American Association for Respiratory Care

Board of Directors Meeting

Hilton Crystal City
2399 Jefferson Davis Highway
Arlington, VA 22202

April 9-10, 2016

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
AARC Executive and Finance Committee Meetings – April 8, 2016
Board of Directors Meeting – April 9-10, 2016

Friday, April 8

3:00-5:00pm Executive Committee Meeting (Committee Members only) Old Dominion Executive Board Room

5:30-6:30pm AARC Finance Committee Meeting (BOD and HOD members are encouraged to attend) Williamsburg/Yorktown Rooms

Saturday, April 9

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

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

9:00am Kathryn Schubert – Cavarocchi, Ruscio, Dennis Associates, LLC

10:00am Bill Sims - Salmon, Sims, & Thomas - Auditor's Report (by phone)

10:45am Lawrence M. Wolfish - Wolfish & Newman, P.C. (by phone)
Board Member Fiduciary Responsibility & Conflict of Interest

11:15am John Barrett & Brooke Garafalo – Merrill Lynch –Investment Report

12:00pm LUNCH BREAK (Daedalus Board Meeting)

1:30pm RECONVENE

General Reports pg. 38
- President pg.39 (R)
- Past President pg. 43
- Executive Director Report pg. 44 (A)
- Government & Regulatory Affairs pg. 64
- House of Delegates pg. 75
- Board of Medical Advisors pg. 76
- President's Council pg. 81

2:30pm Standing Committee Reports pg. 88
- Audit Subcommittee pg. 89 (R)
- Bylaws Committee pg. 90 (R) (A)
- Elections Committee pg. 91
- Executive Committee pg. 93
- Finance Committee pg. 94
- Judicial Committee pg. 95
- Program Committee pg. 96
- Strategic Planning Committee pg. 98

Specialty Section Reports pg. 99
- Adult Acute Care pg. 100
- Continuing Care-Rehabilitation pg.101
- Diagnostics pg. 103
- Education pg. 106 (R)
- Home Care pg. 109
- Long Term Care pg. 112 (R)
- Management pg. 114
- Neonatal-Pediatrics pg. 116
- Sleep pg. 117 (R)
- Surface to Air Transport pg. 118

3:00pm **BREAK**

3:15pm Special Committee Reports pg. 119
- Benchmarking Committee pg. 120
- Billing Codes Committee pg. 121
- Diversity pg. 122
- Federal Govt Affairs pg. 123
- Fellowship Committee pg. 126
- International Committee pg. 127
- Membership Committee pg. 129
- Position Statement Committee pg. 131 (R)
- State Govt Affairs pg. 152
- Virtual Museum Committee pg. 153

4:15pm Nominations for Life & Honorary Membership
(see pg. 86 for criteria)

Nominations for Legends of Respiratory Care
(see pg. 230 for criteria)

5:00pm **RECESS**

Sunday April 10

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

8:00am Call to Order

Special Representatives pg. 154
- AMA CPT Health Care Professional Advisory Committee pg. 155
- American Association of Cardiovascular & Pulmonary Rehab pg. 156
- American Heart Association pg. 158 (A)
- American Society for Testing and Materials (ASTM) pg. 159 (R)
- Chartered Affiliate Consultant pg. 161
- Comm. on Accreditation of Medical Transport Systems pg. 162
- Extracorporeal Life Support Organization (ELSO) pg. 163
- International Council for Respiratory Care (ICRC) pg. 164 (R)
- The Joint Commission (TJC) pg. 167-169
- National Asthma Education & Prevention Program pg. 170
- Neonatal Resuscitation Program pg. 171

9:30am BREAK

9:45am Roundtable Reports pg. 172

10:00am Ad Hoc Committee Reports pg. 174
- Advanced RT Practices, Credentialing, and Education pg. 175 (R)
- RTs and Disease Management pg. 181
- Research Fund for Advancing Respiratory Care Profession pg. 182
- Student Website Enhancement pg. 183

12:00 pm LUNCH BREAK

1:30 pm RECONVENE

1:30 pm Other Reports pg. 184
- ARCF Report pg. 185
- CoARC Report pg. 187 (A)
- NBRC Report pg. 188

2:00 pm **UNFINISHED BUSINESS** pg. 191
- CoARC/CoBGRTE
- State Initiative Workgroup pg. 192
- Taskforce on Competencies for Entry into Respiratory Care pg. 203

NEW BUSINESS pg. 205
Policy Review

- BOD.002 – Board of Directors – Board of Directors Liaisons to Committees, Task Forces, Focus Groups, Panels, and Special Representatives pg. 206

- BOD.008 – Board of Directors – Joint Session with House of Delegates pg. 209
- BOD.013 – Board of Directors – Professional Attire pg. 210
- RT.001 – Roundtables – Roundtables pg. 211

3:00 pm ARCF Achievement Award Nominations pg. 214
Bird pg. 215
Hudson pg. 219
Petty/Invacare pg. 224
Mike West pg. 227

ANNOUNCEMENTS

TREASURER'S MOTION

ADJOURNMENT

(R) = Recommendation
(A) = Attachment

Recommendations

(As of March 24, 2016)

AARC Board of Directors Meeting

April 9-10, 2016 • Arlington, VA

President

Recommendation 16-1-4.1 "That the AARC Board of Directors ratify the Ad Hoc Committee on State Initiatives.

- **Chair** – John Wilgis
- **Committee Members**: Sam Giordano, Joseph Goss, Gene Gantt, Kenneth Alexander, Jan Fields, (additional members to be added as committee needs)
- **AARC EO Liaisons**: Tom Kallstrom and Cheryl West
- **Objectives**:
    i. Research possible initiatives that can be put into a format to deliver to state affiliates in order to create better access to RTs by patients who are on state services such as Medicaid.
    ii. Act as a subject matter expert/resource to the state affiliates who need guidance and support as they put forth the initiatives created by the committee."

Recommendation 16-1-4.2 "That the AARC Board of Directors ratify Margaret Traband as a special representative to CoBGRTE."

Audit Sub-Committee

Recommendation 16-1-13.1 "That the AARC Board of Directors accept the audit report as presented."

Bylaws Committee

Recommendation 16-1-9.1 "That the AARC Board of Directors find that the Oregon Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (See attachment 'Oregon Society for Respiratory Care')."

Recommendation 16-1-9.2 "That the AARC Board of Directors find that the Montana Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (See attachments '2015 MSRC – Montana Bylaws Revisions Summary and 2015 Bylaws Montana Revised')."

Recommendation 16-1-9.3 "That the AARC Board of Directors find that the South Dakota Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (See attachment 'Bylaws changes South Dakota 2016 Final and Bylaws AARC South Dakota approved July 2014')."

Recommendation 16-1-9.4 "That the AARC Board of Directors find that the Arkansas Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (See attachment 'ASRC Bylaws 2015 Revisions, Bylaws Cover Letter 2016, and Bylaws Chart and Rationale to ASRC Bylaws')."

Recommendation 16-1-9.5 "That the AARC Board of Directors find that the Mississippi Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (See attachment 'Mississippi Bylaws Proposed 2016')."

Recommendation 16-1-9.6 "That the AARC Board of Directors find that the MD/DC Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (See attachment 'MDDC Society Bylaws 2016 Update')."

Education Section

Recommendation 16-1-53.1 "That the AARC develop a program to recognize outstanding clinical receptors in respiratory care education."

Long Term Care Section

Recommendation 16-1-57.1 "That the AARC BOD authorize the AARC president to work with the LTC Chair to draft a letter to the NAMDRC President requesting that NAMDRC formally review and endorse the AARC 2010 Position Statement 'Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care'."

Sleep Section

Recommendation 16-1-58.1 "That the AARC BOD allow the Sleep Section Chair to work with interested members to develop a Sleep Section specific Mission and Vision Statement to serve as a guide for section's future activities."

Position Statement Committee

Recommendation 16-1-26.1 "That the Board of Directors approve the Position Statement 'Cultural Diversity' with no revisions."

Recommendation 16-1-26.2 "That the Board of Directors approve the Position Statement 'Delivery of Respiratory Therapy Services in Long Term Care Skilled Nursing Facilities Providing Ventilator and/or High Acuity' with no revisions."

Recommendation 16-1-26.3 "That the Board of Directors approve and publish the Position Statement 'Home Respiratory Care' with no revisions."

Recommendation 16-1-26.4 "That the Board of Directors approve and publish the Position Statement 'Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialist' with no revisions."

Recommendation 16-1-26.5 "That the Board of Directors approve and publish the newly developed Position Statement 'Respiratory Disease Manager'."

Recommendation 16-1-26.6 "That the Board of Directors add the goal of reviewing/revising all White Papers on the same three (3) year schedule the committee reviews all position statements."

Recommendation 16-1-26.7 "That the Position Statement Committee submit the Position Statement 'Administration of Sedative and Analgesic Medications by Respiratory Therapists' to BOMA for their recommendations of revising or retiring this statement."

American Society for Testing and Materials (ASTM)

Recommendation 16-1-65.1 "That the ASTM be removed from the list of AARC Special Representatives."

International Council for Respiratory Care (ICRC)

Recommendation 16-1-70.1 "That the AARC Board of Directors include in the 2017 budget and subsequent budgets funding for two US ICRC delegates to participate in the international meetings and activities associated with the AARC International Congress and the ICRC Annual Business Meeting"

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

Recommendation 16-1-31.1 "That the AARC Board of Directors Adopt the CoARC proposed revision to the APRT working definition to read:

> 'The Advanced Practice Respiratory Therapist (APRT) is a ~~trained,~~ credentialed, ~~and~~ licensed respiratory care practitioner ~~who is employed to~~ trained 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 advanced, evidence-based, ~~complex~~ diagnostic and therapeutic clinical practice and disease management'."

Recommendation 16-1-31.2 "That the AARC Board of Directors adopt the revised committee objectives to read:

'Objectives: (In priority order)

1. Create the framework for the needs assessment, retain a third party consultant to conduct the needs assessment, conduct the needs assessment, and evaluate completed needs assessment to determine appropriate next steps.
2. General - Licensure - identify states where passage of APRT licensure or certification would have the greatest chance of success.
3. General - Identify at least one educational institution to offer an educational pilot program(s) for APRT.
    a. Identify possible mechanisms to provide funding through the ARCF or other stakeholder(s) (e.g., employers) to support the pilot program(s).
4. AARC - Reimbursement issues - Clearly define the pros and cons of both an "incident to" and "independent practice" approach related to APRT reimbursement and provide information that assists in determining the best approach to establish for future use.
    a. Include information related to direct billing versus salaried positions from a physician or hospital/ facility and level of supervision.
5. Align work of the committee with the Taskforce on Competencies for Entry into Respiratory Care Professional Practice, the Ad Hoc Committee on AARC Research Fund for Advancing the Respiratory Care Profession, the Ad Hoc Committee on Respiratory Therapists and Disease Management, and with the work of specific AARC Goals Committees.
6. NBRC – Upon formal request from the AARC, develop the credential for the APRT.'"

Past Minutes

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

November 5, 2015 • Tampa, FL

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, RRT-SDS, RPFT, RPSGT, AE-C, CTTS, Secretary/Treasurer
Ellen Becker, PhD, RRT-NPS, FAARC
Cheryl Hoerr, MBA, RRT, CPFT, FAARC
Keith Lamb, RRT
Doug McIntyre, MS, RRT, FAARC
Natalie Napolitano, MPH, RRT-NPS, FAARC
Timothy Op't Holt, EdD, RRT, AE-C
Sheri Tooley, BSRT, RRT-NPS, CPFT, AE-C, FAARC
Lisa Trujillo, DHSc, RRT
Gary Wickman, BA, RRT, FAARC
Kimberly Wiles, BS, RRT, CPFT

Consultants

Steve Boas, MD, BOMA Chair
Dianne Lewis, MS, RRT, FAARC, President's Council President
Mike Runge, BS, RRT, FAARC Parliamentarian
Deb Skees, MBA, RRT, CPFT, Past Speaker

Excused

Bill Lamb, BS, RRT, CPFT, FAARC
John Lindsey, Jr., MEd, RRT-NPS, FAARC

Staff

Tom Kallstrom, MBA, RRT, FAARC, 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 Regulatory Affairs
Kim Turner, Esq., Director Legislative Affairs
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER

President Frank Salvatore called the meeting of the AARC Board of Directors to order at 8:55am EST. Secretary/Treasurer Karen Schell called the roll and declared a quorum. Two students who came to observe the meeting were introduced.

DISCLOSURE

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

WELCOME AND INTRODUCTIONS

Members introduced themselves and stated their disclosures as follows:

Karen Schell –FDA Pulmonary Allergy Committee, Community member; Advisory Board KCKCC; CoBRGTE member

Lisa Trujillo – CoBGRTE member; Advisory Board Northeastern University MSRT Program; Western Schools author and reviewer

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; Board of Directors Chicago Asthma Consortium; Chicago-area Patient-Centered Research Outcomes Network (CAPriCORN) Steering Committee

Tim Op't Holt – CoBGRTE member

Natalie Napolitano – Research relationships with Aerogen, Nihon-Kohden, Draeger, Philips, CVS Health, CoBGRTE member, Allergy & Asthma Network Board member

Gary Wickman – CoBGRTE member

Frank Salvatore – Member of CTSRC

Keith Lamb – Covidien, Masimo, Sunovian, Bayer

Cheryl Hoerr – Southmedic, clinical advisor, Rolla Technical Institute Advisory Committee; MO State University West Plains Advisory Committee; Lindenwood Adjunct Faculty

Cyndi White – Philips, Aerogen, Vapotherm

Tom Kallstrom – Board member of Allergy & Asthma Network

Kimberly Wiles – Board of Directors Pennsylvania Association of Medical Supplies; Advisory Board member of IUP/West School of Respiratory Care

APPROVAL OF MINUTES

Sheri Tooley moved to approve the minutes of the July 16, 2015 meeting of the AARC Board of Directors.

Motion carried

Karen Schell moved to approve the minutes of the July 17, 2015 meeting of the AARC Board of Directors.

Motion carried

E-motions

There were no E-motions since the last Board meeting that needed to be ratified.

GENERAL REPORTS

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

Government Affairs
Cheryl West, Anne Marie Hummel and Kim Turner provided a detailed description of the most recent Government Affairs efforts in both the state and federal arena. Updates were provided regarding various state legislative and regulatory actions as well as on the federal level pending new Medicare regulations on ventilators and clinical lab personnel requirements Ms. Turner provided a 2016 Hill strategy to move HR 2948 the Telehealth Parity Act forward.

House of Delegates
Speaker John Wilgis thanked the Board of Directors for attending the Color Guard ceremony earlier today and invited sections chairs to give reports at the House meeting in the afternoon.

Ad Hoc Committee on Advanced RT Practices, Credentialing, and Education
Lynda Goodfellow moved to accept 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.'*."

Natalie Napolitano moved to make a friendly amendment to add "working" to "…..accept the working definition……"
Motion carried

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

Cyndi White moved to refer to president.
Motion carried

Lynda Goodfellow moved to accept 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."

Cyndi White moved to refer to president.
Motion carried

Lynda Goodfellow moved to accept 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."

Lynda Goodfellow moved to refer to president.
Motion carried

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

Lynda Goodfellow moved to refer to president.
Motion carried
Ellen Becker abstained because she is on the committee.

