor for RT Interns & Junior colleagues
  - Coordinates Post-Graduate students in Research
  - Active member– Editorial Board Indian Journal of RC
  - Member AARC
  - CRT & RRT credentials through NBRC
  - 1st non MD Fellow from India
  - Hosts
  - Kansas City, KS – Karen Schell
  - Atlanta, GA – Doug Gardenhire

Sponsors to Date: AARC, AARC HOD, AMP/NBRC, Draeger Medical, Medtronic, Philips/Respironics, Teleflex

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.

No requests in 2015.

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

We continue to correspond with practitioners from around the world..

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

Membership Committee

Submitted by Gary Wickman – Congress 2015

Recommendations

That the AARC Board of Directors create an Ad Hoc work Group led by the Membership Committee to review and revise the student web site.
(We would like to recruit several Program Directors and the help of the Executive Office to undertake this work.)

Report

Objectives

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

New Projects

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

1. Communication of dues increase to membership, Affiliate Presidents and Membership Chairs
    a. Two emails were sent to each member who was renewing in October, November and December informing them of the increase and the opportunity to renew before the increase on October 1st to take advantage of the old dues fees.
    b. An article was placed on the website and it came out in AARC News Now.
    c. We sent out a survey to the Affiliate Presidents and Membership Chairs asking for questions and input on the dues increase, to have something to work from on the webinar. Some high level questions were:
        i. Can you compare our dues to other professional organizations?
            1. We shared that on the webinar.
        ii. Can people pay over time?
            1. Executive Office working on this.
        iii. Show members "What have you done for me?"
            1. Shared what was being done and asked for more input

iv. Review the progress and changes that the AARC has undergone to better serve our members and our patients.
    1. Talked about Infographic, Congress video and the theme of the Congress.
v. Can you bundle other things people want?
    1. Netflix or Hulu membership? Did talk about new credit card, GEICO insurance discount.
vi. This large increase will negatively affect membership numbers.
    1. Discussed this concern and made sure they were aware that we were taking this into account in THE budgetary process.
vii. Have smaller increases more frequently.
    1. Most people were in favor of more frequent and smaller increases.
viii. Give members something for joining.
    1. This was the Public TV concept, getting something tangible even though small for renewing.

d. Held a webinar for Affiliate Presidents and Membership Chairs to discuss the increase and answer their questions and concerns about the dues increase.
e. So far, there has not been very much backlash to the dues increase communications. We will continue to monitor.

2. Student recruitment work:
    a. We discussed the results of the survey we sent to program Directors on Best Practices to engage new student members.
    b. We are in the process of putting that into a nice graphic to share with all educational programs.
    c. The committee reviewed and discussed the current student website and while it has improved, we feel that it could be more engaging and have information that students want.
    d. We will bring a recommendation to identify a group led by our committee but with the help of the Executive Office and some Program Directors to revamp this website.
3. Committee member's communication to their Affiliates and the Affiliates that they support.
    a. The committee has reached out to Affiliates and we get mixed reviews. Mostly have a hard time getting any response or the contact information is not up to date.
4. Win Back Program
    a. We continue to work on this program which has been very successful in "winning back" lapsed members. Sherry continues to have pretty good success with this program

Data Review

We continue to evaluate the data. We still hover between 38,000 and 39,000 active members. However, we are seeing less of a drop from month to month and we have been at the highest levels in the past two years. This may be because people are renewing early

to take advantage of the costs before the dues increase takes effect. We will continue to monitor.

Next Steps

The Membership committee is engaged and wants to work on the Student web site and we would like to solve the contact issues with Affiliate Membership Chairs. We still plan to put together the brochure on Best Practice on Student Engagement and hold another webinar to share and discuss this with the Program Directors and Directors of Clinical Education from the educational programs to generate more energy around student engagement.
We would like to see the ability to auto renew finished for 2016. We feel that Membership needs to be a "Grass Roots" function and with that in mind will work on continuing to communicate with Affiliates and their Membership Chairs, encourage the local folks to get out to the membership in their Affiliates and provide them with the tools to market the AARC.
We want to encourage the AARC Board to also get out to your Affiliates and market the AARC and make it a goal of each board member to make at least one visit, talk at a conference or some other in person communication to your own Affiliate members.

Other

I would like to thank the members of my committee-Jeffrey Davis, Janelle Gardiner, Garry Kauffman, Tom Lamphere, Ray Pisani, Karen Schell, Sheri Tooley, Sarah Varekojis, Mikki Thompson and John Steinmetz and Sherry Milligan and Asha Desai from the Executive Office for their help with this campaign.

Position Statement Committee

Submitted by Colleen Schabacker – Congress 2015

Recommendations

Approve and publish the revised Position Statement "Electronic Cigarettes". This paper is submitted for your review as attachment #1. Text to be deleted appears with a strike through and words to be added are underlined.

Justification: The committee felt the term "middle school" needs to be replaced with "adolescents" because the use of this device has increased in this entire population, not just in middle school.

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

Justification: In response to motion FM 15-2-84.1 "that the AARC Board of Directors forward the 'Entry Level Respiratory Therapy Education' position statement to the Position Statement Committee to blend together with the recently approved 'Respiratory Therapy Education' position statement into one document." from the July Board meeting. We took the position statement that was presented by the Strategic Plan (#2) Workgroup and approved by this Board and combined it with the current AARC Position Statement on Respiratory Therapy Education. For your convenience, I have also attached both position statements as they were before we combined them; attachments #3 and #4.

That the Position Statement Committee develops a position statement on the "Pulmonary Disease Manager", and present it at the 2016 Spring Board meeting.

Justification: Since COPD readmissions are the "hot" topic, and since the AARC has given a name to the therapist who helps decrease these readmissions – Pulmonary Disease Manager – a position statement supporting the respiratory therapist is the best discipline to be in this role is timely.

Report

Objectives:

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

We developed two new position statements this year: "Insertion and Maintenance of Vascular Catheters by Respiratory Therapists" and "Insertion and Maintenance of Arterial Lines by Respiratory Therapists".

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

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

In 2015 the position statement “Development of Baccalaureate and Graduate Education Degrees” was retired after combining it with the position statement “Respiratory Therapy Education”. The "Electronic Cigarette" Position Statement is being presented again this year as requested by the Board.

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

This schedule was presented and approved at the April 2015 Board meeting.

Other Info

A sincere thank you to the members of this committee for their input: Kathleen Deakins, Deryl Gulliford, Linda Van Scoder, Tony Ruppert and Karen Stewart. I would also like to thank Natalie Napolitano for her input. Extra recognition goes to Linda Van Scoder for taking the bull by the horns and doing the work on combining the two education position statements.

Attachment #1

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

Position Statement

Electronic Cigarette

In line with its mission as a patient advocate and in order to ensure patient safety, The American Association for Respiratory Care (AARC) opposes the use of the electronic cigarette (e-cigarette). Even though the concept of using the e-cigarettes for smoking cessation is attractive, they have not been fully studied and the use among ~~middle school children~~ adolescents is increasing year after year. There is no evidence as to the amount of nicotine or other potentially harmful chemicals being inhaled during use or if there are any benefits associated with using these products. The effects of nicotine on the body are known to be harmful and this does not change when ingested in a smokeless route. Additional safety concerns are emerging concerning ingestion of the Liquid Nicotine Solution (LNS) by young children as poison control centers report a continual increase in calls as e-cigarettes become more popular.

Effective 4/2014
Revised 12/2014
Revised 11/2015

Attachment #2

Position Statement of the American Association for Respiratory Care

Respiratory Therapist Education

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

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

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

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

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

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

~~The profession of Respiratory Care itself, the leadership of respiratory care departments and services, and most importantly the care of our patients will be advanced as our members themselves advance their qualifications through higher academic preparation. Academic institutions which conduct respiratory therapy education should develop bachelors, masters and doctoral programs at this time to support the need for such higher education within our field.~~
~~Effective 1998~~
~~**Revised 03/2009**~~
~~**Revised 04/2012**~~
~~**Revised 07/2015**~~

~~-~~Respiratory therapists provide direct patient care, patient education, and care coordination. They practice in acute care facilities, long-term acute care facilities, skilled nursing facilities, assisted-living centers, subacute care units, rehabilitation centers, diagnostics units, and in the home. Their clinical decisions are increasingly data-driven by scientifically supported algorithms (protocols) to deliver respiratory care. They are involved in research and need to be adept at understanding the practical ramifications of published research. Respiratory therapists use sophisticated medical equipment and perform complex therapeutic procedures and diagnostic studies. They also provide education to patients and other members of the public. Respiratory therapists must possess an in-depth understanding of human physiology and apply that knowledge in the clinical setting.

The continually expanding knowledge base of today's respiratory care field requires a more highly educated professional than ever before. Factors such as increased emphasis on evidence-based medicine, focus on respiratory disease management, demands for advanced patient assessment, and growing complexities of American healthcare overall, clearly mandate that respiratory therapists achieve formal academic preparation commensurate with an advanced practice role.

The primary purpose of a formal respiratory care educational program is to prepare competent respiratory therapists for practice across multiple health care venues. Respiratory care educational programs are offered at technical and community colleges, four-year colleges, and universities. Training and education for entry-to-practice as a respiratory therapist should be provided within programs awarding a bachelor's or master's degree in respiratory care (or equivalent degree titles) and all newly accredited respiratory care educational programs must award, as a minimum, the bachelor's degree in respiratory care (or equivalent degree title). Associate degree respiratory care programs which are currently accredited by the Commission on Accreditation for Respiratory Care (CoARC) should be allowed to continue in good standing as long as they remain in compliance with all other CoARC polices and standards. The AARC supports existing and future articulation agreements between associate and baccalaureate respiratory therapy programs. Respiratory therapists seeking to practice in advanced clinical settings, leadership roles, research, and in professional educator roles should seek higher education at the masters or doctoral levels.