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

Lynda Goodfellow moved to refer to president.
Motion carried

RECESS
President Salvatore recessed the meeting of the AARC Board of Directors at 10:22am EST.

RECONVENE
President Salvatore reconvened the meeting of the AARC Board of Directors at 10:36am EST.

President Salvatore introduced two new students who came to observe the meeting.

Doug Laher commented on what to expect at the Congress this year.

Board of Medical Advisors (BOMA)
Chair Boas reminded the Board of Directors to use BOMA more often. He thanked the Board for their support during his year as Chair. Dr. Janet Lioy joined BOMA in August and she represents the American Academy of Pediatrics (AAP).

President's Council
Tim Op't Holt moved to accept Recommendation 15-3-8.1 "That the AARC BOD approves the revisions to BOD Policy.001."
Motion carried

Cyndi White moved to accept Recommendation 15-3-8.2 "That the AARC BOD approves the revisions to 'Attachment D-AARC Awards Guidelines'."
Motion carried

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

Lynda Goodfellow moved to refer to Bylaws Committee.
Motion carried

George Gaebler moved to accept the General Reports as presented.
Motion carried

STANDING COMMITTEES REPORTS

Bylaws Committee
Lynda Goodfellow moved to accept 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."
Motion carried

Lynda Goodfellow moved to accept 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."
Motion carried

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

Lynda Goodfellow moved to refer to president.
Motion carried

Lynda Goodfellow moved to accept 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."

Lynda Goodfellow moved to refer to president.
Motion carried

Finance Committee
Cyndi White moved to ratify the capital purchase of an air conditioning unit for $8,126.33.
Motion carried

Doug McIntyre 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

Membership Committee
Cyndi White moved to accept 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."

Gary Wickman moved to accept for information only. (President Salvatore has created an Ad Hoc Committee on AARC Student Website Enhancement, Tom Lamphere, Chair.)
Motion carried

Position Statement Committee
Cyndi White moved to accept Recommendation 15-3-26.1 "That the AARC Board of Directors approve and publish the revised Position Statement 'Electronic Cigarettes'."
Motion carried

Cyndi White moved to accept Recommendation 15-3-26.2 "That the AARC Board of Directors approve and publish the Position Statement 'Respiratory Therapist Education'."
Motion carried

Cyndi White moved to accept 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."
Motion carried

Sheri Tooley moved to accept the Special Committee reports as presented.
Motion carried

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

SPECIAL REPRESENTATIVES REPORTS

Extracorporeal Life Support Organization (ELSO)
Cyndi White moved to accept 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."

Keith Lamb moved to refer to Executive Office for collaboration with ELSO and specialty sections.
Motion carried

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

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

RECESS
President Salvatore recessed the meeting of the AARC Board of Directors at 12:04pm EST.

JOINT SESSION
Joint Session was called to order at 1:40pm EST. 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 2016 election:

President-Elect:	Brian Walsh
Director-at-Large:	John Lindsey, Doug McIntyre, Debra Skees, Pattie Stefans
Sleep Section:	Marilyn Barclay
Home Care Section	Zachary Gantt
Neonatal/Pediatrics Section	Steve Sittig

Government Affairs

AARC's new Washington DC lobbyist, Ms. Kim Turner was introduced to the House of Delegates and provided an outline of the legislative strategy AARC and its telehealth coalition partners will undertake in the 2016 session. Additional details were provided on state activities of note, and more details were provided on Clinical Lab personnel requirements impacting the RT.

Sheri Tooley moved to go into Executive Session at 2:35pm.
Motion carried

Lynda Goodfellow moved to come out of Executive Session at 2:50pm
Motion carried

Bylaws Committee

Troy Whitaker, Bylaws Chair, presented the second reading of the proposed Bylaws changes.

A moment of silence was given in honor of Debbie Fox.

Frank Salvatore and John Wilgis thanked Sherry Milligan for her 35 years of service to the AARC and wished her well on her retirement. She was presented with a plaque and vase from the Board of Directors and House of Delegates.

Karen Schell and Lisa Trujillo introduced Dr. Esther Robi. She is a Respiratory Care Program Director, University of Ghana Respiratory Care Program, Accra, Ghana.

President Salvatore adjourned the Joint Session at 3:20pm EST.

RECONVENE

President Salvatore reconvened the meeting of the AARC Board of Directors at 3:35pm EST.

Roundtables Continued

FM 15-3-1.1 George Gaebler moved that the president charge the Executive Office with the development of communities for the improvement of communications and member involvement for the replacement of Roundtables.
Motion carried

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

AD HOC COMMITTEE REPORTS

Ad Hoc Committee on Cultural Diversity on Patient Care
Cyndi White moved to accept 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."

George Gaebler moved to amend the name to "Committee on Diversity" and change to a Special Committee.
Motion carried

President Salvatore introduced three students who came to observe the meeting.

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

Gary Wickman moved to refer to the president.
Motion carried

Cyndi White moved to accept 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."

George Gaebler moved to refer to the president.
Motion carried

Cyndi White moved to accept 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."

George Gaebler moved to refer to the president.
Motion carried

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

George Gaebler moved to refer to the Executive Office.

Motion carried

Sheri Tooley moved to accept the Ad Hoc Committee reports as presented.
Motion Carried

OTHER REPORTS
Tom Kallstrom gave highlights of the submitted ARCF report.

The reports from CoARC and NBRC were reviewed.

Cyndi White moved to accept the other reports.
Motion carried

UNFINISHED BUSINESS

FM 15-3-9.5 Tim Opt Holt moved to accept the Bylaws second reading as read during Joint Session.
Motion carried unanimously

FM 15-3-12.1 Lynda Goodfellow moved to accept the 2016 AARC budget as presented.
Motion carried

Taskforce on the Creation of Collaborative Efforts with External Organizations
President Salvatore asked the Board for their opinions of the presented document. Chair of the Taskforce, George Gaebler, provided comments about the charges.

CoBRGTE
President Salvatore informed the Board of Directors of recent communication with Tom Barnes who had asked for a last minute meeting at Congress with the AARC Executive Committee. Frank declined due to the hectic schedules at Congress. Tom wanted to ask AARC to become a sponsoring member of the new CoBRGTE accreditation arm. Frank offered a meeting post-Congress.

Official statement per Salvatore - We received the request but it was too late for the Board to make an informed decision.

RECESS
President Salvatore recessed the meeting of the AARC Board of Directors at 4:30pm EST.

RECONVENE
President Salvatore reconvened the meeting of the AARC Board of Directors at 4:40pm EST.

Deb Skees, Past Speaker, informed the Board of Directors that all 6 proposed bylaws changes and the budget passed in the House of Delegates meeting.

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

The AARC was asked by UHC to work with them on a white paper because they needed an organization such as ours to create this document. Shawna Strickland spearheaded this project. The Board of Directors was asked to review and offer changes/comments.

FM 15-3-26.4 Sheri Tooley moved to refer to Position Statement Committee for review and comments.
Motion carried

Cheryl Hoerr moved to amend **FM15-3-26.4** to refer to the Position Statement Committee for review to collaborate with the UHC to revise and amend by April 2016 Board meeting.

Cheryl Hoerr moved to rescind **FM15-3-26.4**.
Motion carried

Shawna Strickland is the liaison for the UHC paper and will relay the Board's comments to them.

President Salvatore informed Kim Wiles that the Homecare Section has until December 1, 2015 to reach 1,000 members or they will lose their Board seat.

RECESS

President Salvatore called a recess of the AARC Board of Directors meeting at 5:00pm EST.

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

_____ _____

Karen Schell Date
AARC Secretary/Treasurer

Attachment “A”

Electronic Cigarette Position Statement
Respiratory Therapist Education Position Statement

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 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 04/2014
Revised 12/2014
Revised 11/2015

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

Position Statement

Respiratory Therapist Education

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
Revised 11/2015

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

November 6, 2015- Tampa, FL

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, RRT-SDS, 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
Cheryl Hoerr, MBA, RRT, CPFT, FAARC
Keith Lamb, RRT
Natalie Napolitano, MPH, RRT-NPS, FAARC
Ellen Becker, PhD, RRT-NPS, FAARC
Kimberly Wiles, BS, RRT, CPFT

Consultants

Mike Runge, BS, RRT, FAARC Parliamentarian
Dianne Lewis, MS, RRT, FAARC, President's Council President
Deb Skees, MBA, RRT, CPFT, Past Speaker
Steve Boas, MD, BOMA Chair

Excused

Bill Lamb, BS, RRT, CPFT, FAARC
John Lindsey, Jr., MEd, RRT-NPS, FAARC

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
Kim Turner, Esq., Director of Legislative Affairs
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER

President Frank Salvatore called the meeting of the AARC Board of Directors to order at 8:06am EST. Secretary-Treasurer Karen Schell declared a quorum.

President Salvatore introduced 4 students who came to observe the meeting.

UNFINISHED BUSINESS

Strategic Goals Update – President Salvatore asked that each of the Strategic Plan Workgroups give an update of their work.

FM15-3-83.1 Natalie Napolitano moved to refer the recommendations for Summer Forum and Congress 2016 ideas from the Strategic Goals workgroup #3 to the Executive Office.
Motion carried

FM15-3-83.2 Natalie Napolitano moved to refer recommendation #3 from Strategic Workgroup #3 to the ARCF for their consideration.
Motion carried

RECESS

President Salvatore recessed the meeting of the AARC Board of Directors at 9:42am EST.

RECONVENE

President Salvatore reconvened the meeting of the AARC Board of Directors at 10:02am EST.

President Salvatore introduced 4 students who came to observe the Board of Directors meeting.

FM15-3-83.3 Gary Wickman moved to establish a formalized Speakers Bureau of present and past members of the AARC Board of Directors to attend affiliate meetings with the main goal of increasing AARC membership.

Gary Wickman moved to refer to the Executive Office.
Motion carried

FM15-3-83.4 Gary Wickman moved to create a written program much like the DELP program to engage diverse members of the association and provide scholarships to the Leadership Institute to prepare diverse professionals and organizational leaders.

Gary Wickman moved to refer to the president.
Motion carried

FM15-3-83.5 Gary Wickman moved to consider a Board of Directors mentorship program, much like the House of Delegates student mentorship, that brings in young state leaders.

Gary Wickman moved to refer to president.
Motion carried

President Salvatore asked the Strategic Goals workgroups to write their objectives for 2016 and send to him by December 31, 2015.

Tom Kallstrom presented the revised Conflict of Interest document to the Board of Directors.

FM15-3-83.6 Gaebler George moved to adopt the revised Conflict of Interest document as policy for the AARC.
Motion carried

The policy number will be BOD.028 – Board of Directors – Conflict of Interest. (See Attachment "A").

NEW BUSINESS

POLICY REVIEW

BOD.003 – Board of Directors – Use of AARC Corporate Credit Card
Sheri Tooley moved to change reviewed date and accept.
Motion carried

BOD.014 – Board of Directors – Attendance at Receptions
Karen Schell moved to change reviewed date and accept.
Motion carried

(See attachment "B" for all policies.)

Deb Skees, HOD Past Speaker, gave the results of the 2016 HOD elections. Keith Siegel, Speaker-elect; Kerry McNiven, Secretary, and Curt Merriman, Treasurer

President Salvatore began a discussion about the results of the Board Self-Assessment survey.

RECESS
President Salvatore recessed the meeting of the AARC Board of Directors at 10:40am EST.

RECONVENE
President Salvatore reconvened the meeting of the AARC Board of Directors at 10:50am EST.

Charlene Lamka, founder of FACES (Family and Caregivers Education and Support) Foundation, gave a presentation about an award that honors respiratory therapists.

The Board of Directors presented President Salvatore with a thank you gift.

President Salvatore thanked Sheri Tooley and Gary Wickman for their work on the Board.

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

MOTION TO ADJOURN

Sheri Tooley 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 11:20am EST.

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

_____ _____

Karen Schell Date
AARC Secretary/Treasurer

Attachment “A”

BOD.028 – Board of Directors – Conflict of Interest

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: Conflict of Interest

EFFECTIVE DATE: November 2015

DATE REVIEWED: November 2015

DATE REVISED:

Purpose
To avoid conflicts of interest or even the appearance of a conflict of interest.

Issue
Because the AARC is composed of leaders in the field of Respiratory Care, their business and professional relationships may put them into situations where a conflict of interest or even its appearance, may arise. This document is designed to provide guidance in (a) identifying conflicts of interest; (b) analyzing conflicts of interest; (c) resolving conflicts of interest; and d) providing guidance to AARC employees, directors or agents of the Association when speaking or authoring articles for competing meetings is a conflict of interest.

Statement of the Challenges
(1) The AARC Must Remain Neutral: The respiratory care industry is serviced by a plethora of manufacturers, pharmaceutical companies and other for-profit organizations. The industry serving our profession involves the use of medical products, drugs, education, and services for which said companies frequently seek employees, directors or agents of the AARC to act as advocates for their products.

If an individual acts as a spokesperson for, or an advocate for a particular product, device, service or procedure, it is important that they understand that their participation as a recognized employee, director or agent of the AARC can be a powerful marketing tool for companies and infer AARC endorsement.

Acting in accordance with, and in the context of their regular employment, and/or, as an independent contractor, working in conjunction with those in industry may not create a conflict of interest for the AARC The AARC does not take a position with regard to whether this is appropriate within the scientific community. However, when the same individual is identified as an officer, elected official, chair, employee, or agent of the AARC, it effectively creates an inference AARC sponsorship for, or implies tacit endorsement of that particular product, activity, or company. This is of concern to the AARC because the Association must take a neutral approach with ALL industry partners and does not take a position of advocating for one product, service or drug over another. To do so would be contrary to our mission.

(2) Attendees at Educational Events Must Be Able to Critically Evaluate Information Presented: When individuals are compensated (or where their travel and lodging are paid for) directly by a manufacturer, in order to present clinical or scientific information, this may also create the appearance of a conflict of interest, if it is not disclosed. Someone may rightly wonder if a person who is being paid $1,000 to speak to a group about a particular piece of equipment is doing so out of a committed belief in a particular product or service, or out of lucre. This would be unacceptable.

Therefore, ethical principles suggest full disclosure of your relationship with industry, whether at AARC sponsored events or not. Please keep in mind that full disclosure of all industry relationships is best practice. It is not the responsibility of the presenter/author to determine what constitutes a real or perceived conflict of interest. That responsibility lies with the meeting attendee.

I. Identifying Conflicts of Interest

Conflicts of interest may arise in a variety of ways, but the following are two situations that good easily occur: (a) where because of an affiliation with the AARC or a state society, an individual is recruited to act as a spokesperson or presenter on a specific manufacturer's products or services, and the manufacturer intends to mention the AARC affiliation in its marketing; and (b) where an individual is asked to present information that is arguably favorable to a particular manufacturer's product or service and an underlying financial arrangement, either direct (the payment of cash honoraria) or indirect (the reimbursement of expenses or investment in the company) is not disclosed to those in attendance.

II. Analyzing Conflicts of Interest

The following policy guidance is provided to help individuals analyze conflicts of interest.

General AARC Policy Regarding Disclosure of AARC Affiliations in Advertising

Underlying Principle
AARC Neutrality Must Be Maintained.

Policy
As a general rule any director or officer of the AARC who is taking the position of, or suggests through photos, images or selective sharing of data that a particular product or service is beneficial may do so without using their AARC position in any advertising. Thus an attribution like: "As recommended by Bob Smith, St. Lukes Hospital Department Manager[1]" does not create a problem. However, "Recommended by Bob Smith, AARC BOD member" does create a conflict of interest. Any AARC employee, director or agent who is asked to endorse a product or

[1] Individual hospitals may have specific limitations on employees endorsing medical products. This policy does not address that issue.

service must do so only under circumstances where they are speaking in their own right, and may not mention or trade upon their AARC affiliation.

If a manufacturer refuses to remove references to a person's AARC affiliation from their marketing material, the only recourse to resolve the conflict may be to resign or discontinue their affiliation with the manufacturer.

General AARC Policy Regarding Disclosure of Corporate Interests

Underlying principle
A financial interest in a product or service is not a per se disqualification from speaking on that subject, but arrangements between speakers and manufacturers must be disclosed to permit attendees to evaluate the potential for bias in the presentation.

Policy
Any individual who is presenting at any AARC sponsored event, or any event for which CRCE credit is sought from the AARC must disclose verbally (or in writing) of any compensation, in cash or in kind, whether direct or indirect that was provided by a manufacturer, sales organization, or any other person or entity that may directly benefit from the presentation. This is common practice throughout the medical community. AARC recommends that you ask about sponsorship or peripheral requirements when first approached to present.
While specific amounts need not be disclosed a statement to the effect that "Mr. Smith's presentation today is underwritten by XYZ Medical" is sufficient to place attendees on notice that the speaker has an indirect financial interest in the presentation.

An individual who owns stock in any company that he or she may mention during the course of a presentation should similarly disclose this information on disclosure forms: "Mr. Jones owns stock of various medical product makers but has no direct financial interest in any product being discussed," is sufficient to put the attendees on notice that the speaker has an indirect financial interest in the presentation, where the presentation makes any mention of a product or service provided by that company. Similarly "ABC Corporation Has Sponsored This Lecture" is sufficient to put attendees on notice that ABC may have a corporate interest in the material being provided.

Where an individual is presenting the results of research that involve a product or service, but where the speaker has no direct or indirect financial interest in the product or service, this does not require disclosure. There is no actual conflict of interest.

Best Practice
If a presenter believes that anyone might reasonably question their independence, or their biases as a result of an arrangement they have with a manufacturer, sales organization, or other entity, they should err on the side of disclosure.

Examples

A) No compensation = no disclosure

Mrs. Jones presents results from a study of a particular brand of suction device. Her research indicates that it is effective and has resulted in lower rates of infection. She neither owns stock in, nor is being compensated in any way for her presentation by the manufacturer of the device. No disclosure is required.

B) Contingent and Indirect Compensation = disclosure

Mr. Jones presents results from a study of a particular brand of suction device. His research indicates that it is effective and has resulted in lower rates of infection. He is not being compensated directly for his presentation. However, he has been told that if "enough people switch to the product this year, you'll receive an opportunity to get shares when the company goes public." Here disclosure is required because Mr. Jones has a contingent, indirect deferred compensation arrangement with the manufacturer, which must be disclosed.

C) Incidental Mention = no disclosure

Ms. Smith desires to present on the topic of the use of music in ventilator weaning. Ms. Smith owns stock in Best Buy Corporation (NYSE: BBY). During questions following her presentation she mentions that she purchased headphones for patients from Best Buy, but does not endorse any particular brand or suggest that others obtain headphones in this way. No disclosure is required as this was not a focus of her presentation.

D) Reasonable Suspicion of Bias = Err on the side of disclosure

Mr. Doe has always used Brand X ventilators. He has never considered any other ventilator for his hospital. He has routinely read every positive piece of literature associated with Brand X, and has steadfastly refused to read anything relating to other ventilators because "we don't use those here." He has no financial relationship with Brand X. He does not ask for Brand X to sponsor him, although he frequently gets calls for recommendations from people looking to buy their product. Every year at Christmas he receives a $10 bottle of wine from the local Brand X representative. While there is not a technical conflict of interest, there is a prudential conflict of interest. Any presentation Doe does on the Brand X ventilator should be preceded with a disclosure that Brand X is the only ventilator he has ever used at his hospital.

III. Resolving Conflicts of Interest

A conflict of interest in the situation where an individual is asked to present on a subject and has a financial interest is resolved by disclosing the interest.

A conflict of interest in the situation where an individual's AARC affiliation is mentioned in advertising or marketing is addressed by either (a) getting the manufacturer to pull the offending marketing material from circulation; or (b) by resigning from the leadership position with the AARC.

IV. Guidance Based on Position and Role within the AARC

AARC employees, paid consultants and in-term AARC presidents are not permitted to accept direct compensation for any professional services or consulting engagement rendered to companies working within the respiratory care industry. This does not prohibit these individuals from working with said companies so long as compensation does not change hands, is done on behalf of the AARC (not the individual) and is done with the sole purpose to strengthen strategic partnerships with industry partners.

Executive committee members should seek permission from the AARC president before speaking for or on behalf of company in which compensation or endorsement of a product or service is provided.

Officers of the Board of Directors and House of Delegate Officers are not limited to having industry relationships, to speak for or on behalf of industry or to consult with industry so long as their role and/or position within the AARC is not used to promote their stature or provide tacit endorsement for a product or service. It is best practice however and in situations where their relationship with industry is "grey", to consult with the AARC president for advisement.

V. Identifying Conflicting Organizations/Publications

Meetings
AARC employees, officers, directors of agents of the Association are permitted to present at meetings that deliver respiratory care education and NOT be considered in conflict with this document so long as the meeting sponsor meets one or more of the following:

- The meeting sponsor is not a member organization that specifically targets respiratory therapists as their primary demographic. For example, the American Thoracic Society is a member organization that allows respiratory therapists as members, but their primary demographic is physicians.
- The meeting sponsor is NOT direct competitor of AARC. *Exceptions to this are industry sponsored educational events so long as the respiratory therapist does not have to pay a registration fee to attend.*
- The meeting sponsor does NOT utilize exhibitor revenue as the sole source to fund the meeting.
- Revenues from the meeting are donated to charity
- It is acceptable to present at local meetings (i.e. community hospitals or universities) so long as all revenue from the meeting must is re-invested into promoting the

research/science of respiratory care OR for the professional growth and development of the respiratory therapist (employees of the sponsoring organization).

- The meeting sponsor is an AARC state affiliate or the event is sponsored by an AARC state affiliate.
- Educational meetings which do not fall under one of the categories above must receive prior approval from AARC's President

Scientific, Peer-reviewed Publications
All AARC employees, directors, officers, or agents are encouraged to submit manuscripts to reputable, peer-reviewed, scientific publications.
While it is encouraged that manuscripts are submitted for publication in RESPIRATORY CARE, publication in external peer-reviewed journals IS NOT considered to be a conflict.

Respiratory-Related Magazines
It is considered a conflict for any AARC employee, director, agent, or officer to author an article which is published in any publication considered in direct competition with AARC Times magazine for subscriptions, advertising, and sponsorships

Attachment “B”

BOD.003 – Board of Directors – Use of AARC Corporate Credit Card
BOD.014 – Board of Directors – Attendance at Receptions

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Use of AARC Corporate Credit Card**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: ~~April 2011~~ November 2015

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

Policy No.: BOD.014

SECTION: Board of Directors

SUBJECT: **Attendance at Receptions**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: ~~April 9, 2011~~ November 2015

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:

E-Motions

(Since Last Board Meeting in November 2015)

E16-1-15.1 "That the 2018 Summer Forum be held in San Antonio at the JW Marriott Hill Country Resort & Spa."

Results – February 7, 2016
Yes – 16
No – 0
Abstain – 0
Did Not Vote – 1

E16-1-15.2 "That the practitioner component of the Sputum Bowl be eliminated if 15 teams are not registered to compete by June 1, 2016."

Results – February 7, 2016
Yes – 10
No – 6
Abstain – 0
Did Not Vote – 1

E16-1-15.3 "That the AARC Board of Directors ratify the Chair and members of the 2016 Sputum Bowl Committee as noted:

2016 Sputum Bowl Committee
Chair: Renee Wunderley
Past Chair: Sherry Whiteman
Moderator: Tom Lamphere
Moderator: Rick Zahodnic
Timer/Scorekeeper: Angie Switzer"

Results – February 7, 2016
Yes – 16
No – 0
Abstain – 0
Did Not Vote – 1

General Reports

President Report

Submitted by Frank Salvatore– Spring 2016

Recommendations

That the AARC Board of Directors ratify the Ad Hoc Committee on State Initiatives.

- **Chair** – John Wilgis
- **Committee Members**: Sam Giordano, Joseph Goss, Gene Gantt, Kenneth Alexander, Jan Fields, (additional members to be added as committee needs).
- **AARC EO Liaisons**: Tom Kallstrom and Cheryl West
- **Objectives**:
    i. Research possible initiatives that can be put into a format to deliver to state affiliates in order to create better access to RTs by patients who are on state services such as Medicaid.
    ii. Act as a subject matter expert/resource to the state affiliates who need guidance and support as they put forth the initiatives created by the committee.

That the AARC Board of Directors ratify Margaret Traband as a special representative to CoBGRTE.

Report

The following is an accounting of my activities done prior to and around the April 2016 Board meeting:

1. December 11-13, 2015 – NBRC Board Meeting – AARC Presentation – Austin, TX
2. January 21-24, 2016 – Attended the 2016 World Patient Safety Summit – Dana Point, CA
3. February 29- March 1, 2016 – NHLBI COPD Town Hall Meeting – Bethesda, MD
4. March 11, 2016 – CoARC Board Meeting – Conference Call (Tom and Shawna attended)
5. March 28-29, 2016 – AARC Corporate Partners Meeting – Dallas, TX
6. April 7, 2016 – Kansas Society for Respiratory Care Conference – Video Presentation

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

1. **15-3-31.2** – That the AARC Board request the Association share the accepted definition with the Tripartite for their acceptance. - **Completed**
2. **15-3-31.3** – That the Board designates 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. **- Completed**

3. **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. – **Accepted for Information and Understood**
4. **15-3-31.5** – That the current committee composition would be effective in continuing this work post needs assessment. – **Accepted for Information and the Committee is Extended**
5. **15-3-31.6** – That the AARC formally request the NBRC explore the development of the APRT credential and examination. – **Motion is Premature, NBRC advised of the Committee's Work, but the formal request will occur at a more appropriate time**.
6. **15-3-9.1** - That the AARC Board of Directors considers developing a more formal onboarding/orientation program for new committee chairs. – **In Progress**
    - Participated in a "Section Chairs" webinar on 1/6/16. It went well and I think this could be the template for the future orientation of committee chairs/co-chairs. I'm going to ask that President-Elect Brian Walsh take this on in preparation for his Presidency.
7. **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. – **In Progress**
    - This has been communicated to the by-laws committee and should appear in the by-laws amendments that will come out for the June 2016 BOD/HOD meetings.
8. **15-3-29.2** – That the Board of Directors establishes a Cultural Diversity Round Table for its diverse members. – **In Progress**
9. **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. – **In Progress**
10. **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. – **In Progress**
11. **FM 15-3-83.4** – To create a written program much like the DELP program to engage diverse members of the association and provide scholarships to the Leadership Institute to prepare diverse professionals and organizational leaders. – **No movement as of yet.**
12. **FM 15-3-83.5** – To consider a Board of Directors mentorship program, much like the House of Delegates student mentorship that brings in young state leaders. – **I've taken the liberty of asking the HOD Student Mentorship group to allow the students to rotate through the board meetings in the summer and fall meetings**.

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

1. Comments to CMS regarding implementation of the merit-based incentive payment system, promotion of alternative payment models, and incentive payments for participation in eligible alternative payment models (CMS-3321-NC) (November 17, 2015)
2. Letter to Tom Barnes – CoBRGTE questions (January 2015)
3. Letter to Housing and Urban Development regarding instituting smoke free public housing; docket no. FR 5597-P-02 RIN 2577-AC97. (January 19, 2016)
4. Letter of support for Allergy and Asthma Network's application for the CDC and prevention funding opportunity; "national collaboration to support health, wellness and academic success of school-age children. (January 19, 2016)

5. Letter to CMS providing comments to CMS-3327-NC: Request for information to aid in the design and development of a survey regarding patient and family member experiences with care received in long-term care hospitals. (January 19, 2016)
6. Signed onto a coalition letter on behalf of the AARC providing comments to the AHRQ Technical Brief titled Telehealth: An Evidence Map for Decision Making. (January 19, 2016)
7. Letter to Texas Health Promotion and Chronic Disease Prevention Section regarding the development of a Strategic Plan addressing chronic respiratory disease for the citizens of Texas. (January 21, 2016)
8. Letter to the Chair and Ranking Members of the Senate Finance Committee regarding the release of a policy options document released in December 2015 related to work done by the committee's bipartisan chronic care working group. (January 26, 2016)
9. Reviewed an article being done by the Pennsylvania Patient Safety Authority on behalf of the AARC titled "Missed Respiratory therapy Treatments: Underlying Causes and Management Strategies". (February 11, 2016)

It has been an honor and a privilege to serve this profession as its President. I look forward to my final year as your President and look to help Brian Walsh prepare for his two years. 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.

Coalition for Baccalaureate and Graduate Respiratory Therapy Education
Corporate Address: PO Box 392, 27 Spruce Lane Tenants Harbor, Maine 04860-0392

March 7, 2016

Frank R. Salvatore Jr., RRT, MBA, FAARC
President – American Association for Respiratory Care
Dallas, Texas

Dear Frank,

The leadership of CoBGRTE, respectfully requests that the AARC appoint a special CoBGRTE representative. We believe the representative would help to strengthen further the communication between the two associations. This has become increasingly important as we combine efforts to help transition associate degree programs to the point where they can offer a Bachelor of Science in Respiratory Care.

Thanks again for the AARC Board's leadership on approving and posting on 1/5/16 the AARC Position Paper on Respiratory Therapist Education. This truly helps the profession improve recognition from the medical community and governmental agencies.

Please let me know the AARC Board's decision after the April meeting.

Sincerely,

Tom

Tom Barnes, EdD, RRT,
FAARC President, CoBGRTE

www.cobgrte.org
617-851-3529
"Dedicated to Improving Respiratory Therapy Education"

Past President Report

Submitted by George Gaebler– Spring 2016

Report will be handed out at the meeting.

Executive Office

Submitted by Tom Kallstrom – Spring 2016

Recommendations

None

Report

Welcome to Washington, DC and we hope we hope to have a productive meeting. We also look forward to a successful Hill Day following the Board Meeting of which many of you will be joining us. Below is an update of the activities that the AARC Executive Office has been involved in since we last met in November.

MEMBERSHIP

As of March 1, 2016, our membership numbers were 48,191. We will have a more current number to report at the board meeting in April. The AARC closed 2015 with a 79.1% member retention rate, which is an increase of 2.5% over the 2014 member retention rate and higher than the AARC's five year average of 78.6%. The 2015 Marketing General Incorporated Membership Marketing Benchmark Report indicates that mean non-profit member association retention rates are 79% (median 82%).