Effective 1998
Revised 03/2009

Revised 04/2012
Revised 07/2015

Attachment #3

Position Statement of the American Association for Respiratory Care

Respiratory Therapy Education

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

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

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

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

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

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

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

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

Attachment #4

Entry Level Respiratory Therapy Education

Position Statement:
Respiratory therapists (RTs) provide direct patient care, patient education, and care coordination. They practice in acute care facilities, long-term acute care facilities, skilled nursing facilities, assisted-living centers, subacute care units, rehabilitation centers, diagnostics units, and in the home. Clinical decisions by RTs are increasingly data-driven by scientifically supported algorithms (protocols) to deliver respiratory care. RTs are involved in research and need to be adept at understanding the practical ramifications of published research. RTs use sophisticated medical equipment, manage mechanical ventilators, and administer invasive and noninvasive mechanical ventilation in all care settings. RTs provide extracorporeal life support to critically ill neonatal, pediatric, and adult patients, and safely transport patients via ground and air. They perform numerous diagnostic studies, including sleep studies. They also provide the traditional forms of aerosol, oxygen, and bronchial-hygiene therapy, and patient education on these therapies. RTs are an integral part of care in the home and subacute settings. RTs care for the critically ill mechanically ventilated patient using protocol-driven approaches to ventilator support, many of which will be integrated into the mechanical ventilator. Complex ventilation modes recently introduced in the United States require RTs to have in-depth understanding of respiratory physiology and the response of the ventilator to changes in patient status. All of these modes are forms of closed-loop controlled, protocoled approaches to ventilatory support that are mastered by the RT. RTs apply their understanding of complex physiology and the application of these physiologic monitors. Health care in general is increasingly driven by the concept of evidence-based medicine. RTs analyze studies to determine if the findings are appropriate for their practice, and critique the findings and apply them when appropriate.

The primary purpose of a formal respiratory care educational program is to prepare competent respiratory therapists for practice across multiple health care venues. Respiratory care educational programs are offered at technical and community colleges, four-year colleges and universities. Training and education for entry-to-practice as a respiratory therapist should be provided within programs awarding a bachelor's or master's degree in respiratory care (or equivalent degree titles) and all new respiratory care educational programs must award, as a minimum, the bachelor's degree in respiratory care (or equivalent degree title). Associate degree respiratory care programs which are currently accredited by CoARC, however, should be allowed to continue in good standing as long as they remain in compliance with all other CoARC polices and standards.

Rationale:
The first paragraph is taken from first 2015 and Beyond conference whose findings were approved by the AARC Board. The second paragraph speaks directly to the need for baccalaureate and graduate education. This was a finding of the third 2015 and Beyond conference and was recommended 12 years ago in the AARC/CoBGRTE white paper on baccalaureate and graduate RT education in 2003. The attached statement does not use the term "moratorium" which constitutes "temporary" versus a permanent improvement in education. The second paragraph also deals directly with maintaining ASRT programs in place to alleviate fear of a workforce shortage.

State Government Affairs Committee

Submitted by: Raymond Pisani - Congress 2015

Recommendations

None

Report

The State Government Affairs Committee continues to work closely and coordinate efforts with the Federal Government Affairs Committee and the AARC's Government Affairs staff. Our recent focus is to help generate grass root support from RTs and those who support the profession to promote legislative issues critical to the profession. This year of course that effort was to encourage the use of AARC's Capitol Connection to send emails to Congress in support of HR 2948 the Medicare Telehealth Parity Act. Our efforts were most intense during both the initial Virtual Lobby Week in March just prior to Capitol Hill Day and then in August when we did an official Virtual Lobby Reboot right after the introduction of the bill.

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

As noted in the Summer Report, several RT Licensure laws (CO, NM and IL) have been going through the licensure Sunset process. We are pleased to say that all 3 states have extending licensure laws. In addition NJ also had their licensure law extended via the regulatory route and thankfully without any opposition.

The Hawaii RT license will face its first Sunset review in 2016 but with the State Auditor reviewing and then issuing a positive report concluding that HI RTs must continue to be licensed, it appears that there will not be any measurable difficulty in the HI legislature in passing the licensure extension. Nevertheless the Hawaii Society will be actively making sure the legislative extension process proceeds without incident.

RT societies are mindful of other state based activities, more fully detailed in the State Government Affairs Report submitted by AARC staff. It is clear that the RTs in all of states have been and continue to be ready to meet the challenges and opportunities.

Virtual Museum

Submitted by: Trudy Watson - Congress 2015

Recommendations

None

Report

It has been a productive year for the committee: a total of six new galleries were added to the AARC's Virtual Museum during this calendar year.

The galleries added since my last report include *Pulmonary Tuberculosis*, *Humidifiers*, and *Aerosol Delivery Devices*. In addition, *Reflections*, a gallery featuring video clips of our members discussing their entry into the profession has been created. If you haven't already done so, please participate in a mini-interview for inclusion in this gallery at the next available opportunity.

The committee continues to seek new content for current and future galleries. I am again requesting the assistance of each BOD member to help track down images for the museum and for use during the Association's upcoming 70th anniversary activities. (Although the AARC's anniversary is approximately 18 months away, we need to start gathering images now: photos from the early years of your career, photos from Summer Forums and AARC Congresses, AARC Committee meetings, etc.)

Later this month, we will begin utilizing student volunteers from the respiratory care program at Collin College to assist with scanning early serial publications of the AARC. Having ads, photos, and articles from our earliest publications available in the digital format will be beneficial to supplement our museum content.

The 2015 committee members included Gayle Carr, Colleen Schabacker, Dianne Lewis, Karen Schell, Steve DeGenaro, and Karen Stewart.

I'd like to acknowledge the efforts of the Executive Office staff who assist with the operation of the virtual museum, especially Asha Desai and Tom Kallstrom for their continued support and guidance.

Special Representatives Reports

AMA CPT Health Care Professional Adv Comm

Submitted by: Susan Rinaldo Gallo – Congress 2015

Recommendations

None

Report

There was a request for a new seat on the CPT Health Care Professional Advisory Committee (HCPAC) to include the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM®). If approved this organization would represent acupuncturists and oriental medicine practitioners.

The term of all HCPAC advisors (including myself) will expire May 2016. Nominations are due by mid-November.

Meaningful Use Criteria was updated October 6th. These were too new to be reported on at this meeting.

CMS has proposed some new NCCI (National Correct Coding Initiative) edits related to the Ventilator Management codes and physician Evaluation & Management codes. As a reminder, NCCI codes apply to physician services and hospital outpatient services only. The edits are not final as of this date so specifics are not available. It does not appear that these changes will affect Respiratory Care services billing practices. Additional information will be provided as it becomes available.

A telehealth work group has been created to examine the need for additional CPT codes for telehealth services. At this point only physician E&M codes which can be provided via telehealth are being discussed. According to the press release issued during the course of the meeting, the goal of the group is to "provide editorial input on proposed coding changes and additions to CPT intended to enhance the reporting of innovative telehealth services to advance medicine's overarching goal of reducing disease burdens, improving health outcomes and reducing long-term care costs". Additional information will be provided as it becomes available.

A coding application was submitted to create a separate code for moderate sedation for GI. The rationale is that it takes more time to get GI patients to a sufficient level of sedation. During the discussion, panel members generally did not see the need for such distinction.

The minutes from this meeting will be available in 10 – 14 days. We will not know the final action on any proposals at that time.

"The CPT code set is the foundation upon which every participant in the medical community - physicians, hospitals, allied health professionals, payers and others - can efficiently share accurate information about medical services," said AMA President Steven J. Stack, M.D. "Input from the Telehealth Services Workgroup will help the CPT code set reflect new technological and telehealth advancements available to mainstream clinical practice, and ensures the code set can fulfill its role as the health system's common language for reporting contemporary medical procedures."
As emerging telehealth services and remote patient monitoring become more important to the management of patient care, the Telehealth Services Workgroup will provide editorial input on proposed coding changes and additions to CPT intended to enhance the reporting of innovative telehealth services to advance medicine's overarching goal of reducing disease burdens, improving health outcomes and reducing long-term care costs.
"Ensuring that CPT codes accurately reflect the telehealth services provided to patients is only possible through the dedication and direct input of the advisors on the Telehealth Service Workgroup," said Dr. Stack. "Tapping into the clinical and technological expertise of the health care community and innovators produces the practical enhancements that CPT needs to reflect the coding demands of the modern health care system."

Tab 21 Am Coll of Cardiology

Category I Surgery Cardiovascular System Heart (Including Valves) and Great Vessels

Conversion of Category 3 code to a Category 1 code

●3333XX – Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, when performed, catheter placement(s), left atrial angiography, left atrial appendage angiography, radiological supervision and interpretation (Do not report 3333XX in conjunction with 93462) (Report cardiac catheterization procedure [93451-93461, 93530-93533] separately for indications distinct from the left atrial appendage closure procedure)

(For left ventriculography performed by transseptal approach for indications distinct from the left atrial appendage closure procedure, use 93565) (Do not report 3333XX in conjunction with 93452, 93453, 93458-93461, 93531-93533 unless catheterization of the left ventricle is performed by a non-transseptal approach for indications distinct from the left atrial appendage closure procedure)

(Do not report 3333xx in conjunction with 93451, 93453, 93456, 93460, 93461, 93530-93533 unless complete right heart catheterization is performed for indications distinct from the left atrial appendage closure procedure) Not positively receuved

Tab 68- Moderate Sedation for GI

Panel asked why GI felt that they need a MS code that is special to them?

GI maintains that the data supports that it is different, they want >.25. They maintain that it takes more time to get GI patients to a sufficient level of sedation. The discussion from the panel members indicated that they didn’t buy it.

Code Proposal FYI

Moderate (also known as conscious) sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a cardiovascular function or a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Moderate sedation does not include codes (+99145, +99150, 991X1X, 991X2X, 991X3X, 991X4X) are not used to report administration of medications for pain control, minimal sedation (anxiolysis), deep sedation or monitored anesthesia care (00100-01999). For purposes of reporting, intra-service time of moderate sedation is used to select the appropriate code. The following definitions are used to determine intra-service time (vs. pre- and post-service time). For purposes of reporting, moderate sedation for trans-oral, trans-rectal, and trans-ostomy endoscopic procedures is considered pre-service work for the endoscopic procedure it supports. The time used to select the appropriate code(s) include the time required to administer (or supervise administration of) moderate sedation medication(s) until sufficient sedation is accomplished to initiate the endoscopic procedure, and any time utilized during the endoscopic procedure in which the physician must interrupt the procedure to personally administer further doses of medication and wait to achieve a sufficient level of sedation to proceed. During the period after the patient enters the procedure room, or after the procedure is completed prior to being stable for recovery status, if the patient requires assessment specific to the sedation needs of the procedure (as distinguished from assessment of the patient's stability to initiate or continue the procedure being supported), then such time may also be considered for reporting. An "independent trained observer" is an individual qualified to monitor the patient during the procedure, but who has no other duties (eg, assisting at surgery) during the procedure. When providing moderate sedation, the following services are included and not reported separately: * Assessment of the patient (not included in intraservice time); * Establishment of IV access and fluids to maintain patency, when performed; * Administration of agent(s); * Maintenance of sedation; * Monitoring of oxygen saturation, heart rate and blood pressure; and * Recovery (not included in intraservice time). Pre-Service Work The pre-service activities required for moderate sedation are included in the work described by each code (+99145, +99150, 991X1X-99X4X) and are not reported separately. The following pre-service work components are not included when determining intra-service time for reporting: * Assessment of the patient's past medical and surgical history with particular emphasis on cardiovascular, pulmonary, airway or neurologic conditions; * Review of the patient's previous experiences with anesthesia and/or sedation; * Family history of sedation complications; * Summary of the patient's present medication list; * Drug allergy and intolerance history; * Focused physical examination of the patient with emphasis on: o Mouth, jaw, oropharynx, neck and airway for Mallampati score assessment; o Chest and lungs; o Heart and circulation; * Vital signs including heart rate, respiratory rate, blood pressure and oxygenation with end tidal CO2 when indicated; * Review of any pre-sedation diagnostic tests when these are indicated and have been ordered; * Completion of a pre-sedation assessment form (with ASA Physical Status classification); * Patient informed consent;

* Immediate pre-sedation assessment prior to first sedating doses; * Initiation of IV access and fluids to maintain patency. Intraservice time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation. Intra-Service Work Intra-service time is used to determine the appropriate CPT code for reporting for moderate sedation services: o Begins with the administration of the sedating agent(s); o Ends when the procedure is completed, the patient is stable for recovery status, and the physician or qualified health care professional providing the sedation ends personal face to face time with the patient; o Includes ordering and/or administering the initial and subsequent doses

of sedating agents; o Requires continuous face-to-face attendance of the physician or QHP; o Requires monitoring patient response to the sedating agents, including: o Periodic assessment of the patient; o Further administration of agent(s) as needed to maintain sedation; and o Monitoring of oxygen saturation, heart rate and blood pressure; o If the physician/QHP who provides the sedation services also performs the procedure supported by sedation (991X1X, 991X2X, 991xx10, +991xx3,+99145), the physician/QHP will supervise and direct an independent, trained observer who will assist in monitoring the patient's level of consciousness and physiologic status throughout the procedure. Post-Service Work The post-service activities required for moderate sedation are included in the work described by each code (991X1X- +99150) and are not reported separately. Once face-to-face time with the patient has ended, additional face-to-face time with the patient is not added to the intra-service time, but is considered part of the post-service work. The following post-services work components are not included when determining intra-service time for reporting: o Assessment of the patient’s vital signs, level of consciousness, neurologic, cardiovascular and pulmonary stability; o Assessment of patient’s readiness for discharge following the procedure; o Preparation of documentation regarding sedation service; o Communication with family/caregiver regarding sedation service. These are not intraservice work/times and are not used to select the appropriate code level. Do not report 99143-99150 +99145, +99150, 991X1X, 991X2X, 991xx10, 991X3X, 991X4X in conjunction with 94760, 94761, 94762. Do not report 99143, 99144, 99145, 991X1X-991X2X in conjunction with codes listed in Appendix G., (which lists

Am Assn of Cardiovascular & Pulmonary Rehabilitation

Submitted by Gerilynn Connors – Congress 2015

No report submitted as of October 21.

American Heart Association

Submitted by Keith Lamb – Congress 2015

Recommendations

None

Report

Nothing to report.

Recommendations

None

Report

Nothing to report.

Chartered Affiliate Consultant

Submitted by Garry Kauffman – Congress 2015

Recommendations

None

Report

I have remained in contact with and support those chartered affiliates with whom I have worked with over the past 7 years to provide ongoing assistance to their business planning and operations. These include New York, Pennsylvania, Virginia, West Virginia, Kansas, Indiana, Georgia, Iowa, New Jersey, Washington State, and Utah.

I am engaged by the acting president of the Idaho Society for Respiratory Care to facilitate a strategic and operational planning session. I conducted this work session the weekend of June 19-21, 2015. The issues as presented to me were discussed with AARC President Frank Salvatore and AARC CEO Tom Kallstrom prior to the work session. In addition to loss of tax-exempt status, which is the most pressing issue to resolve, other issues included membership, meeting attendance, revenue constraints, nominations/elections to board positions, among others. I facilitated the creation of a new mission, core operating values, key organizational objectives, and provided a template for the leadership to create, document, and manage their operations. Since there was only one elected member to the BOD, I recommended to him to make a motion to suspend the bylaws and to create an interim leadership team for their state society. This was done and all 9 participants eagerly committed to restart their leadership team and utilize the operational template to guide their organization throughout the remainder of this year. Given the financial status and timeline, they agreed to not hold their annual seminar this year, but to begin working on the plan to hold an annual meeting in 2016. They also voted unanimously for an interim president to lead the organization until such time that they can restart their bylaws with respect to nominations/elections.

While this report sounds bleak, I want to both congratulate the acting president and the group that dedicated their personal time to begin the turnaround for their state society. The mix of seasoned individuals and several new folks (note: 2 staff RTs!) should serve them well as they launch their operational plan.

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

Commission on Accreditation of Air Medical Transport Systems

Submitted by Steve Sittig – Congress 2015

Recommendations

None

Report

The Board of Directors for CAMTS just met October 15th – 17th in Long Beach California prior to the National Air Medical Conference. The board completed 22 transport program reaccreditation deliberations. The treasures and the executive director's reports were presented to the board.

The meeting dates for 2016 meetings were also discussed. The spring meeting will be held in Denver at the new hotel at the airport in April. The summer meeting location is yet to be decided but the tentative date is the week of July 11th. The fall meeting will be in Charlotte NC in September again prior to the Air Medical Transport Conference.

Discussion also centered on fatigue studies initiated by CAMTS and other organizations looking at shift length utilizing formulated risk management tools filled out by the flight crews. The executive and executive directors discussed their upcoming meetings they are attending as the 10th edition of the CAMTS Standards are now out and will take effect January 1st 2016. As mentioned the 10th edition on the CAMTS standards is now finalized and published. This edition contains the most mention of transport RT's including advanced credentials and needed training.

Discussion also was undertaken looking at the feasibility of the creation of a separate CAMTS EU (Europe) as there is an increasing interest and demand for this type of accreditation in Europe. As one would imagine the systems and government regulations are variable from US processes.

On Sunday October 18th CAMTS celebrated its 25th Anniversary with a reception on the Queen Mary for accredited programs leadership and staff.

Extracorporeal Life Support Organization

Donna Taylor - Congress 2015

Recommendations

That the Board of Directors investigate some avenues for the AARC and ELSO to collaborate on position statements and/or publications.

Justification: ELSO is currently working with other organizations and societies regarding ECMO technologies and I would like to have both organizations partner in similar joint endeavors.

Report

I was in attendance at the 26th annual Extracorporeal Life Support Organization (ELSO) meeting last month in Atlanta, Georgia. An exciting event took place this year at the meeting. The inaugural Fellowship in Extracorporeal Life Support (FELSO) designation was established and the first inductees were announced. Early ECMO pioneers such as Ted Kolobow who invented the oxygenator and John H Gibbon who is credited with the first heart lung machine were inducted as well as ECMO forefathers Bob Bartlett and Billy Lou Short. Criteria and a process for nomination of future candidates are being developed by the ELSO Steering committee.

Efforts are continuing to have a method to certify physicians at institutions who provide ECMO therapy. Dr. Bartlett has created an ECMO test that would serve to demonstrate that a physician would have basic ECMO knowledge to manage ECMO patients. This has arisen from the request for ELSO to provide a means to ensure those taking care of ECMO patients have a foundational knowledge and provide an official way to verify this knowledge.The test will be available for specialists as well. At this time, ELSO is not actively pursuing credentialing of providers or ECMO specialists due to the complexities and structure needed to create this credentialing process and provide for its ongoing maintenance.

The first inaugural cannulation cup based on the AARC Sputum Bowl, took place in Atlanta. The event was a big success, filling the room with onlookers as the teams answered questions in jeopardy gameshow format. Questions from ECMO history to anticoagulation challenged and entertained the participants. Dr. Bob Bartlett served as one of the judges adding to the excitement of the event. The team from the UK garnered the most points to win the prize of a free registration to the next year's ELSO meeting. I plan to discuss with the ELSO conference planning coordinator plans to enhance and incorporate the Cannulation Cup in all future ELSO meetings.

ELSO continues to grow internationally as an organization. The numbers of adult ECMO runs are mounting in the ELSO registry. ELSO is focusing its efforts on being the looked-to organization for this life support technology information and education for all populations.

International Council for Respiratory Care

Submitted by Jerome Sullivan – Congress 2015

Recommendations

None

Report

I. **Fundamental Respiratory Care Support Course (FRCSC):** the Steering Committee with representation from eight countries is currently reviewing over 70 pages of draft materials. The committee is using a shared Dropbox for transmittal of mark ups, review and revisions. The draft materials include Module Lesson Plans for lecture/demonstrations and Skill Stations, and a Template Example Module on Oxygen Therapy. The Committee is also in the process of identifying Content Experts to write a number of additional Modules.

II. **International Education Recognition System (IERS):** Eighteen applications for potential IERS Approval have been reviewed this year to date. Of those, fifteen programs at various Levels have been approved. There has been a large increase in the number of applications from Mainland China. Several of those programs are identified later in this report.

III. **Growth and development of Respiratory Care (RC) related activities, educational seminars & programs in China:** A large increase in the number of Chinese RC related seminars have applied to the International Education Recognition System (IERS) for program approval. The focus of those seminars range from the establishment of an internet RC communication platform for China, a month-long respiratory therapist training program, a medical school sponsorship of a mechanical ventilation forum, a health care company sponsored seminar, to an RC educational exchange program between the US and China. Across the Provinces of China, RC educational programs designed to promote safe, effective care for patients afflicted with respiratory disorders have experienced increases in attendance and in quality indicators. In the last five years multiple seminars and programs have been held in Shanghai, Hangzhou, Changsha, Xi'an, Beijing, Wuhan, Tianjin, Zhengzhou, Chengdu and Xiamen, among others.

IV. **Establishment of an internet RC communication platform for China:** A group of dedicated Chinese Respiratory Therapists have carried out a project to translate into Chinese the International Council for Respiratory Care (ICRC) eNewsletter , *International Respiratory News.* This was part of a larger effort to help promote Respiratory Care throughout China and the Association of Chinese Respiratory Care (ACRC). The group began to organize a team of respiratory therapists across China to build a professional communication platform for exchange of ideas and information. Key to this success was translation of materials like the Newsletter into Chinese and to use the internet to reach as many RT's in China and Taiwan as possible. As a result of their efforts respiratory related news and information from around the world is shared via the internet on the "WeChat" platform which is similar to Facebook in the US. The

project is impressive and has met with great success. Currently almost every RT in China is on this platform, and every province in China has individuals focused on this platform. The RT pages on WeChat have more than 2000 Followers and more than one million hits.