In January 2016, the AARC hired a new Membership Development Manager. Ms. Amanda Feil is a graduate of the University of Texas at El Paso and has several years of experience in non-profit organizations. Since joining the AARC, Ms. Feil has improved automated notification systems that has resulted in increased student renewals and is currently working on reformatting membership messages and developing tutorials for members to engage more meaningfully with AARConnect.

Early Student Renewals

The membership and customer service team focused on maximizing the efficiency of the early student renewal process, both the student notifications and the actual process. The student notifications are now automated on a schedule based on the student's graduation date. Since automating this process, early student renewals have been increasing daily. As of March 1, 2016, 340 early student renewals have been processed. The customer service and IT teams are currently testing an improved renewal process that will reduce manual data manipulation. This will improve the member experience during renewals as well as reduce potential human error. The testing phase has been initiated and it is expected that the fully automated process will be in place by the end of March 2016.

Retired Members

The number of retired members has improved from 80 at the last Board report to 120. However, this is still lower than expected. The membership and customer service teams are working to develop a strategy to reach out to retired members.

Revenue Sharing/Co-Marketing
As of March 10th there have been 47 states (46 in 2015) that have signed their co-marketing and revenue sharing agreements, which is an all-time record. And as per usual Missouri, California, and Tennessee have not signed.

SOCIAL MEDIA

Please see the attachment "AARC Social Report Feb 2016".

MEETINGS & CONVENTIONS

AARC Congress 2015, held in Tampa, was very successful for the Association in meeting the education needs of our members and in exceeding our financial budget. Content was outstanding and the Open Forums delivered another strong year with more than 300 original research posters presented in 12 Open Forums over 4 days. In its second year, the new Open Forum formats allowed presenters the opportunity to present their original research in the traditional method, as well as poster only presentations in the Exhibit Hall, and the top 12 posters were highlighted in a stand- alone session in which they could present their research via PowerPoint Presentation, one of which has already been approved for publication in RESPIRATORY CARE.

The Keynote Address delivered by Patrick Reynolds was well received and delivered a much needed message to our members regarding the importance smoking cessation and the role of the respiratory therapist. The closing ceremony also had rave reviews and left attendees with tears of emotion and a sense of pride as Amy Van Dyken delivered a moving presentation detailing her path to Olympic stardom, her life with asthma (and the role of the respiratory therapist) as well as the devastating accident that left her paralyzed following an ATV accident in 2014.

The Program Committee continued to provide a diverse faculty for the meeting that included a balanced mix of experienced presenters, international faculty, as well as an estimated 35 first time speakers.

In lieu of a challenging economic climate, limited travel and education budgets from employers, and the overall impact of the Affordable Care Act, communicating value of attendance at future meetings must continue to be a primary focus moving forward. The cost of travel (airfare, parking, cab fare, hotel, and food – all of which are out of AARC control) carries a heavy burden for conference goers. It will be the role of the AARC Executive Office and the Board of Directors to consider new paradigms, platforms, locations and constructs of future meetings that address the education and networking needs of members in a more affordable fashion. In turn, a new revenue model for the Association should be considered that has lesser reliance on Meetings & Conventions as a primary revenue stream.

AARC Congress 2015 did not host the Speaker Academy, but that will return in 2016. The Speaker Academy is slated to be conducted every other year to maintain interest. As a refresher, the Speaker Academy is an opportunity given to individuals who have never

presented at an AARC Congress and provide them with an "audition" for an opportunity to present at the following year's Congress.

2016 AARC Program Committee Meeting

The AARC Program Committee met in January to create the Program for the AARC Summer Forum and Congress. There was a slight decrease in the number of proposals that were submitted for the '16 Congress with between 650-700 proposals submitted for consideration. The $2^{1/2}$ day meeting concluded with a full program developed for both Congress and Summer Forum and was inclusive of a pre-course for Summer Forum. Based on high demand from exhibitors, there will be no AARC hosted pre-courses in 2016 at Congress. Instead, these time slots will be offered as sponsorship opportunities, of which we believe, will be in high demand. This paradigm shift will serve to generate additional revenue for the Association as well as reduce previously allocated staff resources that had been previously committed to overseeing the logistics of multiple pre-courses. We are now in the process of contacting individuals who submitted proposals indicating our acceptance or rejection of their proposals.

2016 AARC Summer Forum

The 2016 Summer Forum will be held June 26-28 in Ponte Vedra Beach, FL. The meeting will be held at the Sawgrass Marriott Golf Resort & Spa.

Primary demographics for those who attend this meeting will include department directors, managers and supervisors, hospital-based educators, program directors and directors of clinical education.

A post-graduate pre-course has been scheduled for the AARC Summer Forum titled "Focus on the Future: Maximizing Program Effectiveness". This pre-course serves as a "Part II" to last year's pre-course and Program Director in-depth insight into improving the talents and faculty/students and influence communities of interest. This course will be held in collaboration with the CoARC and NBRC.

There will be a nominal fee associated with this course.

AARC Congress 2016

Progress is well underway for the logistical planning for AARC Congress 2016 to be held in San Antonio, TX Oct. 15-18, 2016. The program is well balanced and representative of all specialty sections, roundtables and content categories required for re-credentialing. Formatting for the Congress agenda will remain identical to 2015 regarding session length (35 minutes) and unopposed exhibit hours (8 hours). The Program Committee has however elected to run fewer concurrent sessions than in year's past. This will slightly reduce overall costs, but will in turn provide a more focused, better-attended curriculum. Instead of 10 concurrent rooms, there will only be 8 in 2016.

The AARC Congress Facebook fan page will continue to be used to generate and maximize excitement surrounding the meeting throughout the entire year. I would encourage all of you to

become “fans” of the page if you are not already and would ask that you promote the page with friends and colleagues who have an interest in keeping up-to-date with the meeting.

https://www.facebook.com/aarc.congress

The AARC will continue its utilization of our electronic and digital portal for exhibitors to more easily engage with the association while better enabling them to participate in our meeting. On this site exhibitors will be able to electronically select booth space, pay for booth space, and create an online exhibitor e-booth which attendees (who will be invited to visit the site later in the year) will be able to peruse to learn more about participating companies and the products and services they provide to the respiratory community. This technology brings AARC practices more current with existing practices taking place in the meetings and conventions industry. In turn, this technology was also used on-site in Tampa to pre-sell booth space and locations to on-site exhibitors. This is a satisfier for exhibitors and also allows the Association to acquire booth revenue 4-8 months earlier than would otherwise.

The Exhibitor Prospectus and Rules & Regulations will have already been published on the AARC website at the time of this meeting.

Leadership Workshop

The Leadership Workshop for state society leaders was suspended in 2015 due to poor turnout. In late 2015, the AARC resumed the planning for this workshop. Though the announcement was made at a time that prohibited some states from joining the session, the current RSVP list is comprise of 40 individuals from 18 states, including all four states with an executive office. The workshop will be held on May 13-15, 2016, in Irving, TX. The participants will be broken into 7 small groups that will rotate through 7 tables with specific topics and content experts: engaging volunteers (Amanda Feil), recruitment/ retention (Asha Desai), board effectiveness (Frank Salvatore), engaging student members (Dana Evans), using AARConnect to engage state members (Rob Wenger, CEO of HigherLogic), social media (Katie Kelley), and viability of state meetings (Doug Laher). In addition, President Salvatore and Cheryl West will both be providing plenary sessions.

SPECIAL PROJECTS

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.

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

The AARC has been working with the University Health System Consortium (UHC) to develop a joint paper on the safe initiation and management of mechanical ventilation. Per the Board’s request, the AARC/UHC taskforce worked with the AARC Position Statement committee under the lead of Ms. Colleen Schabaker and had respectfully submitted a final draft of the document.

Higher Logic
The AARC is participating in a study being conducted by the AARConnect vendor, Higher Logic. The goal is to improve membership retention and engagement rates of new members using a strategy of automated actions that require minimal staff time after setup. Results thus far have been encouraging. The AARC's success rates have been featured in Higher Logic presentations to organizations both in the US and overseas. The strategy is still building out and results are expected from the study in approximately 12 – 18 months.

CDC Tips from Former Smokers Campaign
The AARC has been contracted by the CDC to promote the 2016 Tips from Former Smokers campaign. The marketing-communications department has coordinated social media and web content to highlight the campaign and the AARC's efforts will be highlighted in a CDC webinar on March 16, 2016. We have received word from the CDC that this year's campaign even in its early stage has been a rousing success. They are also partnering with COPD Foundation and Allergy and Asthma Network, both longstanding partners with the AARC.

CUSTOMER SERVICE
The customer service department has performed a critical analysis of their processes and systems. The analysis revealed several manual processes that can be automated to improve user satisfaction, reduce data manipulation – and, therefore, human error, and maximize the customer service representatives' time and effort.

EDUCATION
NBRC Collaboration
The AARC and NBRC implemented the NBRC CRCE information-sharing program in September 2015. As of February 29, 2016, over 990 different individuals uploaded their AARC transcripts to the NBRC Continuing Competency Program since the program launch.

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 in Washington DC. Carolyn Williams has agreed to coordinate that event again. The HOSA event will be held in Nashville, TN, in June. Dr. Christine Hamilton, Kim Christmon, and David Johnson will be coordinating that event.

Professor's Rounds and Current Topics in Respiratory Care
The 2016 Current Topics in Respiratory Care series has been launched. Tim Myers and the marketing team have begun planning the 2017 series.

Respiratory Care Education Annual
The RCEA published issue 24 in September 2015. Dr. Dennis Wissing continues to function as editor and Dr. Kathy Rye and Dr. Kathy Myers-Moss are the new associate editors. Helen Sorenson has joined the editorial board for the 2016 season. The call for papers is complete and the editorial board has begun review. A special paper is in development to address learner attributes and the changing face of education. Contributors to this paper are Dr. Will Beachey, Dr. Ellen Becker, Dr. Doug Gardenhire, Dr. Kathy Myers-Moss, Dr. Kathy Rye, and Dr. Dennis Wissing.

Pulmonary Disease Educator course in Chicago
The Pulmonary Disease Educator course will be held for the third time in March 2016. Rush University sponsored the space for the course. Course registration is sold-out at 165 registrations. The AARC executive office has been collaborating with AACVPR, COPD Foundation, AAN, CF Foundation, and others to determine next steps, which include taking the content to the studio for recording.

CDC Strategic National Stockpile Ventilator Workshops
The AARC has 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 Alabama/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 was released to all RTs in mid-October 2015 and data dissemination from the study is expected in early 2016.

Specialty Sections
The education department has been working with the specialty sections to hold virtual meetings this spring. As of March 1, 2016, 8 of the 10 sections have either held or scheduled their virtual meetings.

Additions to Education
Several additions to AARC University are in the works for 2016. The Congenital Heart Defects course (5 CRCE), collaboration with Duke Pediatrics was released in March 2016. A comprehensive neonatal-pediatric specialist review course is in development and is tentatively scheduled for launch in summer 2016. Collaboration with Marilyn Barclay, Sleep Section Chair, is underway to develop new sleep-focused content with a tentative release of November 2016.

2016 Educational Product Sales/Attendance Trends at a glance (as of 3/1/16)

	2016 YTD	2015	2014	2013	2012	Comments for 2016
Webcasts and JournalCasts	1,372 (457)	9,149 (415)	8,812 (383)	7,511 (442)	6,289 (370)	Per session attendance in parentheses
Asthma Educator Prep Course	34	183	268	203	224	Slightly under budget
COPD Educator Course	132	859	820	570	420	Trending over budget
Ethics	661	1,928	1,757	2,361	2,711	Trending well over budget
RT as the VAP Expert	11	63	115	81	275	Under budget
Alpha-1	8	74	125	98	330	Under budget
Exam Prep	28**	180*	39	40		*F&P grant (150) + 30 **F&P grant (21) + 7
Leadership Institute	22	68	89			Slightly over budget
Asthma & the RT	260	446	172			Trending over budget
ACCS	30	121				Trending over budget
PFT: Spirometry	77	228				Trending well over budget
PFT: Pediatrics	28	43				Trending over budget
PFT: Advanced Concepts	67	79				Trending well over budget
Tobacco Training	46	85				Trending well over budget

Advertising and Marketing

Advertising

Print advertising is tracking close to budget at the time of this report (end of 1st quarter). A renewed interest from some previous advertisers and pending contracts for the latter half of 2016 from a "new voice" from the Daedalus sales perspective may increase revenues as the year moves on.

Digital advertising on aarc.org continues to remain consistent and strong through our partner, Multiview. In fact, we have incorporated a new technology that allows for AARC.org ads to be "retargeted" on other sites. We are a beta tester of this technology with Multiview and were allocated 8 slots (7 of which have sold) already. RESPIRATORY CARE JOURNAL has also been added to the portfolio and is off to a slowly than expected start. With a proposed redesigned

website, we are considering other potential opportunities on Your Lung Health website, but we will need time to build traffic once this has been redesigned.

Other advertising channels through eNewsletters, ePubs and recruitment ads are also part of the digital advertising footprint. Recruitment ads have gotten off to a fantastic start compared to prior years and are a very positive trend for the association as the advertising has a high ROI for the AARC. Last year recruitment ads brought in $98,000 in revenues and 2016 is off to a better start. We have also seen an uptake on eNewsletter ads and many of our regular publications have at least 1 as sold throughout the remainder of 2016.

Corporate Partners

We had a very successful year of revenue and sponsorships from our 2015 Corporate Partners. 2015 and 2016 has seen more communication and pre-planning with Corporate Partners to facilitate "smart spends" and better project outcomes for AARC and its members. A strong interest in Current Topics, Webcast, New Educational Products and digital advertising are some of the stronger areas of interest (outside of AARCongress).

2016 Partners: Carefusion, Masimo, Medtronic, Monaghan, Philips/Respironics, Drager, Maquet, Teleflex, Boehringer Ingelheim, Astra Zeneca, Mallinckrodt, ResMed and Fisher-Paykel (new).

We will be meeting with the Corporate Partners on Monday evening and all day Tuesday just before our BOD meetings in DC. A verbal update can be provided at that time if needed.

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 2016. The ability to better track and monitor our endeavors is proving us critical feedback on the optimal methods to move marketing endeavors forward. We know receive a monthly report from Marketing and Social Media to gauge our engagement.

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 seen a boost in revenues from that program in 2015. This allowed us to renegotiate a new contract with higher royalties. We also continue our relationship with the malpractice insurance group for our members. We also launched a new membership credit and reloadable debit card program with VISA. Both of these new programs are off to a slower than expected start, but will require marketing in 2016 to reach our members. We are also currently investigating a travel affinity program as well as one that offers small personal loans.

Products

Benchmarking continues to see a decline in membership early in 2015 as the economic reigns are tightening for hospitals with approximately 50-60 hospitals (-10-12%) around the US and

in Middle East (2). The Benchmark Committee conducted an assessment of the program, possible upgrades and a potential new product line to insure it is a current and valued tool to its participants. We approach our current vendor, Devore Technologies in "rebuilding" the Benchmark database system and received a very high quote for this work. We are investigating other options.

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. 2015 was our fourth year outsourcing RC Week products to Coleman. We realized a similar royalty to previous years. And will look to continue and hopefully enhance these sales for RC Week in 2016, but is not as popular as this once was 5-10 years ago.