V. 2015 Tongji Mechanical Ventilation Forum Builds on Tradition of Excellence: Tongji Mechanical Ventilation Forum was sponsored by two major hospital affiliates of Tongji University School of Medicine. The primary clinical sponsors of the Forum were Shanghai East Hospital and Shanghai Tenth People's Hospital both of Tongji University. The Forum was held July 24 - 26, 2015 and featured international faculty from the US, Norway and the United Kingdom as well as many outstanding scholars from many Provinces of China. In addition to lecture demonstrations there were simulated ventilation workshops and tours of the large hospital facilities which help to serve the 26 Million residents of the area. Shanghai East Hospital Trauma and Emergency Center alone serves over 1,000 patients a day and has its own ICU. Lecture topics, among others, ranged from Ventilator Induced Lung Injury to the Influence of Abdominal Surgery on Respiratory Function to topics such as the Use of NAVA in Patients With COPD. For the fourth consecutive year the Forum was Approved by the International Education Recognition System (IERS). This year the Approval was for Level II Recognition. There were over 230 registrants participating in the lectures and workshops and final evaluations of the seminar were overwhelmingly positive.

VI. **Chinese RT Participates in clinical education exchange program at the University Of Virginia Medical Center:** Huiqing Ge, MSc, RRT from Hangzhou, China was invited to participate in a three-week clinical education exchange program at the University Of Virginia Medical Center, in Charlottesville, Virginia, USA. The rotation lasted from May 18th to June 6th 2015 and Huiqing Ge's professional mentor during the exchange visit was Daniel D. Rowley, MSc, RRT-ACCS, NPS, RPFT, FAARC. In his role as Clinical Coordinator of Pulmonary Diagnostics & Respiratory Therapy Services Daniel was in a unique position to provide Huiqing Ge with a comprehensive educational experience in all aspects of a contemporary respiratory care in a world class health care institution. She was able to make respiratory rounds and was directly involved in experiences in the ER, MICU, SICU, NICU, PICU, and in the Pulmonary Function Laboratory. Huiqing Ge was impressed with the RTs' professional competence and cooperation as members of the Health Care Team. She also was honored to have the opportunity to be a speaker at the 2015 Virginia Society for Respiratory Care (VSRC) Annual Meeting held at beautiful Virginia Beach. Huiqing Ge presented the topic of "Respiratory care in China: Two decades of Progress". The main content of the presentation was the current situation of respiratory therapy in China and featured case studies on their experience with lung protective ventilation. Beyond her professional experiences Huiqing Ge enjoyed sharing friendship at the reception following the conference and learning more about American culture during her three-week visit. Her hope is not only to see the exchange program continue in the future but also to see an in-depth cooperation develop between the two countries as we move forward to further improve respiratory care for our patients.

VII. **Hunan Provincial People's Hospital One-Month RT Training Class:** The one-month long Respiratory Therapists Training Class was sponsored by Hunan Provincial People's Hospital for the 9th consecutive year. The length, intensive instruction and high quality of this Course attracted a class of more than 80 students from a number of

surrounding cities in Hunan Province. The 2015 training class began on August 24th ran for a month and concluded with final examinations and program evaluations on September 25th. For the first time in 2012, the six[th] Respiratory Therapists Training Class applied to the International Education Recognition System (IERS) for recognition and approval. The program met the organization's guidelines for quality international seminars and was formally approved as an IERS Level II program. Dr. Han, Medical Director of Respiratory Therapy, explained the significance and importance of IERS Approval: "We are pleased that our Seminar is approved by IERS as the guidelines have been developed and approved by the International Council for Respiratory Care (ICRC), and the American Association for Respiratory Care (AARC) recognizes the quality of international educational programs which meet or exceed IERS guidelines." Since 2012, the training classes offered by the Respiratory Therapy Department of Hunan Provincial People's Hospital have been approved by IERS. The Faculty of the programs has been comprised of highly respected and honored professors, therapists and nurses from China and Taiwan as well as faculty from the US. The courses include theory courses, labs and clinical practices, which can help the students to have a firm grasp of the respiratory therapy professional practice. At the completion the 2015 Respiratory Therapy Training Class almost 800 students will have been successfully trained in RT. Many of the students have been doctors, nurses and others from medical colleges and universities. The program sponsors at Hunan Provincial People's Hospital hope with the teamwork efforts for the training program, there will be more and more graduates from the class to join the Respiratory Therapist team in China.

Joint Commission - Ambulatory PTAC

David Bunting - Congress 2015

Recommendations

None

Report

The Joint Commission is proposing an antimicrobial stewardship standard for the Ambulatory Care (AHC) and Office-Based Surgery (OBS) accreditation programs. This standard will align these programs with current governmental initiatives and professional/scientific organizations as well as promote patient safety and quality. This is part of a larger, ongoing discussion regarding antimicrobial resistance in healthcare in general.

The discussion also included a potential National Patient Safety Goal (NPSG) focused on CT Imaging standards to prevent unnecessary pediatric CT imaging.

Other

Continue monitoring Joint Commission initiatives regarding an antimicrobial stewardship standard for the Ambulatory Care (AHC) and Office-Based Surgery (OBS) accreditation programs as these initiatives potentially affect other areas.

Explore any potential roles for respiratory therapy in antimicrobial drug monitoring and overall patient safety.

Next meeting is scheduled for November 20, 2015.

Joint Commission - Home Care PTAC

Submitted by Kimberly Wiles – Congress 2015

Recommendation

None

Report

Nothing to report

Joint Commission - Lab PTAC

Darnetta Clinkscale - Congress 2015

Recommendation

None

Report

The LABORATORY ACCREDITATION PTAC Meeting scheduled for September 8, 2015 was CANCELED. No report since this was the only meeting scheduled since the last AARC Board Meeting!

Additionally, the AARC executive staff contacted me to assist in getting the Joint Commission's position on an issue that the AARC membership has regarding arterial blood gas analyses and the qualifications of those doing ABG competency assessments. Most competencies are done in the Respiratory Care Department. The Joint commission responded quickly and I forwarded their response to Anne Marie Hummel, Director, Regulatory Affairs for AARC. No resolution as yet.

National Asthma Education & Prevention Program

Submitted by Natalie Napolitano – Congress 2015

Recommendations

None

Report

Made recommendations for members of the Technical Expert Panel for the new guidelines.

No meetings since last report.

Neonatal Resuscitation Program

Submitted by John Gallagher – Congress 2015

Recommendations

None

Report

The NPR Steering Committee has been constructing the final edits to the NRP curriculum and 7th edition program text book since last meeting in Elk Grove, IL in March of 2015. These efforts have been made through independent work and teleconference meetings over the span of 6 months. Because of these substantial time commitments, the textbook remains on schedule for an April 2016 release. As a precursor to the textbook, the updated NRP guidelines will be published electronically in Pediatrics in mid-October 2015.

Upcoming events for the NPR Steering Committee include a group meeting on October 21-23, 2015 on site at the American Academy of Pediatrics NCE national meeting in Washington, D. C. The meeting will include a planning session for the future endeavors of the program and a review of grant proposals followed by the allocation of funds for awarded investigators. The AARC liaison is the primary reviewer for proposals that focus on respiratory related studies and interventions.

Roundtable Reports

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

Ad Hoc Committee Reports

Ad Hoc Committee on Cultural Diversity in Patient Care

Submitted by Joseph Huff/Joseph Buhain – Congress 2015

Recommendations

That the Board of Directors approves a status change of the AARC's Cultural Diversity in Care Management Committee from Ad Hoc Committee to a regular committee.

Justification: The Cultural Diversity Committee was started over 25 years ago by President Jerome Sullivan. Since that time the committee has tried to represent the Diverse Members of the AARC by closely adhering to the Goals of each President. Diversity will always be a part of our culture and must be recognized for it's important as it changes as society evolves.

That the Board of Directors establishes a Cultural Diversity Round Table for its diverse members.

Justification: A Round Table will provide a forum for diverse members to express themselves and their ideas as it relates to the AARC and the Profession. A Round Table could act as a portal to recruit new members into the AARC. A Round Table, if the Board of Directors so desire, can evolve into a Section. This will help with providing a viable candidate as a Board Member if the interest and membership is there.

That the Board of Directors recommend to each State Affiliate that they establish a State Culture Diversity Committee with the purpose of recruiting and retaining diverse members in their state.

Justification: This will help each affiliate to recruit diverse members to join the committee thereby encouraging participation on their Boards.

That the Board of Directors recommend to each State Affiliate that they establish a mentoring program at the state level for diverse members of their state.

Justification: A mentoring program at the State level will allow diverse candidates to attend meetings and learn how the Board functions. This will peak their interest to get involved at the State level.

That the AARC provide a visible button on the AARC's website to direct members to the diversity webpage.

Justification: The Survey showed that there is a lack of knowledge about the Diversity Web Site. It also showed a lack of knowledge about the Diversity Committee. A button would increase awareness for both.

Report

Charge:	Survey State Affiliate Boards, AARC House of Delegates and the AARC Board of Directors to determine the level of diversity. Report to the AARC Board of Directors and House of Delegates at the July 2015 meetings in Phoenix, AZ the level of diversity in each area.
Status:	The Committee developed a questionnaire to survey the State Affiliates Boards, AARC House of Delegate, AARC Board of Director and the Executive Office to determine the level of diversity in the AARC **Complete: To view survey results:** https://www.surveymonkey.com/results/SM-WVRYG6N2/ The Committee collected the Data on the level of diversity in the AARC at the State Affiliate, Board of Directors and the House of Delegates levels. The Committee worked with the Executive Office to complete this charge
Charge:	Develop a program that can be used by the state affiliates and AARC Board to bring diversity in the leadership of the profession.
Status:	The Committee made the above recommendations to this charge.
Charge:	Research and compile a comprehensive list of related links and resources on cultural diversity in health care for inclusion on the AARC web site to include but not limited to: • Info related to specific cultural groups • Workforce diversity • Linguistic/communication competence • Disparities in healthcare • Case studies in cultural competence • Cultural Competence
Status:	The Committee will collect an up-to-date list of Resources on Cultural Diversity in health care for inclusion on the AARC's Web Site. The list will be reviewed by the Committee for its accuracy before submission to the AARC. This Review will be conducted twice yearly. Once prior to the summer report and again prior to the Fall report. In process

Charge:	The Committee and the AARC will continue to monitor and develop the web page and other assignments as they arise.
Status:	Ongoing: Web site has been updated and many outdated sites removed.
	The Committee will be responsible for reviewing and updating the Web Site twice yearly. Once prior to the summer report and again prior to the Fall report.
	In process

Ad Hoc Committee on RTs and Disease Management

Becky Anderson – Congress 2015

No report submitted as of October 21.

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

John Wilgis/Shane Keene – Congress 2015

Recommendations

That the Board accept the definition of an Advanced Practice Respiratory Therapist (APRT) as defined below:

a. *"The Advanced Practice Respiratory Therapist (APRT) is a trained, credentialed, and licensed respiratory care practitioner who is employed to provide a scope of practice that exceeds that of the registered respiratory therapist. After obtaining the NBRC RRT credential, the aspiring APRT must successfully complete a CoARC-accredited APRT graduate level education and training program that provides a curricular emphasis that enables the APRT to provide evidence-based, complex diagnostic and therapeutic clinical practice and disease management."*

That the AARC Board request the Association share the accepted definition with the Tripartite for their acceptance.

That the Board designate a committee, consisting of member representatives of the AARC, NBRC, CoARC, and other organizations as deemed appropriate to use this definition as a basis to perform a job analysis and needs assessment.

That the job analysis and needs assessment results may refine a definition of APRT based on the responses from individuals and organizations in the field of respiratory care.

That the current committee composition would be effective in continuing this work post needs assessment.

That the AARC formally request the NBRC explore the development of the APRT credential and examination.

Report

Committee Objectives:

1. General – Identify an institution (or institutions) to be pilot programs and provide funding through ARCF or other source.
2. General (Licensure) – identify states where passage of APRT licensure would have the greatest chance of success.
3. CoARC – Develop application and accreditation documents for APRT Standards.
    a. Validate if a needs assessment was done to create the CoARC standards (if it was done, share it with the group) and if not, do a survey of the current needs assessment.

4. AARC (Reimbursement) –
    a. The APRT workgroup supported an ‘incident to’ approach versus an ‘independent practice’ approach.
    b. Direct billing versus salary from physician/facility.
        i. One suggestion - 75% of physician fee schedule should be competitive with AA/CRNA, ANP, CNM, and PA;
        ii. Level of supervision (general/direct/indirect).
5. NBRC – Develop the credential for the APRT.

- Held monthly conference calls with committee members and worked on committee’s objectives in an approach to achieve objectives.
- Examined relative data from each organization to determine useful information.
- Reviewed information and discussed the legislative and regulatory environment to which an APRT may practice at the state level.
- The Committee determined that objectives 1, 2, 4, and 5 are premature at this time until a job analysis / needs assessment is complete and communicated this to the AARC Executive Director Tom Kallstrom and President Frank Salvatore.
- Developed a draft definition of APRT with support information for consideration by the Tripartite.
- Agreed on the value of a job analysis and needs assessment; and, the complexities of such work was beyond the abilities and time constraints of this committee for accomplishment.
- Provided on-going updates from each organization of the Tripartite.
- Worked cooperatively with the AARC Executive Office staff to facilitate the needs of the group.

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

ADVANCED PRACTICE RESPIRATORY THERAPISTS
DRAFT DEFINITION
SEPTEMBER 2015

The Advanced Practice Respiratory Therapist (APRT) is a trained, credentialed, and licensed respiratory care practitioner who is employed to provide a scope of practice that exceeds that of the registered respiratory therapist. After obtaining the NBRC RRT credential, the aspiring APRT must successfully complete a CoARC-accredited APRT graduate level education and training program that provides a curricular emphasis that enables the APRT to provide evidence-based, complex diagnostic and therapeutic clinical practice and disease management.

INTRODUCTION AND BACKGROUND

A changing national strategy for healthcare delivery[1], the complexity of tasks and competency employers and patients expect[2], and the subsequent increase in professional maturity[3] has coalesced into a need to adapt and broaden the classification of the respiratory care practitioner.[4] This compulsory response to the dynamic healthcare environment assures every patient we care for will receive best clinical practices by a process of continuous development of the profession and the practitioners doing the work.

As an essential prerequisite, an updated comprehensive nationally recognized definition of respiratory therapist classifications is required. This can be followed by the elucidation of an advanced practice professional and systematically described career ladder. This effort may also serve as a catalyst to increase the number of respiratory therapists with advanced education needed to serve as educators, researchers, managers, clinical specialists, and leaders throughout the healthcare delivery system.[5]

A broad understanding of the individual job classifications is essential. The information in this document provides a draft definition for two levels of currently practicing respiratory therapists (i.e., newly graduated minimal experience, and practicing therapist with demonstrated workplace competency); followed by a draft definition of the anticipated Advanced Practice Respiratory Therapist (APRT).

PURPOSE

This is a DRAFT DOCUMENT, whose purpose is to define the training, credentialing, expertise, and function of the APRT. It has not been submitted or accepted by any appropriate organization(s), which will include the American Association for Respiratory Care (AARC), medical sponsoring organizations, the National Board for Respiratory Care (NBRC), the Commission on Accreditation for Respiratory Care (CoARC), and state licensing or regulatory organization(s).

A Committee, consisting of member representatives of the AARC, NBRC, and CoARC will use this DRAFT DEFINITION as a basis to perform a job analysis and needs assessment; and, to refine a definition of APRT based on the responses from individuals and organizations in the field of respiratory care.

EXISTING DEFINITIONS IN RESPIRATORY CARE

- **Certified Respiratory Therapist** (**CRT**) - is a nationally recognized credential awarded by the NBRC to individuals who have satisfied the necessary requirements. The CRT credential is a registered trademark of the NBRC.

- **Registered Respiratory Therapist** (**RRT**) – is a nationally recognized credential awarded by the NBRC to individuals who have satisfied the necessary requirements. The RRT credential is a registered trademark of the NBRC.

CURRENTLY LICENSED RESPIRATORY THERAPIST

- **Entry-level Respiratory Therapist (CRT or RRT)**
    - A practicing respiratory therapist who has demonstrated a minimally acceptable level of competency through programmatic assessment aided by accreditation standards and the NBRC credentialing process.
- **Practicing Respiratory Therapist (Workplace competency assessment and accredited continuing education; CRT or RRT)**
    - An experienced practicing respiratory therapist who functions competently, reliably and with a scope of practice based on current state and local standards. This may occur with or without specialty credentials in any area of respiratory care. Assured through employer assessment and licensure oversite in 49 of 50 states.

THE SCOPE OF ADVANCED PRACTICE

The scope of practice and the degree of autonomy with which an APRT practices shall be determined by state licensing laws, medical direction, the employer, and/or the work environment in which the APRT practices.

In the clinical setting, the APRT shall have demonstrated wide-ranging, advanced competence and proficiency, with reliance on the use of cost-effective clinical practice guidelines, attention to detail, and utilization of medical director guidance.

It is predicted that the majority of APRTs will be employed and supervised, directly or indirectly by practicing physicians or other health care provider systems. It is also predicted that much of the scope of work of the APRT shall be based upon state defined scope of practice through licensure, medical director delegation, and specific needs of a given community or health care setting.

As the scope of practice is expected to be different from a RRT, the impact on the size of the respiratory care work force should be minimal. A Committee of select subject matter experts should be convened to determine the specifics of a typical scope of practice to be put forward for consideration based on the job analysis and needs assessment. A refined scope of practice should also help to refine a definition of APRT based on the responses from individuals and organizations in the field of respiratory care.

KEY WORDS

Education, credentialing, licensed, advanced practice provider, APRT, employed, Co-ARC-approved post-baccalaureate educational training, Post-RRT training, supervised.

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3. Kacmarek RM, Durbin CG, Barnes TA, Kageler WV, Walton JR, O'Neil EH. Creating a vision for respiratory care in 2015 and beyond. Respir Care 2009;54(3):375-389.

4. Barnes TA, Kacmarek RM, Kageler WV, Morris MJ, Durbin CG, Jr. Transitioning the respiratory therapy workforce for 2015 and beyond. Respir Care 2011;56(5):681-690.

5. CoARC Accreditation Standards for Degree Advancement Programs in Respiratory Care. 2015.

END OF DOCUMENT

ARCF
CoARC
NBRC

American Respiratory Care Foundation

Submitted by Michael T. Amato – Congress 2015

The ARCF has been busy over the past several months as we gear up for the AARC International Congress in Tampa, FL. Below are updates of these activities:

New in 2015

- Alpha One Antitrypsin Association/AARC/ARCF
  Matching funding for RT who is a member of AARC awarded for post graduate studies that has an emphasis on Alpha One Antitrypsin Disease
- AARC/ARCF
  Matching funding for Fundamentals of Respiratory Care. Funding to be used for teaching RT globally
- Jeri Eiserman, RRT Professional Education Research Fellowship
  Designed to support original university hospital research in respiratory care and airway management

Congress 2015 ARCF Fundraiser

- Vapotherm sponsorship in the amount of $30,000 was received on June 1, 2015. We also have another two-year commitment with them with a schedule of escalating sponsorship.
- The event at the 2016 Congress is sold out.
- Grand Prize donated by Mark Valentine ARCF board member – Caribbean cruise for 2 (including domestic airfare), and the second prize a Las Vegas weekend donated by ARCF Board member Tonya Winders with transportation donated by ARCF Trustees.

ARCF Award Winners

- **Forrest M Bird Lifetime Scientific Achievement Award** –
  John B. Downs, MD
- **Hector Leon Garza, MD Achievement Award for Excellence in International Respiratory Care**
  Jerome M. Sullivan, PhD RRT FAARC
- **Dr. Charles H Hudson Award for Cardiopulmonary Public Health**
  William N. Rom, MD MPH
- **Thomas L Petty, MD Invacare Award for Excellence in Home Respiratory Care**
  Kent L. Christopher, MD RRT FAARC
- **Mike West, MBA, RRT Patient Education Achievement Award**
  Trina M. Limberg, BS RRT FAARC MAACVPR
- **Monaghan / Trudell Fellowship for Aerosol Technique Development**
  Allison C. Anderson, MSc RRT
- **Philips Respironics Fellowship in Mechanical Ventilation**
  Dina Gomaa, BS RRT
- **Philips Respironics Fellowship in Non-Invasive Respiratory Care**