The Best of RESPIRATORY CARE ePublication series launched in 2015 with some mixed success based on issues that were not along specific clinical areas. Rich Branson has inherited this project from the Journal side and a renewed focus has been undertaken specific to clinical areas of high interest. We just released a 3 ePub series around Airway Management topics. There are 3 area currently in various development stages and will be released in 2016. All these are produced in a digital format and available for immediate download with purchase at a cost of < $10 each.

We have also launched a new product line that collaborates with the respiratory care industry to conduct marketing research through Digital Focus groups. This launched late in second quarter of 2015 and saw two such Focus groups conducted. One for 2016 has already been completed as well. These will be highlighted at the Corporate Partner meeting to facilitate more interest.

The Executive Office has again started investigation on working with other organizations and groups on co-marketing products that will provide royalties to the AARC. We are currently close to making a hire into the Director of Business Development position (Dale Griffith's position) which will help facilitate these items.

RESPIRATORY CARE Journal

Overview

- Early 2015 we ended printing case reports and teaching cases in the Journal. This decision was based on the small number of readers accessing case reports and teaching cases, as well as the need to publish more original research without increasing expenses. We are happy to report that after more than a year of this practice, we only received three submissions of case reports and anticipated savings were realized.
- In January Dean Hess and Ray Masferrer met with the AARC Program Committee to review the results of the OPEN FORUM at AARC Congress 2015 as well as the plans for the 2016 FORUM. The committee once again decided to continue with the 3 formats for presentation adopted two years ago (http://rc.rcjournal.com/site/open_forum/2016_call_for_abstracts.xhtml):

- **Editors' Choice** – Authors of this select group of abstracts will prepare a poster for prominent display during the first two days of the Congress. On the third day of the Congress each Editors' Choice presenter will give a 10-minute slide presentation, followed by 10-minute of audience questions and discussion. (On a side note, one of the reasons for this format was to encourage respiratory therapists to prepare and submits manuscripts to the Journal. Eleven abstracts fell in this category in 2015 and we anticipate publishing 6-8 of them.)
- **Poster Discussions** – Authors will prepare a poster of their work to be presented in a session grouped by topic. A brief oral presentation (no slides) and audience questions and discussion will allow presenters to expand on the work feature on the poster. The majority of accepted abstracts fall into this category.
- **Posters** – Authors will prepare a poster to be displayed during Exhibit Hall hours on an assigned day. The presenter is required to be present between 12:00 noon and 1:00 pm to discuss their work. (Note: At the time of submission you may choose for your abstract to be considered as a Poster *only*.)

Deadline for submissions of abstracts to the 2016 OPEN FORUM is May 1, a month earlier than previous years.

- On June 10-11, 2016 the Journal will present the 55th Journal Conference on Pediatric Respiratory Care. Co-chaired by Ariel Berlinski and Brian Walsh, the conference will report changes in pediatric respiratory care and to provide evidence-based recommendations; to detail hose some evidence leads to conflicting conclusions, how to navigate and not avoid those conflicting reports; to provide a rationale for how the conflicts should be resolved; and to contribute to presentations within the conference by discussion, thus providing additional information about the given topic. As always, we are most grateful to the ARCF for their continued support making presentation and publication of the Conference proceedings possible.

Executive Office Referrals

(from November 2015 BOD meeting)

- ***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.* ***Referred to Executive Office for collaboration with ELSO and Specialty Sections.***

  Result: Tim Myers spoke with Peter Ryker and was informed that ELSO is interested in collaborating with the AARC but wanted more specific details. Tim would like to get more specific details from the Board at the April meeting and get back to Mr. Ryker.

- ***FM 15-3-1.1*** *That the President charge the Executive Office with the development of communities for the improvement of communications and member involvement for the replacement of Roundtables.* ***Carried***

  Result: The EO has developed a process by which the Roundtables can be converted to communities after the Board approves the conversion of the Roundtable Policy to a Community Policy within the AARC Policy and Procedures.

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

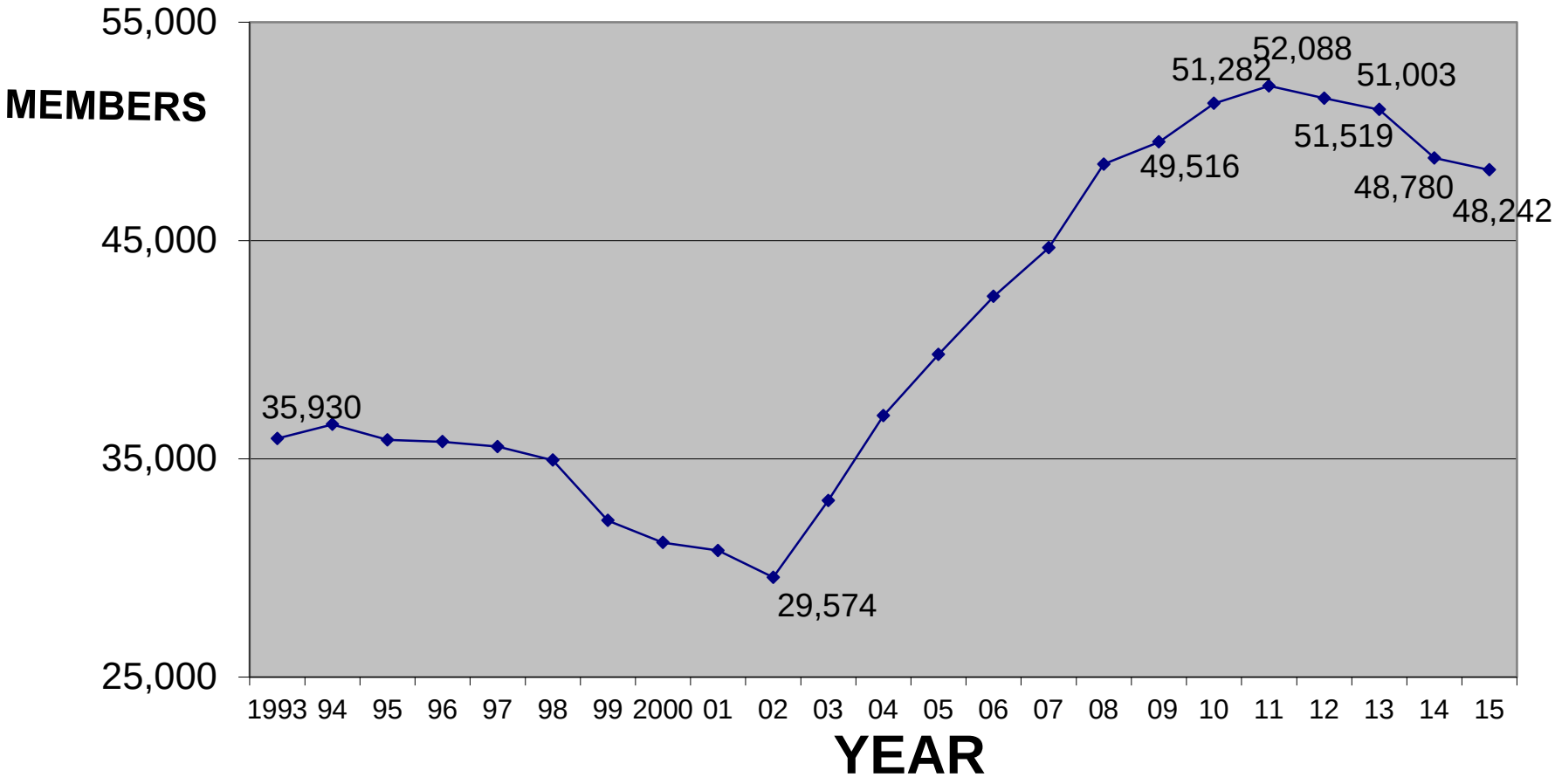
  Result: This Committee is under renovation per President Salvatore. The final committee members and objectives will be presented at the June Board meeting.

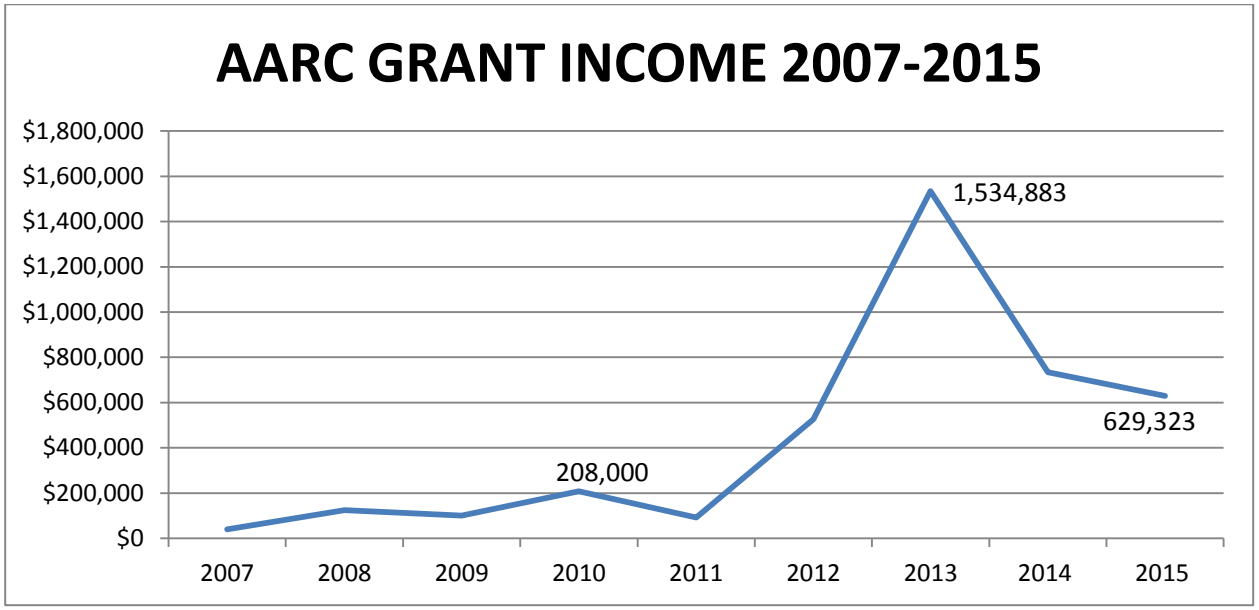
- ***FM 15-3-83.3*** *To establish a formalized Speakers Bureau of present and past members of the AARC Board of Directors to attend affiliate meetings with the main goal of increasing AARC membership.* ***Referred to the Executive Office.***

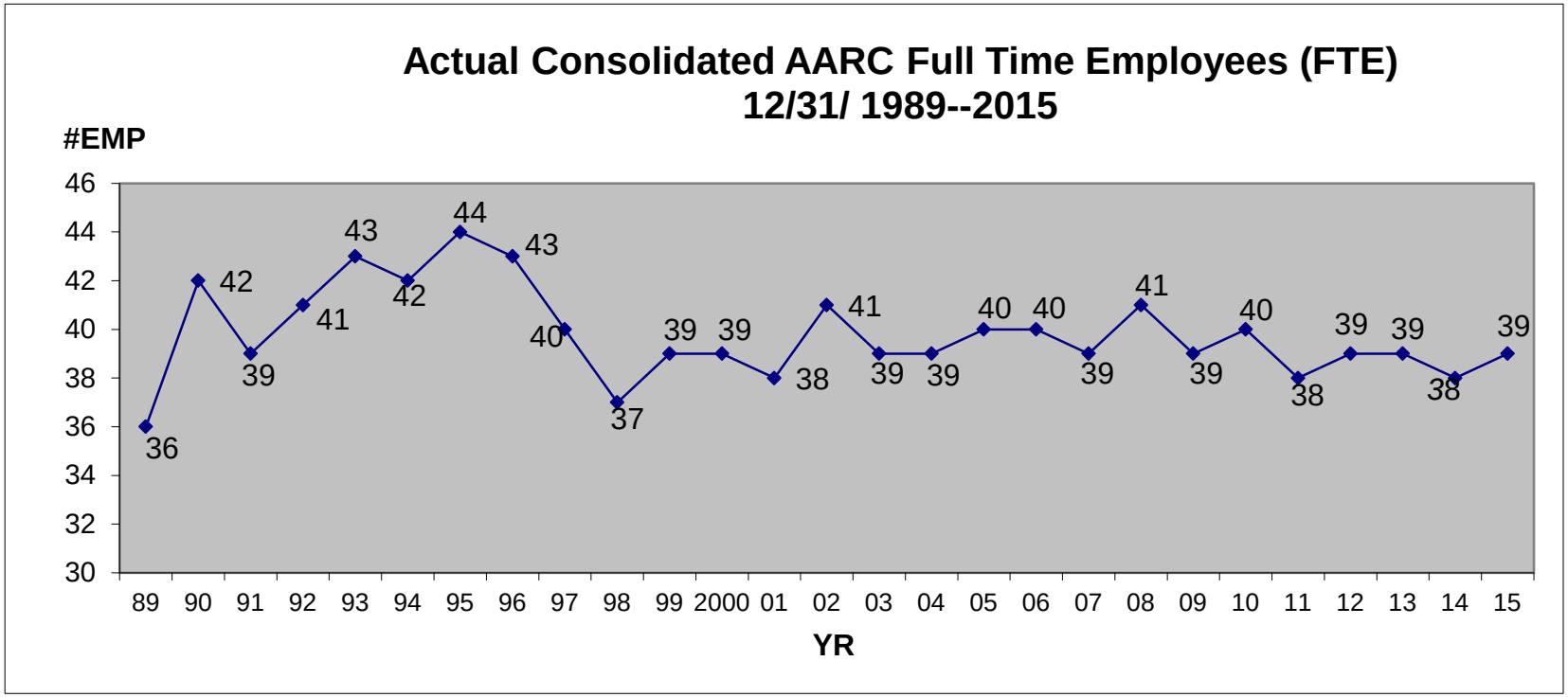
  Result: Shawna Strickland and the membership team have been exploring the use of a new volunteer module. Efforts are ongoing to evaluate and prepare for the addition of the module and develop a speaker's list.