Mark Siobal, BS RRT-ACCS, FAARC

- **Charles W Serby COPD Research Fellowship**
  Richard D. Rice, RRT MEd
- **CareFusion Healthcare Fellowship for Neonatal and Pediatric Therapists**
  Craig Smallwood, BS RRT
- **Jeri Eiserman, RRT Professional Education Research Fellowship**
  Robert Bayer, RRT
- **NBRC/AMP H. Frederick Helmholz Jr. MD, Educational Research Grant** Monica L. Schibig, MA RRT-NPS CPFT
- **William F Miller, MD Postgraduate Education Recognition Award**
  Kelly L. Colwell, MRC RRT NPS CPFT AE-C
- **Morton B Duggan., Jr Memorial Education Recognition Award**
  Haley Cheshier
- **Jimmy A Young Memorial Education Recognition Award**
  Hannah R. Tkach
- **NBRC/AMP Gareth B Gish, MS, RRT Memorial Education Recognition Award**
  Kevin Collins, MS RRT RPFT AE-C
- **NBRC/AMP William W Burgin, Jr., MD and Robert M Lawrence MD Education Recognition Award**
  Karissa L. Kuneli
- **Mallinckrodt Best Paper Award by Best First Author**
  Nicholas D. Werre, MSRT RRT
- **Draeger Literary Award**
  Donald A. Johnston, PhD RRT RN
- **Albert H Andrews Jr., MD Memorial Award (NBRC)**
  Paul A. Selecky, MD FACP FCCP FAARC
- **Dr. Ralph Kendall MD Outstanding Site Visitor of the Year Award (CoARC)**
  Ian Gilmour, MD and Kelli Chronister, MS RRT CPFT NPS

International Fellows

- **Peifeng Xu – China**
  First City Host: Honolulu, HI
  Second City Host: Charlottesville, VA
- **Musa Muhtaroglu -Cyprus**
  First City Host: Ogden, UT
  Second City Host: Greenville, NC
- **Ramesh Unnikrishnan, MSc RRT - India**
  First City Host: Kansas City, KS
  Second City Host: Atlanta, GA
- **Hussain Jassim Khatam, MHS RRT FAARC – Bahrain**
  First City Host: Winston-Salem, NC
  Second City Host: Lyons, IL

Respiratory Care Journal Conference

The Journal Conferences are presented under the auspices of the American Respiratory Care Foundation. The Foundation and the Journal will present the 55th Journal Conference on Pediatric Respiratory Care on June 10-11, 2016 in St. Petersburg, FL. Conference Co-Chairs are Ariel Berlinski, MD and Brian Walsh, RRT. We are currently seeking sponsorship for the event.

RESPIRATORY CARE
The science journal of the American Association for Respiratory Care
Established 1956
Dean R Hess PhD RRT FAARC, Editor-In-Chief

55th RESPIRATORY CARE Journal Conference

Pediatric Respiratory Care

Ariel Berlinski MD
Brian K Walsh MBA RRT-NPS FAARC
Conference Co-chairs

June 10-11, 2016

Vinoy Renaissance Resort, St Petersburg, Florida

Presented under the auspices of the

American Respiratory Care Foundation
9425 MacArthur Blvd, Irving, TX 75063 • (972) 243-2272 • ARCFoundation.org
Supported by unrestricted educational grants to the Foundation from

55th RESPIRATORY CARE Journal Conference
Pediatric Respiratory Care

Attendance limited to faculty, representatives from the supporting organizations, and staff.

Overview

Pediatric respiratory care has been evolving at a rapid pace. Much of this is due to the organization of quality improvement and research collaborative, the restructuring of reimbursement, and implementation of evidence based practices. This journal conference will focus on recent findings and practice changes within the pediatric respiratory care community. We will also provide best evidence for the effectiveness of patient and provider education, and improving adherence. Papers covering the topics presented at the conference will be published in RESPIRATORY CARE.

Objectives

- To report changes in pediatric respiratory care and to provide evidence-based recommendations for the audience to consider
- To detail how some evidence leads to conflicting conclusions; how to navigate and not avoid those conflicting reports; and to provide a rationale for how the conflicts should be resolved
- To contribute to presentations within the conference by discussion, thus providing additional information about the given topic

Presentation Rules

- Each presenter will have 30 minutes for a concise presentation. *No additional time will be allotted*. At the conclusion of each presentation, there will be a 15-minute open discussion
- Each presentation MUST focus on the key issues and include thoughts for the future with respect to the assigned topic. The goal of each presentation is to review the pertinent available data but, as importantly, to discuss the topic in terms of new and upcoming strategies
- Remember that the on site audience is composed of only the conference faculty, and, thus, there is no need to review basic material. All conference presenters are deemed experts in the field. However, the manuscript should be written for the readers of RESPIRATORY CARE
- One of the key goals of the presentation is to stimulate discussion. Controversial topics and perspectives are encouraged
- A comprehensive manuscript suitable for publication in RESPIRATORY CARE *must* be submitted to the Journal for review by the conference co-chairs before the time of the conference

Instructions for Presentations/Manuscripts

- Unlike the presentation, the manuscript should be a comprehensive review of the assigned topic. Each manuscript should include a pertinent review of the available literature, the topics presented at the conference, and thoughts for the future care of adult patients with respect to the assigned topic
- It is vital to the success of the conference for the controversial nature of issues to be emphasized for the readers

The discussion associated with each presentation will be transcribed and printed at the conclusion of each manuscript. Please note that you will have a chance to edit the transcript prior to publication.

FRIDAY Morning, June 10

8:00 am – 8:15 am
Overview, Introductions, and Ground Rules
Ariel Berlinski MD

8:15 am – 8:45 am
Oxygen Therapy
Brian K Walsh MBA RRT FAARC
Boston MA
- Does liberal oxygen use lead to increase length of stay in the acute care setting?
- Should we take a second look at HFNC in the face of the NEJM article?
- Why don't we use the lowest FiO_2 possible in the mechanically ventilated patient?
- Are there any new complications from oxygen therapy regardless of setting (home, subacute, acute, critical care)?

8:45 am – 9:00 am
Discussion of Walsh's presentation.

9:00 am - 9:30 am
Aerosol Therapy
Ariel Berlinski MD
Little Rock AR
- What is the best for pediatric asthma, nebulization of pMDI?
- What devices/techniques should be used to deliver aerosols to spontaneously breathing tracheostomized infants and children?
- Delivery of aerosols during non-invasive ventilation. What method improves efficiency?
- Transnasal aerosol delivery in infants and children. Is this the newest route of delivery? Is it the best?

9:30 am – 9:45 am
Discussion of Dr. Berlinski's presentation.

9:45 am – 10:00 am
Break

10:00 am – 10:30 am
Inhaled Pulmonary Vasodilators
Bradley A Kuch BS RRT-NPS FAARC
Pittsburgh PA
- Should inhaled nitric oxide be used outside of the neonatal period?
- Speculate why iNO may or may not be useful outside of its indicated use
- What other pulmonary vasodilators could be considered in the pediatric population?
- What are some of the complications associated with inhaled pulmonary vasodilators administration?

10:30 am – 10:45 am
Discussion of Mr. Kuch's presentation.

10:45 am – 11:15 am
Noninvasive Ventilation
Katherine L Fedor RRT-NPS CPFT
Cleveland OH
- When should noninvasive be initiated and abandoned?
- What are the leading complications of NIV?
- What are the limitations of NIV in infants and children?
- How should NIV patients be monitored?

11:15 am – 11:30 am
Discussion of Ms. Fedor's presentation.

11:30 am
Recess until Friday afternoon, 2:00 pm
(on your own)

FRIDAY Afternoon, June 10

2:00 pm – 2:30 pm
Pediatric ARDS
Ira M Chiefetz MD FAARC
Durham NC

- What is the current definition?
- What is effective in pediatric ARDS?
- What is not effective in pediatric ARDS?

2:30 pm – 2:45 pm
Discussion of Dr. Chiefetz's presentation.

2:45 pm – 3:15 pm
Extracorporeal Life Support in Infants and Children
John C Lin MD
St. Louis MO

- What are the indications for ECMO in infants and children?
- How does one "rest" the lungs while on ECMO to prevent further harm? Can this even be extubation while on ECMO?
- How does one "condition" the lung in preparation for coming off ECMO?
- What are good assessments that determine when a patient is ready to be liberated from ECMO?
- Are there any new techniques or methods that have been incorporated in pediatric ECMO?
- Where do you see ECMO going in 10 years?
- What are the long-term outcomes of ECMO therapy?

3:15 pm – 3:30 pm
Discussion of Dr. Lin's presentation.

3:30 pm – 3:45 pm
Break

3:45 pm – 4:15 pm
Noninvasive Monitoring of Oxygen and Ventilation
Craig D Smallwood RRT
Boston MA

- Are their any new noninvasive technologies to monitor oxygen and ventilation in infants and children?
- What are indications for monitoring oxygen and ventilation?
- What can be indirectly be measured if monitoring oxygenation and ventilation?

4:15 pm – 4:30 pm
Discussion of Mr. Smallwood's presentation.

4:30 pm – 5:00 pm
Respiratory Manifestations of Sickle Cell Disease
Michael R DeBaun MD
Nashville TN

- What are the pulmonary complications of in patients with SCD (i.e. asthma)?
- What are the Sleep disorder breathing problems in patients with SCD
- What are the recommended RT interventions during acute chest syndrome?

5:00 pm – 5:15 pm
Discussion of Dr. DeBaun's presentation.

5:15 pm
Recess until Saturday morning, 8:00 am

6:00 pm - 7:00 pm
Reception
Families and friends are welcome.

SATURDAY Morning, June 11

8:00 am – 8:30 am

Pediatric Lung Transplantation

TBA

- What are the physiologic changes that affect airway clearance that occur after lung transplantation?
- What are the pulmonary complications that occur after lung transplantation?
- What are the pre- and post-transplant pulmonary rehabilitation programs and how do they impact outcomes

8:30 am – 8:45 am

Discussion of presentation.

8:45 am – 9:15 am

Airway Management in Infants and Children

Karen F Watters MB BCh BAO MPH
Boston MA

- What are the different type of procedures used to perform tracheostomy in infants and children?
- What are the currently used de-cannulation protocols in infants and children? (Evidence, advantages and disadvantages)
- What is the status of current quality improvement work in tracheostomy care and how do they impact outcomes and patient safety?

9:15 am – 9:30 am

Discussion of Dr. Watters' presentation.

9:30 am – 10:00 am

Pediatric Neuromuscular Disease

Howard Panitch MD
Philadelphia PA

- What are the airway clearance therapies used in this population?
- What sleep disorder breathing problems are prevalent in this population and when do we need to screen for them?
- When invasive and invasive ventilator support is used in this population?

10:00 am – 10:15 am

Discussion of Dr. Panitch's presentation.

10:15 am – 10:30 am

Break

10:30 am – 11:00 am

Adjunct Therapies for Refractory Status Asthmaticus in Children

Kyle J Rehder MD
Durham NC

- When standard therapies fail to reverse severe airflow obstruction and necessitate the use of adjunctive therapies, which of the following have the best safety profile: IV or inhaled magnesium, heliox gas mixtures, intravenous methylxanthines, IV beta-agonist, inhaled anesthetics and/or IV ketamine.
- Based on safety profiles of adjunctive therapies, which would you recommend and which ones would you use as only a last resort.
- If adjunctive therapies are utilized what are the indications and how do you navigate the application and withdrawal of each of these therapies.
- Are there asthma scoring system or other objective measures or monitors that have shown promise in augmenting the clinical assessment of patients suffering from a severe acute asthma exacerbation?
- Should the use of adjunctive therapies be protocoled?

11:00 am – 11:15 am

Discussion of Dr. Rehder's presentation.

11:15 am

Adjournment

Summary

The ARCF Trustees continues to have frequent communication through quarterly phone conferences and face-to-face meetings. The ARCF will continue in its quest to increase awareness of our Foundation in order to be successful at our mission of promoting respiratory health through the support of research, education, and patient-focused philanthropic activities in respiratory care.

I look forward to presenting this report to you and entertaining any questions you may have while at the Board Meeting.

CoARC Report

Submitted by Tom Smalling – Congress 2015

See Attachment:

“CoARC Update 2015 AARC Congress handouts”

Date: October 8, 2015

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

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

Subject: NBRC Report

I appreciate the opportunity to provide you my final update as President on activities of the NBRC. Since the last meeting, the Executive Committee met to discuss business related items pertinent to the credentialing system and hosted the 24th annual State Licensure Liaison Group Meeting in Kansas City. The following information summarizes the current status of significant changes to several examinations and major activities in which the Board and staff are currently involved.

Collaboration with AARC

The NBRC Board authorized the staff to engage in further discussions with AARC staff to determine whether AARC CRCE data could be transmitted directly into the NBRC's online recertification database for AARC members who choose to participate. Staff of both organizations have been working together on the logistics of this plan, and we are happy to report that a launch of this new functionality occurred on September 17.

Recertification Commission Convened

In September, the NBRC convened a Recertification Commission to take an in-depth look at the NBRC's current Continuing Competency Program (CCP). Much is changing in the world of continuing competence, and to ensure that our program meets the intent of our accreditation with the National Commission for Certifying Agencies (NCCA), we felt it was time to review our program that has now been in place for 13 years. Stakeholders from related organizations (AARC, BOMA, CoARC, state licensure agencies and two volunteer practitioners) along with select members of the NBRC Board of Trustees participated in this day long discussion. Ideas and recommendations from this group will now go to the Continuing Competency Committee for further review and consideration.

2015 Examination and Annual Renewal Participation

Through August 31, 2015, the NBRC has administered 21,135 tests across all examination programs. To date, 52,679 credentialed practitioners have renewed their active status with the NBRC for 2015; active status renewal notices for 2016 were mailed on October 1.

Examination Statistics – January 1 –August 31, 2015

Examination	***Pass Rate***
Therapist Multiple-Choice Examination –10,571 examinations	
• First-time Candidates	Exceed High Cut-Score – 78.4% Exceed Low Cut-Score – 86.5%
• Repeat Candidates	Exceed High Cut-Score – 36.2% Exceed Low Cut-Score – 55.5%
Clinical Simulation Examination –8,934 examinations	
• First-time Candidates	58.1%
• Repeat Candidates	43.3%
Adult Critical Care Examination – 539 examinations	
• First-time Candidates	80.9%
• Repeat Candidates	41.0%
Neonatal/Pediatric Examination – 748 examinations	
• First-time Candidates	78.4%
• Repeat Candidates	46.0%
Sleep Disorders Specialty Examination – 62 examinations	
• First-time Candidates	89.5%
• Repeat Candidates	80.0%
CPFT Examination (thru 6/15/2015) – 139 examinations	
• First-time Candidates	66.7%
• Repeat Candidates	35.0%
RPFT Examination (thru 6/15/2015) – 57 examinations	
• First-time Candidates	78.9%
• Repeat Candidates	47.4%

PFT Examination – 85 examinations

- First-time Candidates — Exceed High Cut-Score – 43.9%; Exceed Low Cut-Score – 77.2%
- Repeat Candidates — Exceed High Cut-Score – 7.4%; Exceed Low Cut-Score - 55.5%

Your Questions Invited

It has been a pleasure serving as President of the NBRC for the past two years, and I have enjoyed working with all of you to move the profession of respiratory care forward. If you have any questions or concerns about any credentialing related matter, the NBRC and I are interested in providing whatever information you need. In addition, the Board of Trustees is committed to maintaining positive relationships with the AARC and each of the sponsoring organizations of the NBRC, as well as the accrediting agency. We continue to 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

- Taskforce on the Creation of Collaborative Efforts with External Organizations *(see attachment)*

- Joint Taskforce on a White Paper Regarding Safe Initiation and Management of Mechanical Ventilation *(see below)*

- Strategic Goals Update

AARC/UHC White Paper

October 8, 2015

SAFE INITIATION AND MANAGEMENT OF MECHANICAL VENTILATION

This paper provides guidance for Best Practices for safe initiation and management of mechanical ventilation. This paper will help define competency, training, and interdisciplinary approach necessary for patient safety and improved outcomes.

Background and purpose

Approximately nine percent of all Safety Intelligence data demonstrate that changes to mechanical ventilator settings performed by health care providers that had no competency training regarding the specific functions of the ventilator in use.[1] Mechanical ventilators are very complex and require training and competency to ensure positive patient outcomes and to avoid harm to patients. Many issues with inappropriate setting changes, changes without changes made to alarm settings, and changes without orders or communication to the interdisciplinary team are under reported.

This White Paper is intended to provide additional guidance to health care institutions and the other providers to ensure that all personnel trained to setup, install, and make setting adjustments have formal training in the basics of mechanical ventilation as well as competency specific to ventilator(s) in use. An interdisciplinary approach with good communication between all members of the healthcare team will result in safe delivery of mechanical ventilation as well as to improve outcomes.

Training and competencies

Purpose

Initiating and maintaining both invasive and non-invasive mechanical ventilation is a complex process. The healthcare provider (HCP) must differentiate among various manufacturers, ventilator models, available modes, and breath types to determine which is appropriate for each individual patient. In addition, the terminology surrounding mechanical ventilation modes and features is not universal. This lack of standardized vocabulary leads to ambiguity and confusion regarding mechanical ventilation application.[2] Once mechanical ventilation is initiated, the HCP must also be able to adjust the ventilator support for the patient based on physiologic response as noted by invasive and non-invasive monitoring results. Therefore, it is imperative that each HCP who initiates and manages mechanical ventilation demonstrate his/her competency before participating in this type of patient care.

Competency

A competency is the ability of a practitioner to integrate the professional attributes required to perform in a given role, situation, or practice setting. These professional attributes include knowledge, skill, judgment, attitudes, values, and beliefs. Many acute care and long term care facilities require annual competencies for staff to document knowledge and skills regarding a multitude of procedures, including invasive and non-invasive mechanical ventilation. The American Association for Respiratory Care (AARC) position statement for “Pre-Hospital

Ventilator Management Competency" advocates for regular competency evaluations of pre-hospital providers of mechanical ventilation.[3] The North Carolina Board for Respiratory Care position statement "Making Adjustments to Functioning Ventilators" also advocates for completion and documentation of competency or skills review for anyone making ventilator adjustments.[4]

Though there is wide support for regularly timed competency demonstrations by HCP who initiate and manage mechanical ventilation, a standardized competency assessment tool has not been developed. Many institutions develop their own assessment tool to be specific to the ventilator models used in that facility. It is important to note that an appropriate competency tool is one that not only addresses the HCP's ability to manipulate the machine correctly but also the HCP's ability to integrate mechanical ventilation principles with the patient's unique condition, physiologic need, and ongoing physiologic status as well as meet identified interdisciplinary team goals. Competencies required of the respiratory therapist with regards to mechanical ventilation include all technical aspects of the mechanical ventilator, indications for mechanical ventilation, pathophysiology, independent application of mechanical ventilation, pharmacology of critical care, mechanical ventilation adjuncts, evidence-based application of mechanical ventilation, protocols and guidelines, management of the airway, bedside monitoring, and effective communication.[5] Goligher et al developed a list of 56 learning objectives through expert consensus that cover respiratory physiology, initiating ventilation, modes of mechanical ventilation, non-invasive ventilation, monitoring, patient-ventilator interactions, complications of mechanical ventilation, and weaning and extubation.[6]

Professional training

Many of the HCP who participate in initiation and management of mechanical ventilation receive training in the professional phase of formal education. Respiratory therapists participate in an average of 900 clinical hours in addition to didactic and laboratory instruction on the function and application of mechanical ventilation.[7,8] A 2010 survey of respiratory therapy educational programs identified that 99.71% of all respiratory therapy programs included competencies on the application of invasive and non-invasive mechanical ventilation, 97.98% included competencies on the application of all ventilation modes, and 97.96% included competencies on the interpretation of ventilator data.[9]

Research indicates that it is unclear how well medical school prepares medical residence to initiate and manage mechanical ventilation.[10] Cox et al identified that a significant percentage (46%) of surveyed medical residents reported being satisfied with mechanical ventilation training and noted that there was a significant difference in perception of the resident's readiness to care for patients receiving mechanical ventilation between the academic program director and the resident.[10] Registered nurses have limited knowledge of mechanical ventilation[11] and data to support education and training for mechanical ventilation during formal nursing education is lacking.

Continuing education

The National Academy of Medicine (formerly the Institute of Medicine) identifies the purpose of continuing education as to "enable health care professionals to keep their knowledge an skills up

to date with the ultimate goal of improving performance and patient outcomes."[12] Some research has focused on the use of continuing education as a mechanism to improving knowledge and skill of initiating and maintaining mechanical ventilation.[11] It has been identified that didactic learning alone is not sufficient; rather, hands-on training, demonstration, and clinical simulations engage the learner and improve ability to retain the information.[13,14] Therefore, continuing education for HCPs engaged in the application of mechanical ventilation should be developed to address knowledge gaps identified in the population and incorporate opportunities to practice skills in an interactive environment.

Ventilator initiation

Ventilator Pre-Use Checks

While all modern ventilators conduct an internal Self-Test at power up, additional pre-testing is necessary to ensure safe ventilator operation prior to placing on a patient. Manufacturer operators' manuals consistently state – "a preoperational check must be performed prior to the ventilator being placed on a patient."[15,16] This check is to confirm the function and integrity of the ventilator circuit including the internal ventilator components, tubing, and the humidifier system. This procedure is generally performed at the time of circuit or humidifier setup. This test must also be completed anytime the circuit is changed or modified.

Patient-Specific Setting Selection

When powered up, some ventilators default to generic predetermined settings while others default to the last settings that it was operating on. Depending on the patient's needs, the default settings may present a hazard to the patient. Many institutions utilize disease driven ventilator protocols that help to reduce the risk of barotrauma or pneumothorax using lung protective strategies.