AARC MEMBERSHIP LEVEL

23 YEAR HISTORY at DEC 31, xxxx




AARC GRANT INCOME 2007-2015
$1,800,000
$1,600,000
$1,400,000
$1,200,000
$1,000,000
$800,000
$600,000
$400,000
$200,000
$0
1,534,883
629,323
208,000
2007
2008
2009
2010
2011
2012
2013
2014
2015


Actual Consolidated AARC Full Time Employees (FTE)
12/31/ 1989--2015
#EMP
46
44
42
40
38
36
34
32
30
36
42
39
41
43
42
44
43
40
37
39
39
38
41
39
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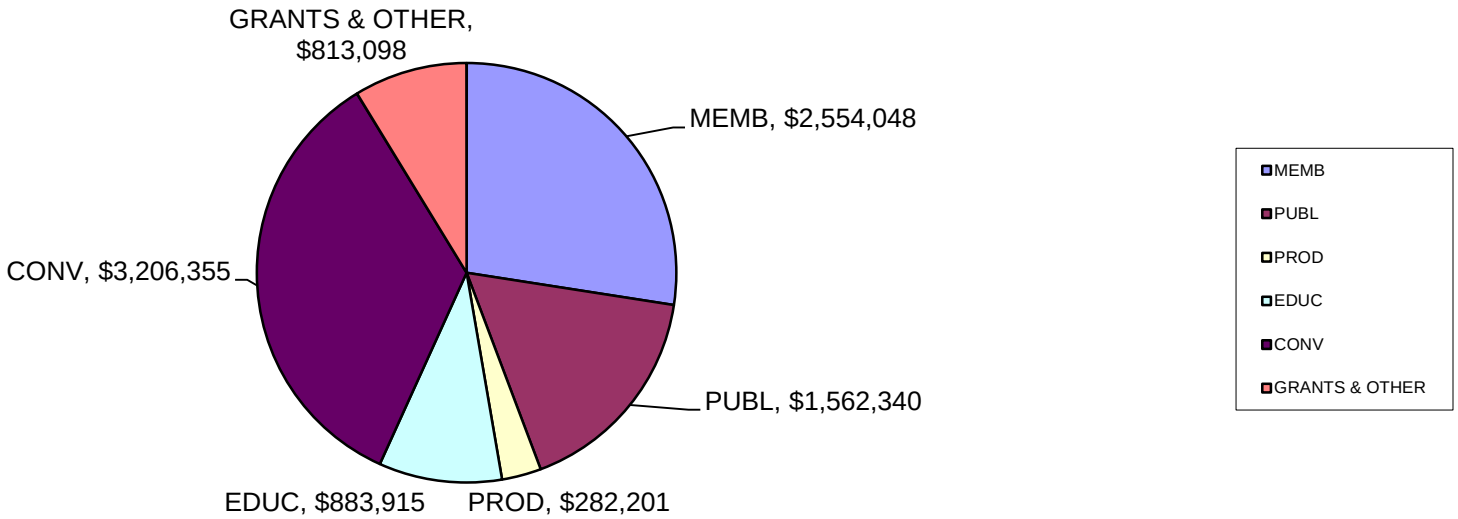
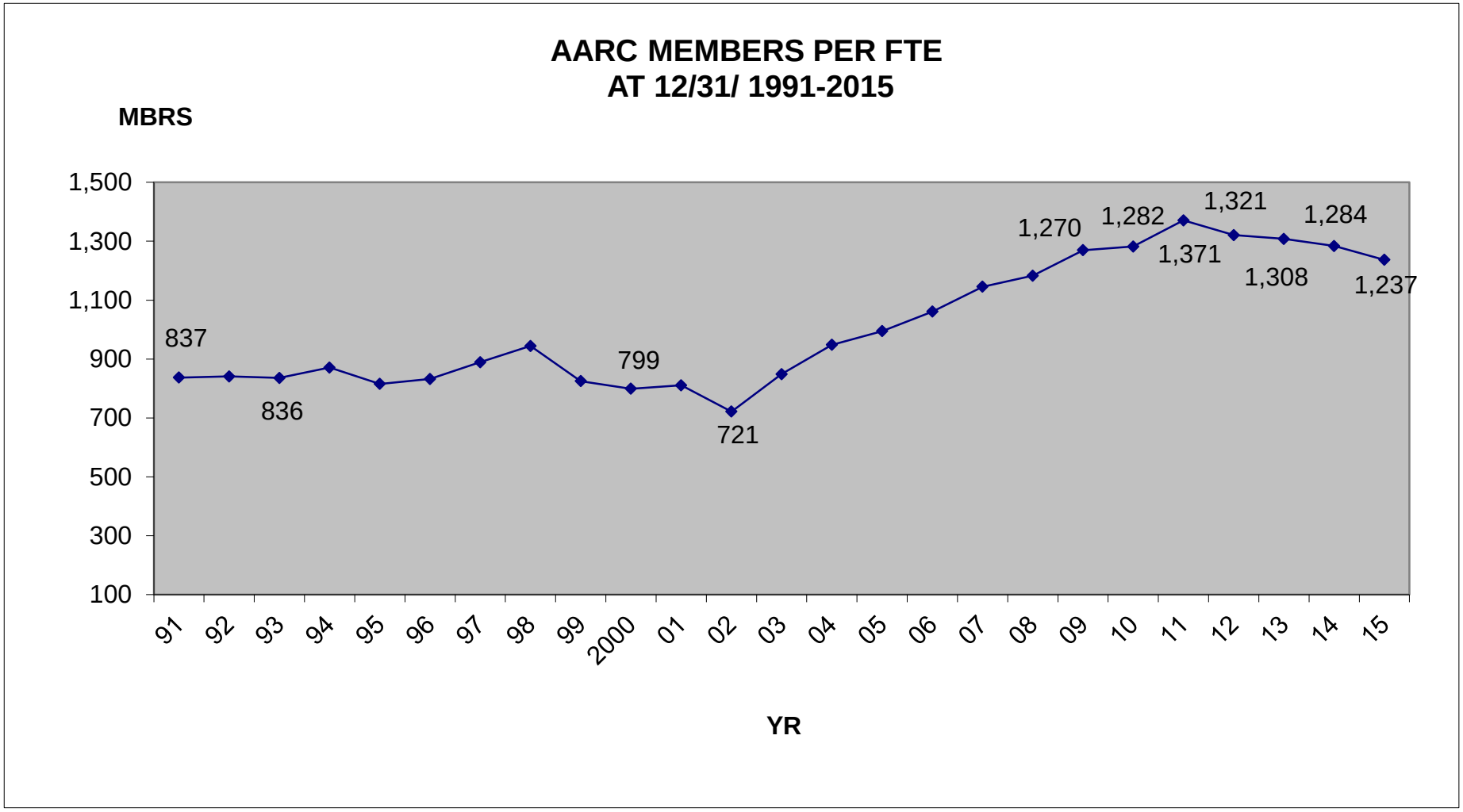
39
38
39
89 90 91 92 93 94 95 96 97 98 99 2000 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15
YR

Consolidated AARC 2015 REVENUE MIX - $$$
(Ignores ALL Investment Activity)




AARC MEMBERS PER FTE
AT 12/31/ 1991-2015
MBRS
1,500
1,300
1,100
900
700
500
300
100
837
836
799
721
1,270
1,282
1,371
1,321
1,308
1,284
1,237
91
92
93
94
95
96
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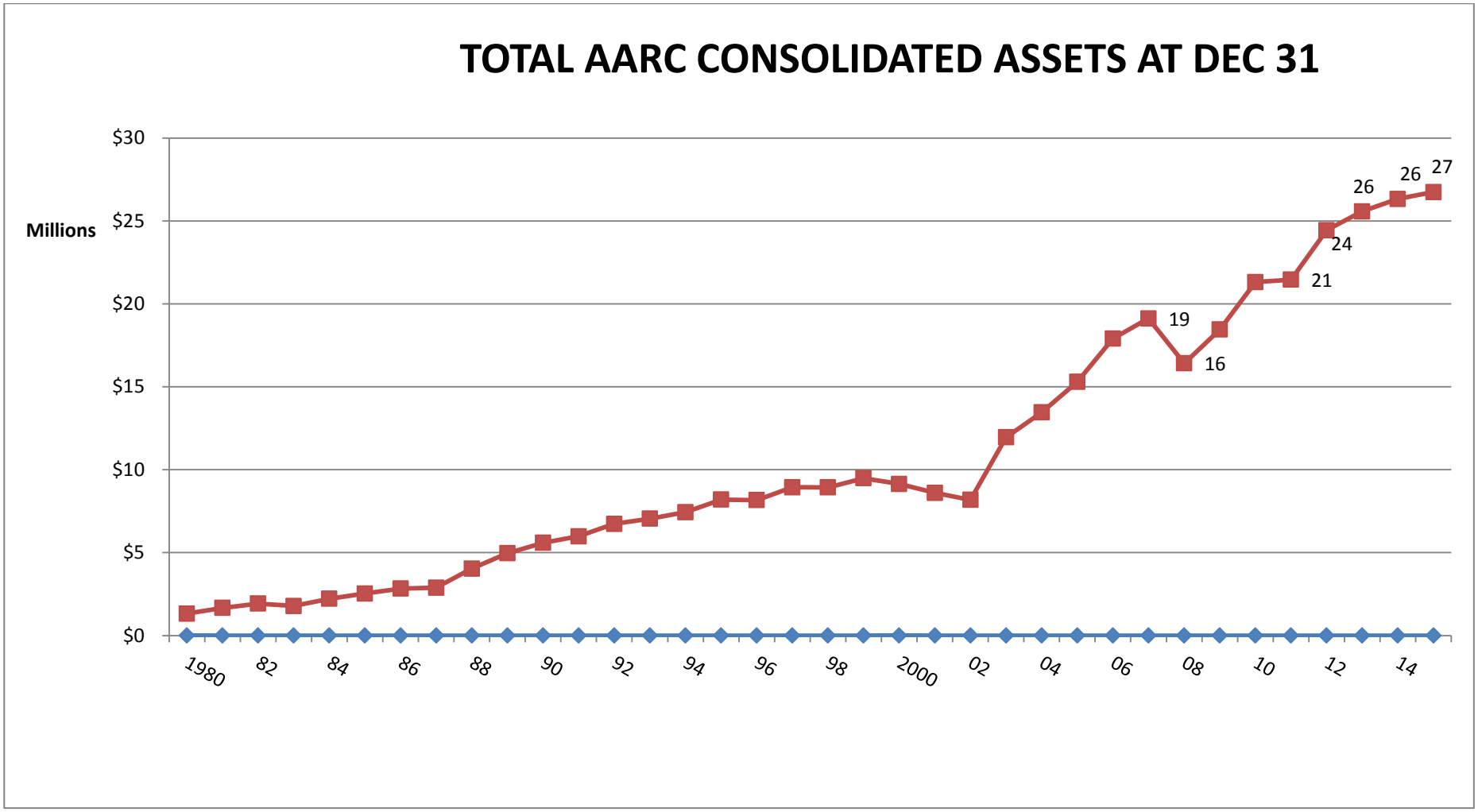
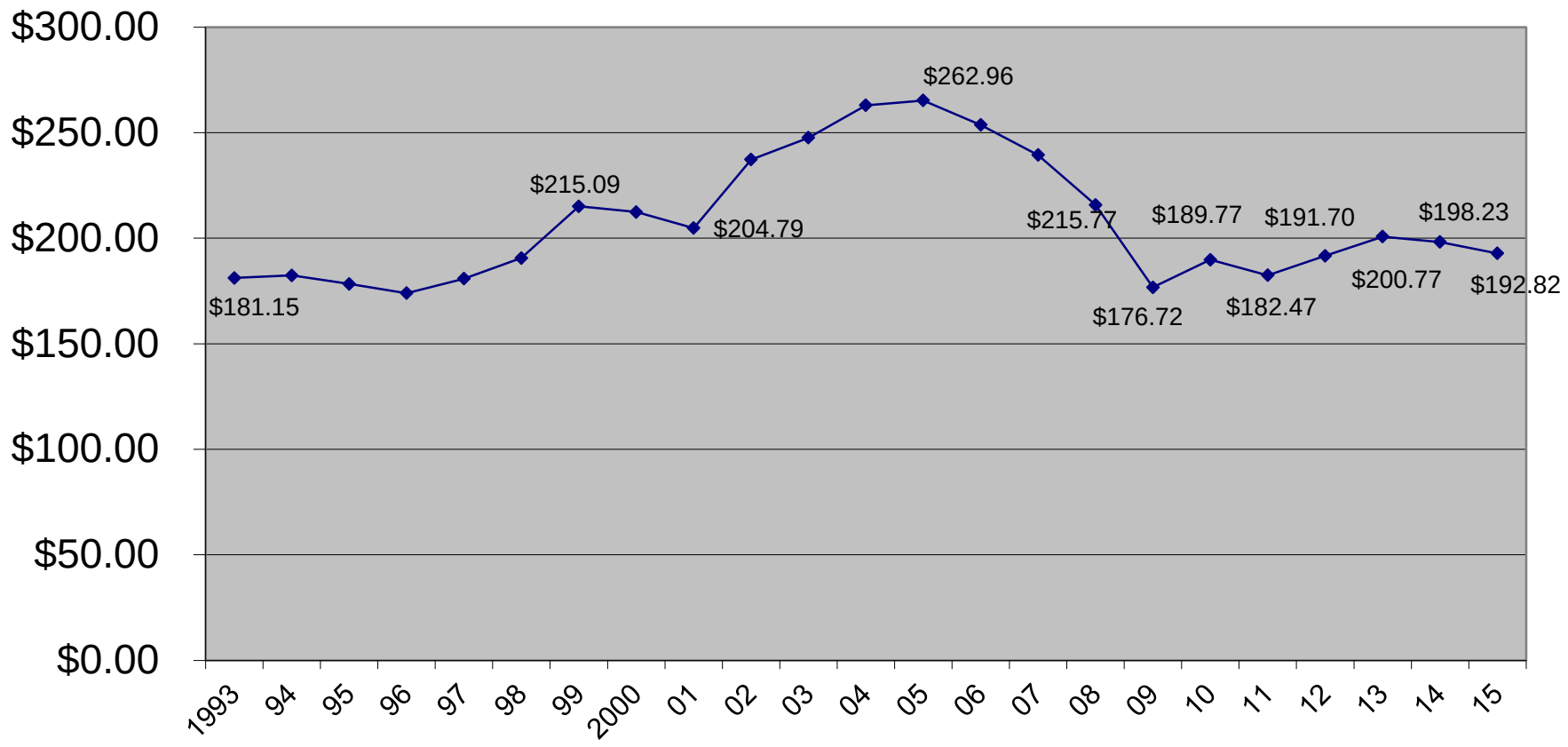
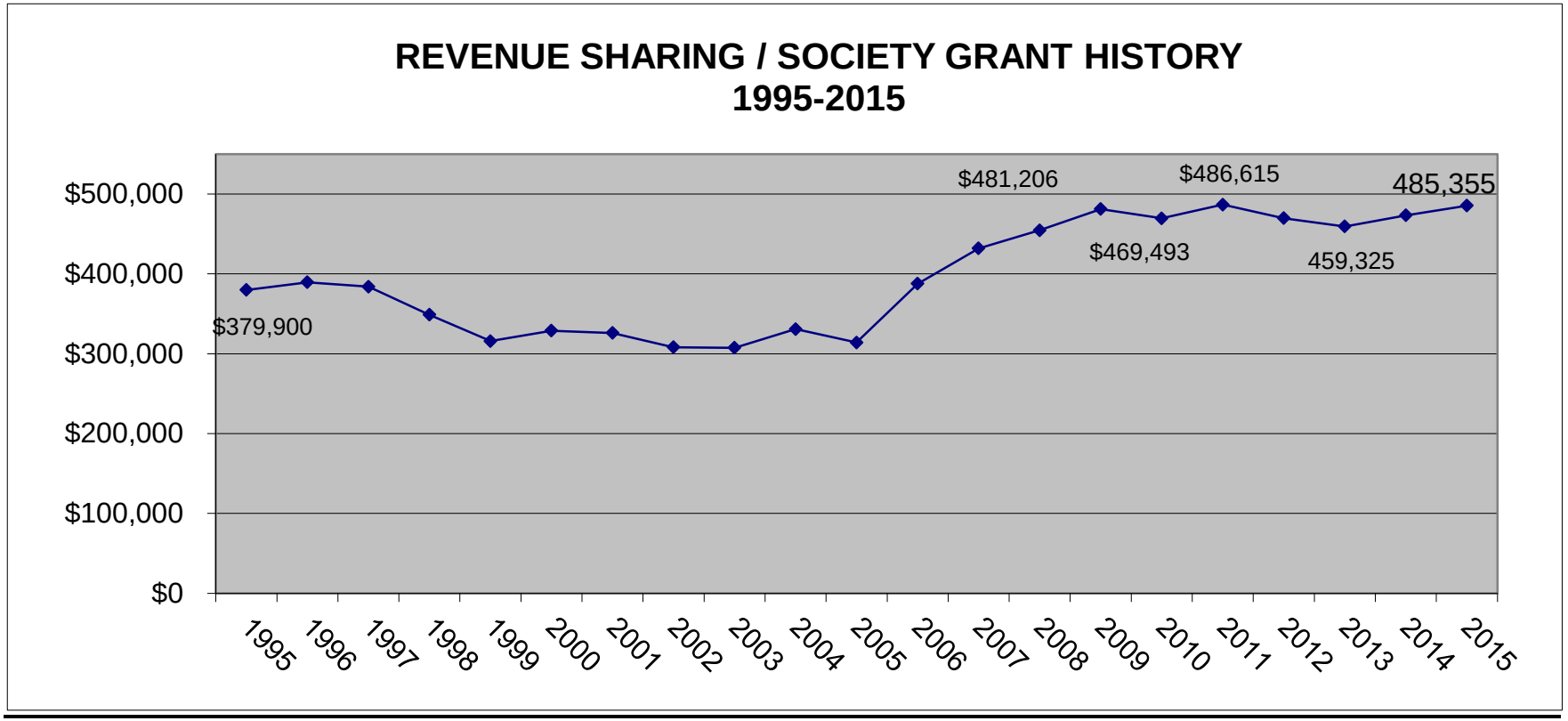
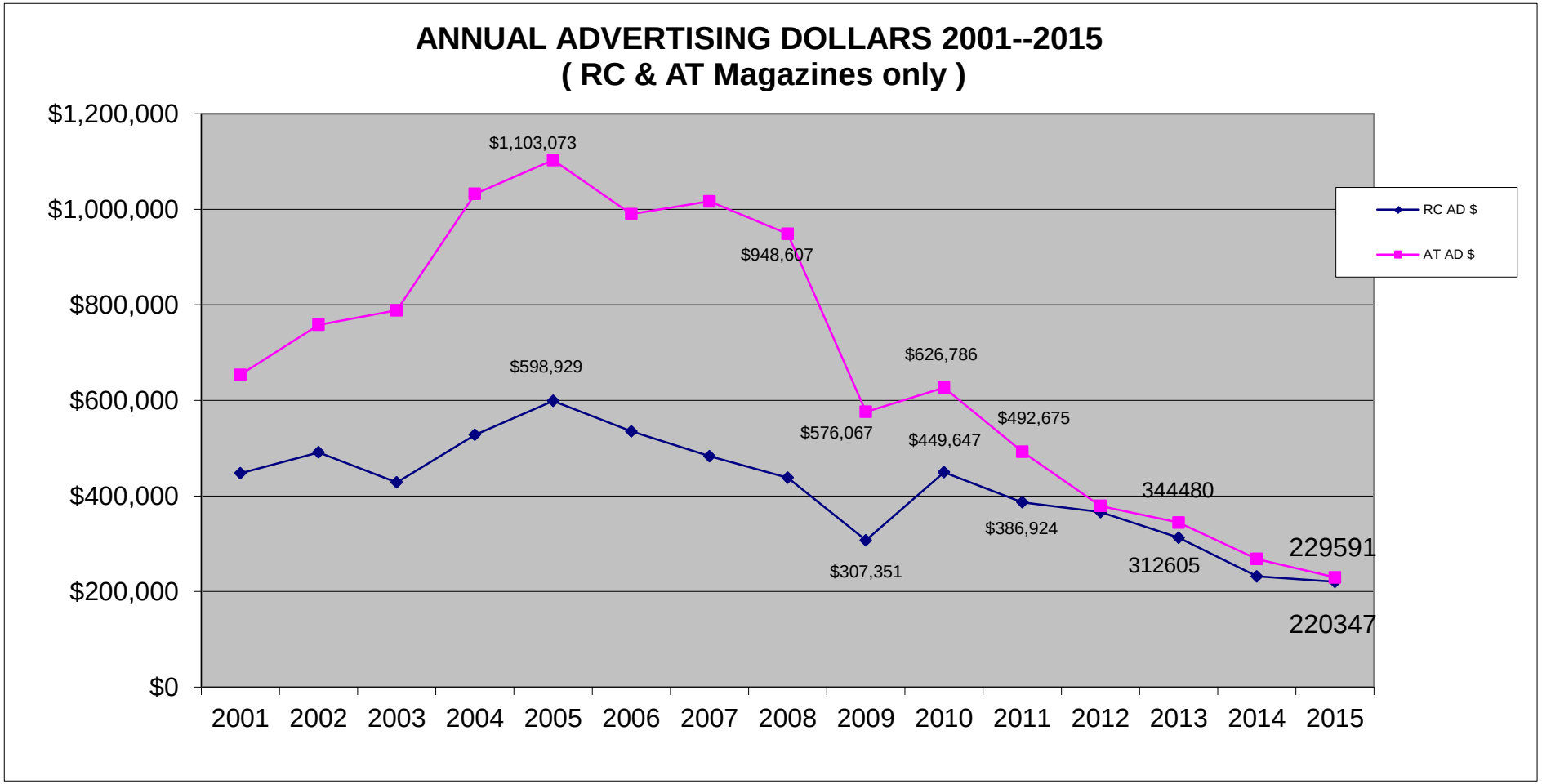
YR


TOTAL AARC CONSOLIDATED ASSETS AT DEC 31
Millions
$30
$25
$20
$15
$10
$5
$0
19
16
21
24
26
26
27
1980
82
84
86
88
90
92
94
96
98
2000
02
04
06
08
10
12
14

AARC CONSOLIDATED REVENUE (W/O INVESTMENT $$) PER MEMBER PER YR




REVENUE SHARING / SOCIETY GRANT HISTORY
1995-2015
$500,000
$400,000
$300,000
$200,000
$100,000
$0
$379,900
$481,206
$469,493
$486,615
459,325
485,355
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015


ANNUAL ADVERTISING DOLLARS 2001--2015
(RC & AT Magazines only)
$1,200,000
$1,000,000
$800,000
$600,000
$400,000
$200,000
$0
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
$1,103,073
$948,607
$626,786
$598,929
$576,067
$492,675
$449,647
344480
$386,924
229591
312605
$307,351
220347
RC AD $
AT AD $

State Government Affairs
Activity Report – April 2016

Cheryl A. West, MHA, Director of Government Affairs

Introduction

Most state legislatures have now convened for what more than likely be a shortened 2016 legislative session. This year is, of course a Presidential election year which also coincides with other Congressional and statewide offices. Therefore legislators will want to wrap up their work early in the fall and focus on the election be it theirs or others that they might be supporting.

This report will provide an update to the issues presented since the December 2015 Winter Report.

RT Licensure Law Sunset

Alabama a bill was introduced to continue RT licensure in the state until 2020. Unlike other states, this Sunset bill was not controversial or required an efficacy review by a state agency. Nevertheless the AL Society closely monitored the bills' progress and it appears at this writing to be moving swiftly towards enactment .

Arizona Just like Hawaii in 2015, the AARC was contacted by the AZ State Auditor asking for information about other state RT Licensing Boards and how these other boards have addressed RT licensure Sunset. AZ licensure is due for Sunset in 2016. The Auditor's Report is due to the legislature the summer of 2016 with legislation (pro or con) to be addressed in 2017. We provided the AZ Auditor with the state agency reports from HI, CO and NM.

Hawaii A very favorable report in support of the continuation of HI respiratory therapy licensure was issued by the HI State Auditor's Office in June of 2015. The Report's conclusion that RT licensure must continue has been critical in the Sunset legislative process. A bill was introduced in late January to continue RT licensure and the Hawaii Society began making contact with key legislatures to assure a swift and straight forward enactment. At this writing the bill to extend RT licensure is moving quickly through the legislature.

RRT "Only" Licensure Efforts

Arizona is also moving ahead via regulations to require a RRT credential as a qualification for licensure. AZ is aiming for an implementation date of sometime in the summer of 2016 although that date is most likely flexible. According to the proposed regs, respiratory therapists who earned the CRT before July 1, 2015 may be "grandfathered" in if the credential is still current and valid. RTs with a valid license from another state, while holding the CRT credential and wishing to relocate to AZ may have a more difficult time doing so, as it appears the regs will require those especially ar licensed RTs (CRT only) to have a RRT or have taken an exam "equivalent" to the RRT.

If AZ implements as per its timeline, it will become the 3rd state (OH and CA) to officially go the "RRT only" route.

North Carolina –in the fall of 2015, a 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. Other legislative issues took precedence and the bill was not acted on. However the

NC Society working closely with the NC RC Licensure Board have re-introduced the legislation again. Since there was strong support in the House and no real objection in the Senate, NC RTs are optimistic that the bill will pass this year.

Montana a member of the MT RC Licensure Board contacted the AARC asking about the status of the RRT initiative in other states. The MT RC Licensure Bd. will begin discussions on the issue, however it is not anticipated that any action will be taken this year. It should be noted that the interest expressed by MT indicates the growing awareness of the RRT only that is being generated in additional states.

Legislation That Includes RT

AZ - The AZ RC Licensure Board evidently feels confident enough that the AZ Auditor's Report will recommend RT licensure continuation that the Executive Director has drafted a bill that revises out of date references (ex. Delete AMA's CAHEA and JRCRTE as RT program accreditors, insert CoARC) in the RT Licensure law. AARC was contacted to provide comments and suggestions. Of note this bill does not include provisions that move to the RRT only. That effort is being undertaken via the rule process.

CT a bill that permits advanced practice nurses to supervise RTs and issue orders. Current CT law already allows PAs to do this.

NH a bill that clarifies the DME exemption in the NH RT Licensure Law. Provisions state that the RT related DME may be delivered to the patient's home by a non-licensed person but "leaves the equipment at the point of delivery and does not set up the equipment or provided calibration or instruction."

NJ very extensive bill advocated by the NJ Society, expands scope of practice (disease mgt. among other provisions) clarifies the use of protocols, allows PAs and NPs to issue RT orders, deletes temporary license. A similar bill was introduced but not acted on in 2015.

NY a bill that was introduced in the last session and re-introduced this year that amends the NY insurance law to expand home care insurance services directed at the patients transition from a hospital, nursing facility or other institutional setting to the home, & specifically adds RTs as a provider of needed services.

Legislation of Interest

Update In the spring of 2015 the Texas enacted a new law that would require the development of a statewide strategic plan to "…significantly reduce morbidity and mortality from chronic respiratory disease, including asthma and chronic obstructive pulmonary disease (COPD)…" In late December the TX agency tasked with carrying out this new mandate reached out to stakeholders, including AARC, asking for our input on how to structure such a plan. AARC provided a detailed response with of course the emphasis on the advantages of using respiratory therapists.

NH has a bill that would allow "unlicensed assistive personnel" to provide and administer bronchodilators, spacers, and nebulizers in schools. NH also has a bill that requires landlords to "keep the apartments" cool via air conditioning when there are tenants with health or respiratory conditions.

Telehealth Legislation

States interest in Medicaid telehealth legislation appears more robust than on a federal level. Perhaps that is simply because monitoring the use of telehealth services and providing incremental expansion on a state level is far easier than on the national Medicare level where nearly 50 million beneficiaries could be impacted.

AK expands (only) telehealth for mental health services

CT a bill that specifically adds respiratory care practitioners as providers of telehealth services.

FL creates a Telehealth Task Force, initially RTs were not on the list of those on the Task Force, however the FSRC lobbyist discussed with the bills' sponsor and RTs were then added as an amendment. Also another bill with extensive provisions goes a step beyond by establishing "telehealth" in FL.

HI expands Medicaid telehealth services however only mentions physicians as providers.

IA adds telehealth services to health insurance coverage for state employees.

KY has introduced a Medicaid telehealth bill, providing limited services but does permit monitoring and measuring oxygen. However the bill stipulates that the services can only be provided by a nurse.

MS would permit telemedicine services, very open ended, but would direct the MS Board of Medical Licensure to develop rules and regs.

MO has a telehealth bill that while including the coverage of monitoring qualified patients with asthma and COPD it then presents a long list of licensed professionals who can provide telehealth services, RTs are not listed. This has been brought to the attention of the MO Society. And another separate bill that simply states if what is provided via telehealth is within a licensed practitioners scope of practice those services may be provided via telehealth which would then include RTs as they meet of course the provision of "licensed practitioners'.

NH a bill that clarifies consultations for the use of telemedicine in practitioner-patient medical circumstances.

OK creates the Telemedicine Expansion Act.

RI would require reimbursement of telemedicine services in the same manner as other health insurance policies and contacts reimburse for health services.

VA has a bill to establish a three year telemedicine project with the goal to reduce ED visits. Provisions require a participating hospital to "establish a telemedicine clinic utilizing nurse practitioners who will collaborate with local primary care physician to assess patient conditions and needs.

VT expands the use of telemedicine services outside the hospital, a list of practitioners who may provide, but no RT.

WA an extensive telehealth law already exists; this is a bill that adds "home" as a telehealth site.

WV bill simply states that the practice of telemedicine is permitted.

Tobacco Legislation
States are introducing legislation addressing smoking and tobacco products on basically four levels: increase taxes on tobacco products; restrict smoking in specific venues; and classify non-tobacco products such as vapping devices and electronic cigarettes under the umbrella of "tobacco" and thus proceed to tax (very big issue) and finally increase the age permitted to purchase tobacco products.

The following states have bills to tax electronic cigarettes: **HI, KY, NM**

States that raise the age to purchase Tobacco Products (most include vapor products): **AK** (age 19), **IL** (age 21) **KY** (age 21) **MD** (age 21), **MS** (age 21) **OK** (age 21 another bill age 19), **RI** (age 21) **WA State** (age 21 BUT WAS DEFEATED), **WV** (age 21)

The following states have restricted smoking in "interesting" venues:
CA no smoking on University of California or State Community College campuses.
FL cannot smoke in a car with anyone under 13 as a passenger
NJ cannot smoke in public parks and beaches or in college dorms
OK cannot smoke in a car with a child under 14
HI, GA, MD cannot smoke in a car with a minor (defined as anyone under 18)

EMT/Paramedic Legislation
As was the case in 2015 Multi-state **Compact** legislation that changes licensing laws to make it easier for EMS personnel to cross state lines without obtaining another license is again being introduced this year in numerous states. Also bills that will create **Community Paramedics** or the more generic **Community EMS or EMT** have also been circulated. This type of legislation's intent is to legally authorize some or all of the tiers of the EMS profession to provide clinic or home care services that are not at all related to emergent care situations.

States that have Compact (Multi-State License) Legislation
ID, MO, TN, UT, VA (passed)

VA also has a bill that would allow VA to recognize other EMS personnel from states that have a Compact.

States that have Community EMS/Paramedic Legislation
CO, CT (calls for a pilot study), **OK**

Nurse Practitioner and Physician Assistants
States continue to introduce and in some cases enact legislation that would expand the authority of nurse practitioners and in some cases physician assistants. Most of these bills are focused on lessening the requirements that these practitioners must work under supervision or close collaboration with a physician. This is especially true for nurse practitioners (NPs).

States that have Legislation relaxing PA and NP physician relationship requirements
FL for PAs allowing more prescription writing authority and expanding on the delegated services they may provide.

VA has several bills that reduce the oversight of NPs by physicians, provides more autonomy.

WA expands hospital privileges to NPs.

WV NPs have same authority as physicians when documenting care.

RT Related Regulations
As often noted, a change in regulations for RT licensure (or other professions for that matter) can have just as much impact on the profession as revising the licensure law itself.

AR and FL - continue the process of revising and updating various RT licensure rules.

IA following up on the 2015 enactment of a polysomnography personnel licensure (creating a duel RT/Polysom Licensure Board), final rules incorporating licensure requirements for polysoms have been issued. In addition the new rule also addresses other RT (and now Polysom) issues such as updating what is not considered to be independent study when continuing education is obtained through electronic means, clarifying the number of hours earned for completion of a new professional certification or recertification, etc.

DE a new rule will now allow an expired RT license to be renewed within one year of expiration.

MO is proposing to reduce the RT licensing fees.

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

Federal Government Affairs Activity Report
April 2016

Cheryl West, MHA, Director Government Affairs
Anne Marie Hummel, Director Regulatory Affairs

The Congress

Congress returned in January for the second session of the 114th Congress. Important legislative initiatives remain for this Congress to address, such as criminal justice reform, the high cost of prescription drugs, and bills that reauthorize numerous key federal programs such as the Children's Health Insurance Program (CHIP). Overshadowing addressing these important issues is, of course, the Presidential election which will color any and all legislative movement. Also, one-third of the Senate and all 435 seats in the House of Representatives are on the ballot this November. Therefore, as it happens every election cycle, this Congressional session will be short, with members of Congress going home for "district work periods' starting in October.

In spite of the shortened Congressional session, Members of Congress may feel compelled to accomplish and pass some legislation that is bipartisan in order to show the voters back home that Washington can deliver policies and laws that benefit their constituents.

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 2015 by Reps. Mike Thompson [D-CA] and Gregg Harper [R-MS], Diane Black [R-TN] and Peter Welch [D-VT]. To recap the highlights, the bill is to be implemented in three phases, each two years apart. It expands telehealth sites to incorporate certain metropolitan areas, adds an individual's home as a telehealth site with respect to certain home health benefits, adds respiratory therapists as telehealth providers, adds respiratory care as a covered telehealth service, and provides incremental coverage of remote patient monitoring (RPM) for certain chronic conditions that include COPD and heart disease when furnished as part of chronic care management services. It also adds store-and-forward technologies not currently covered by Medicare and expands access to evaluate/treat stroke patients regardless of the patient's location.

Virtual Lobby Week 2016

As we have done in years past, we will launch our Virtual Lobby (VL) Week just prior to Hill Day. We rolled out the VLW this year on March 28th with a variety of communications, including tapping into more social media venues. As you know, VLW 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 will provide you with a count of the emails sent to the Hill at the April meeting.

AARC Capitol Hill Advocacy Day

For the first time, the AARC Board of Directors meeting is being held in DC just days before the Hill Day is to begin and RT PACT reps from around the country begin to arrive in DC. The combining (more or less) of both meetings affords the opportunity for many of the BOD to participate in the actual Hill Day and see firsthand how we execute this important event. We will provide more

details, such as number of RT and patient participants, number of scheduled Hill meetings, etc., at the BOD meeting

Legislation Supported by the AARC for Advocacy Day 2016

S. 1065 – School Asthma Management Plan Act

Inhalers containing harmful chlorofluorocarbon (CFC) propellants are no longer being manufactured and newer drugs can be more costly. This bill, introduced by Senator Kristen Gillibrand [D-NY] will help schools and families afford the new inhalers they need by providing over $100 million in funding to schools in low-income, high-incidence areas to purchase inhalers and holding chambers so children with asthma will have access to the treatment they need. Schools are also required to develop and implement asthma management plans. The bill provides additional funding for asthma research and improves collaboration among federal agencies for better asthma surveillance and data collection. (Supported by the Allergy & Asthma Network)

S. 1972 – Airline Access to Emergency Epinephrine Act of 2015

This bipartisan bill was introduced by Senators Mark Kirk (R-IL) and Jeanne Shaheen [D-NH] in August 2015. It requires airlines to 1) clarify that 1:1,000 epinephrine ampules included in emergency medical kits carried on aircraft are intended to be used for the treatment of anaphylaxis; and, 2) to carry not fewer than 2 packs of epinephrine auto-injectors (one for individuals weighing less than 66 pounds and one for use on individuals weighing more than 66 pounds) as an initial treatment for anaphylaxis. Air carriers are also required to provide crewmember training based on the advice of experts and to know how to recognize an acute allergic reaction and how to administer the auto-injectable epinephrine. Last, the bill requires a report to Congress on air carrier policies relating to passengers with food allergies. (Supported by the Allergy & Asthma Network)

H. R. 3355 and S. 488 – Technical Bill to Amend Physician Supervision Requirements for Cardiac and Pulmonary Rehabilitation Programs

Since national implementation of cardiac and pulmonary rehabilitation programs in 2010, the Medicare program has restricted supervision of these programs to physicians only based on very explicit statutory language. Introduced by Reps. Lynn Jenkins [R-KS] and John Lewis [D-GA] and Senators Charles Schumer [D-NY] and Mike Crapo [R-ID], these bills would amend that language to allow physician assistants, nurse practitioners and clinical nurse specialists to supervise cardiac, intensive cardiac and pulmonary rehabilitation programs one year after the date of enactment. The "technical correction" is totally unrelated to the medical direction, i.e., oversight and responsibility for program operation, staff, and patients that medical directors of these services provide. Medical directors have a primary role as leaders of the CR/ PR team. (Supported by the American Heart Association, American College of Cardiology, and the American Association for Cardiovascular and Pulmonary Rehabilitation)

Reauthorization Funding for the Children's Health Insurance Program (CHIP)

Since its inception in 1997, CHIP finances quality health coverage for more than 8 million children in low-income families who do not qualify for Medicaid or cannot afford private coverage. Together, CHIP and Medicaid provide health insurance coverage to more than 40% of children in the U.S., making both programs combined the largest insurer of U.S. children. Congress has passed CHIP funding through 2017 but there are two years of funding remaining. AARC urges Congress to fund CHIP through 2019. (Supported by the Allergy & Asthma Network)

Telehealth Bills in Addition to HR 2948

As you can see below, there are a number of telehealth bills that have been introduced into Congress in the past year. While AARC supports expansion of telehealth and remote patient monitoring services in general, none of these bills add respiratory therapists or the services they provide to bill language.

- **21st Century Cures Act of 2015 (HR 6):** While primarily focused on improving access to new therapies for those with rare diseases, the bill also requires information on patient populations that would benefit from telehealth services and barriers that might prevent expansion.
- **Telemedicine Enhancement Act of 2015 (HR 2066):** Expands telehealth and RPM as part of CMS' bundled payments initiative as well as Accountable Care Organizations.
- **Furthering Access to Stroke Telemedicine (FAST) Act (S 1465):** Covers evaluation and treatment of an acute stroke regardless of where the patient is located.
- **21st Century Care for Military and Veterans Act (HR 2725):** Covers telehealth as part of the military's Tricare and Veterans' Administration insurance programs.
- **Telehealth Modernization Act of 2015 (HR 691):** Sets Federal standards that States should consider in the delivery of telehealth service by a health care professional.
- **Telehealth Innovation and Improvement Act of 2015 (HR 2343):** Requires CMS to test the effect of including telehealth services in Medicare health delivery reform models.
- **VETS Act of 2014 (HR 2516) (S 2170):** Covers telehealth furnished by a licensed, nationally registered or credentialed health care professional designated by the Secretary to furnish telehealth regardless of the professional's location.
- **TELE-MED Act of 2015 (HR 3081):** Permits certain providers licensed in a state to furnish telehealth services to Medicare/Medicaid beneficiaries located in another state without additional licensure.
- **Clinical Opportunities for Novel and Necessary Effective Care Technologies (CONNECT) for Health Act (H.R. 4442) and (S. 2484):** Establishes a telemedicine demonstration waiver as a bridge between the current and future physician payment system and covers telehealth and RPM in alternative payment models and Medicare Advantage programs. This bill is supported by 50 organizations and was introduced on the House side by the same co-sponsors of the Medicare Telehealth Parity Act. In checking with Cong. Harper's staff, we have been assured that both pieces of legislation are viable and that the Connect Act was introduced in order that all telehealth options are vetted as they work toward comprehensive telehealth reform.

Senate Chronic Conditions Working Group

As reported previously, 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 Chronic Care Working Group (CCWG) headed by Senators Isakson (R-GA) and Warner (D-VA) sought public input last year on a number of issues including telehealth to which the AARC submitted comments. More recently, the CCWG developed a Bipartisan Policy Options Document based on the public's earlier input in which a number of recommendations were made prior to drafting legislation. AARC submitted comments that: 1) supported endorsement of the provisions of H.R. 2948; 2) strongly recommended the Independence at Home Demonstration project be expanded to include Medicare beneficiaries in need

of respiratory services; and, 3) encouraged waivers to current telehealth restrictions for Medicare Advantage plans and Alternative Payment Models that would permit RTs to furnish telehealth services.

Regulations and Other Issues of Interest

Update on Rules Pending Final Publication

Two rules that we reported on previously and to which we provided comments still have not been finalized. The FDA Deeming regulation which would give FDA authority to regulate all tobacco products appears to be stuck in limbo at the Office Budget and Management which oversees and approves all regulations of substance prior to publication. The proposed rule to add respiratory services as specialized rehabilitative services in long-term care hospitals is also pending final publication with no guess as to when we will see it. The issue of concern for AARC involves whether RTs would be considered qualified providers if the services are contracted out.

Discharge Planning

CMS has proposed revisions to the discharge planning process in response to statutory requirements set forth in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) Act. The IMPACT Act directs the Secretary to modify COPs and interpretive guidelines to require post-acute care providers, hospitals and critical access hospitals to take into account the patient's care goals and treatment options as part of the discharge planning process. Post-acute care providers are defined as home health agencies, skilled nursing facilities, inpatient rehabilitation hospitals and long-term care hospitals. Further, the IMPACT Act requires use of quality measures that include standardized patient assessments and resource use data to inform the discharge plan.

A new "Design" standard would require the discharge plan be developed with input from the "hospital's medical staff, nursing leadership, as well as other pertinent departments", which means hospital's would have to coordinate with their Respiratory Department on respiratory patient's needs, goals, and preferences. Also, the plan extends to certain emergency department patients identified as benefiting from a discharge plan. AARC submitted comments in support of the proposal, highlighting the fact that anticipated ongoing care post-discharge should include the need for medical equipment and referrals to home medical equipment suppliers.

Ventilators

Previous Board reports have discussed concerns about current local coverage determination (LCD) policies regarding respiratory assist devices (RADs) and the lack of a policy on home mechanical ventilation. The provisions are out of date and do not reflect changes in technologies that have taken place over the past decade.

After exhausting several methods to get CMS to update its policies, representatives from ATS, ACCP, NAMDRC and AARC are working currently on a formal request for CMS to issue a national coverage determination for RADs and mechanical ventilators. Key changes would: 1) establish specific categories of mechanically ventilated patients that recognize chronic respiratory failure may occur intermittently, nocturnally, or on an ongoing basis, 2) remove current obstacles that restrict access to a RAD with a backup rate, and 3) eliminate oximetry criteria for certain categories of patients as necessary to justify use of a ventilatory device. Further discussions on strategy are planned at the March 3 NAMDRC board meeting. A verbal update on the latest thinking will be provided at AARC's board meeting in April.

Prior Authorization of Certain Items of DME

CMS has established a Master List of DME items that are frequently subject to unnecessary utilization (e.g., lack of documentation to show the item meets current Medicare requirements) and may be subject to prior authorization in the future. Several criteria are used to determine which items are included on the list. Certain respiratory assist devices (E0470), CPAP devices (E0601), and oxygen concentrators (E1390) have been added to the Master List. If CMS decides to subject any or all of these devices to the prior authorization process, the public will be notified through rulemaking and have an opportunity to comment.

The prior authorization process requires the supplier to submit evidence that the item complies with all Medicare coverage, coding and payment rules before the item can be furnished and before a claim can be submitted,. A "provisional affirmation prior authorization decision" is a condition of payment. Based on input from Medicare beneficiary groups and beneficiaries themselves who have been part of a prior authorization demonstration project for power mobility devices, the feedback has been largely positive and there have been no issues regarding access or barriers to care.

Survey on Patient Experience in LTCHs

AARC submitted comments in response to a notice from CMS asking for input to aid in the development of a survey instrument that would assess patients' and family members' experiences in the care they received in the long-term care hospital (LTCH) setting. The goal is to meet certain requirements of the National Quality Strategy (NQS) led by the Agency for Healthcare Research and Quality (AHRQ) that aim to ensure that each person and family are engaged as partners in their care and to promote effective communication and coordination of care. The notice also seeks information on publicly available instruments and measures that can be used to capture patients' or family members' experiences with LTCH care in a variety of formats.

The notice asked for topics to consider and included mechanical ventilation as an example. Although care in LTCHs can vary among hospitals, we submitted questions for the survey that we feel is appropriate to gauge patient and family experiences with respect to mechanical ventilation. A big "thanks" goes to Dorene Siegweth and Eric Yeager for advice and input on questions to submit as part of the survey.

HUD Proposal to Ban Smoking in Public Housing

In addition to signing on to joint comments as part of the Tobacco Coalition, AARC also sent separate comments to the Department of Housing and Urban Development (HUD) applauding its proposal to improve the health of public housing residents by proposing to prohibit lit tobacco products inside all indoor areas of public housing, including administrative office buildings and in all outdoor activities within 25 feet of the housing and administrative office buildings. We also strongly recommended the inclusion of e-cigarettes and waterpipe tobacco be included as part of the ban.

Telehealth Coalition Activities

In past meetings, the Board has been apprised of AARC's involvement with a group of like-minded organizations whose goal is to support expansion of telehealth and remote patient monitoring services. Recently the Coalition has chosen to support the CONNECT for Health Act and in doing so has also urged the Senate Finance's Chronic Care Working Group to incorporate the CONNECT for Health Act into its proposals moving forward. Twenty-one members of the coalition signed on to the joint comments to the Working Group. While AARC has been supportive of past activities, we did not sign on to the joint letter since the CONNECT Act would not advantage respiratory therapists as telehealth providers under the waivers.

Tobacco Coalition Activities

As you know, AARC is a member of the Tobacco Partners Coalition represented by approximately 40 patient advocacy organizations whose focus is on reducing tobacco consumption. As such, we often sign-on to joint comments and letters to Congress spearheaded by the Campaign for Tobacco Frees Kids and others in an effort to