Anytime a therapist is initiating mechanical ventilation on a patient, it is important to fully understand the patient's history, reason for ventilatory assistance, anatomy and goal for ventilation. Any of these factors can potentially dictate settings.

Another aspect for consideration is the alarm settings. Alarm settings are both informative and protective. Setting limits on volume, pressure and rate is every bit as important as the ventilatory settings themselves. Many institutions have policies requiring alarm settings to be set at a specific percentage of the ventilation setting. Alarm settings act as a ventilation/pressure limit for patient safety, not just something to make more noise on the unit.

Ventilator management

This White paper supports the Position Statement adopted by the North Carolina Respiratory Care Board which states:

> The Respiratory Care Practitioner is the health professional best suited to provide, monitor, adjust and document ventilator care. In order to ensure the safety of all patients receiving mechanical ventilator support, it is essential to limit the number of individuals who make adjustments to mechanical ventilator settings. Given the scope of practice and training of the Respiratory Care Practitioner (RCP), combined with the daily experience and annual assessment of competency related to mechanical ventilation, the RCP is the individual whose training is most focused on the features and functions of ventilators, who will be

> most familiar and up to date on ventilator technology, and also will be most directly familiar with the organization's policies, procedures and clinical paths that are pertinent to ventilator operation. Therefore, the RCP should be recognized as having the primary role in making all ventilator adjustments. Every adjustment made to the ventilator requires a careful review of alarm settings and adjustments as needed for the safety of the patient.[4]

All HCP who make changes to mechanical ventilators should be able to demonstrate the same level of competency and training as that of the respiratory care practitioner. Each change made to the patients' ventilator settings warrants an assessment of the patient as to how the change affects the patient. Thorough knowledge of patient physiology and response to specific setting changes needs to be part of the competency of any HCP who is making adjustments to the ventilator. Interdisciplinary communication between the physician, nurse, and respiratory therapist is essential to assure that the adjustments are safe. An example would be that, during daily rounds, a physician changes a patient's mechanical ventilator mode to continuous positive airway pressure (CPAP) but does not discuss the change with the nurse or respiratory therapist. The physician does not adjust the alarms on the ventilator or document the changes. The nurse notices that the patient appears in distress with low oxygen saturations. The nurse assumes that the patient is anxious and sedates the patient. A few minutes later, the respiratory therapist is called to the room as the patient is displaying signs of respiratory distress and desaturation. The nurse and respiratory therapist notice that patient's mechanical ventilator has been changed to CPAP and the patient is hypoventilating due to the sedation. The physician must be informed of the situation. Although the physician is well trained in pathophysiology, he/she is not trained on the alarm setting for each type of ventilator or each mode of ventilation. The best practice is interdisciplinary communication, physician entered/written orders, nurse and respiratory therapist verification of the orders, and then changes to be made by the HCP who is trained with documented competency in ventilator management, physiologic response to each mode/setting and ventilator type used, and proper alarm settings.

Alarm management

Establishing appropriate and safe strategies for ventilator alarm management is critical to patient care. Respiratory therapists should place an emphasis on developing policies and procedures that support facility wide emphasis on setting and monitoring ventilator alarms specific to each setting. Evidence suggests that considerable morbidity and mortality can be attributed to inappropriate monitoring and setting of ventilator alarms resulting in an emphasis by The Joint Commission to establish objectives and goals for hospital accreditation consideration. Consistent with this effort, respiratory therapists should advocate for multi-disciplinary teams to generate institutional specific alarm policies, with an emphasis placed on their most crucial alarm activity. This may be accomplished by incorporating evidence-based practice, soliciting the recommendations of all clinicians in the environment of care, and directing policies relative to patient risk.[17] These policies and procedures should also include clinical targets, directives regarding permission to modify alarms settings, and most importantly, providing education validated by competency assessment. Respiratory therapists should establish other key parameters that include, however are not limited to: 1) time required to respond to alarms, 2) establishing a list of parameters that require monitoring, 3) competency assessment intervals, and 4) designation for which alarms are assessed which alarm priority level, i.e. Level 1,2, or 3.[18] Careful consideration should be given to justify

the use of default or “cookie cutter” alarms to avoid inappropriate generalization. Recommendations should support individualized settings in an attempt to create patient specific safety parameters.

Ventilator alarm management policies should incorporate manufacturer specific alarm setting requirements, alarm functionality tests and an associated competency assessment. Standardization amongst manufacturers is non-existent, necessitating equipment specific training to familiarize staff with what alarm features are available, how to modify alarms, what sounds are associated with various alarms to include escalation of priority differences, how to extract alarm data, and reporting procedures for improving practice.
Every effort should be made to establish good practice patterns in an attempt to mitigate nuisance alarms/alarm fatigue, while creating an environment that is safest/most responsive to patient care needs. When available, professional organization recommendations (AARC, FDA, ECRI, AAMI, TJC) should be incorporated into policy and procedure guidelines in support of best practice.

Documentation, orders, and protocols

Written electronically, Signed Physician Orders

In this era of electronic medical records it has become easier to implement standardized orders for the many aspects of respiratory care. These computer-based orders can be used across treatment locations and faculties once developed. Development should be a broad base collaboration between respiratory therapy providers, midlevel providers and physicians. They should be based on evidence-based recommendations of professional societies and have buy-in from all members of the health care team.

These standardized protocols should be entered as order sets that can be easily found in organized drop down menus. They should have the ability to be easily signed by the supervising mid-level or physician based on privileging standards of individual facility. These order sets and protocols should be reviewed and edited based on ongoing recommendations and evolving medical literature.

Documentation

The electronic medical record has had its greatest advantage in its ability to share information across the continuum of care both at the bedside and through remote access. Thus it is imperative that physiologic parameters and the settings of the support technology be entered into the fluid medical record. In the majority of facilities such data can be automatically collected and downloaded by the monitors connected to the patients and the electronically integrated ventilators support devices and medication delivery systems. The record should also be able to communicate with laboratory and pharmacy databases to document pertinent information necessary to titrate therapy. These electronically based systems not only allow rapid and standardized care but can also give us rapidly accessible data bases that can be used for quality improvement and research.

Guidelines and Protocols

At the core of this electronic based care system should be therapist guided protocols and guidelines. Though the perception persists that therapist driven protocols increase RT workload, such standardization has been shown to improve not only real-time patient care and patient

outcomes, but also resource utilization and, therefore, cost.[19,20]

Interdisciplinary communication

Interdisciplinary communication is an essential tool that not only provides the care team with valuable medical information needed to properly manage a patient, but also can help to alleviate unexpected situations that might in fact, harm a patient. Accreditation agencies, such as The Joint Commission, mandate standards regarding care coordination. Joint Commission Standard PC.02.02.01 requires hospitals to coordinate the patient's care, treatment and services based on the patient's need. The hospital must have a process to receive or share patient information when the patient is referred to the other internal or external provides of care, treatment and services. Hand-off communication, or anytime a new provider will be caring for a patient, allows for the giver and receiver to fully discuss patient needs and the care plan.

In a busy caregiver world, it is often difficult to manage assigned workloads, unexpected emergencies and the like. However, activities that are hard-wired into the institutions may help guide the caregiver into promoting safety first and above all other concerns. Having all caregivers of an institution use a standard tool should improve communication efforts.
Utilizing a standard communication tool may enhance effectiveness. A common tool is SBAR, where the caregivers use concise communication techniques. SBAR stands for Situation, Background, Assessment and Recommendation.

Some institutions may use multidisciplinary rounds help enhance patient care. Scheduled rounds help engage the caregivers in what is expected for the shift. However, respiratory therapists should make themselves available to the team when rounds are scheduled, and it should be considered part of the daily assignment to attend rounds. Still, medical emergencies may pre-empt rounds. Respiratory therapists should be responsible for contacting other members of the healthcare team, if rounds are rescheduled, and make arrangements to attend, especially if rounds include patients on medical ventilation.
Some electronic medical records (EMRs) may have advanced tools, such as notes, that can be utilized to communicate concerns or ideas. While face-to-face communication is always best, individuals working on the off shifts may not be able to participate in direct communication. This may be more apparent in smaller facilities or long-term ventilator units or where a respiratory therapist may not be present for all respiratory care activities. If institutions used a note type function in an EMR or even paper record, training on the appropriate content of the note should be included.

While some personnel may find it difficult to offer suggestions or contradict what other are offering, the role of being a patient advocate should be on the forefront of every caregiver's thought process. Fear of criticism can be daunting. But HCPs have a responsibility to ensure quality safe respiratory and patient care. Respectfully stating a position and providing appropriate medical knowledge for the situation is important in order to gain trust of other members of the care team.

Conclusions (Recommendations)

1. Continuing education to improve knowledge and skill in the initiation and management of mechanical ventilation should be developed to address identified knowledge gaps. These educational opportunities should incorporate interactive environments.
2. All parameter and alarm changes on ventilatory support devices should be clearly recorded, documented, and communicated to the entire health care team.
3. Policies and procedures for ventilator alarms should be evidence-based, include clinical targets, directives regarding permission to modify alarms settings, identify time required to respond to alarms, establish a list of parameters that require monitoring, identify competency assessment intervals, and identify the alarm priority level designation.

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New Business

Policy Review

- BOD.003 – Board of Directors – Use of AARC Corporate Credit Card
- BOD.014 – Board of Directors – Attendance at Receptions

Faces Foundation

Board Self-Assessment Survey *(see attachment)*

American Association for Respiratory Care
Policy Statement

Policy No.: BOD.003

SECTION: Board of Directors

SUBJECT: **Use of AARC Corporate Credit Card**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: April 2011

DATE REVISED: July 2005

REFERENCES:

Policy Statement:
Only the President, President-elect, Past President and selected Executive Office personnel shall be authorized to carry Association corporate credit cards.

Policy Amplification:

1. Use of Association corporate credit cards shall require proper detailed reports.

2. The Executive Director shall determine which members of the Executive Office may use Association corporate credit cards.

3. The Board of Directors shall travel under the official travel policy of the Association.

4. The Controller shall be responsible for monitoring the use of corporate credit cards and assuring that use is properly reported.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Attendance at Receptions**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: April 9, 2011

DATE REVISED: July 2005

REFERENCES:

Policy Statement:
Officers and Directors shall attend all receptions to which they are invited and/or which the President directs them to attend.

Policy Amplification:

1. Officers and Directors shall conduct themselves in an appropriate manner when attending any and all receptions.

2. Dress for all AARC required receptions is business attire unless otherwise directed by the President.

DEFINITIONS:

At the fall meeting of the Board of Directors, many receptions are held. Some of the receptions which occur annually are: Board of Medical Advisors at fall meeting, NBRC, Lambda Beta, Chartered Affiliate Presidents and International Council.

ATTACHMENTS: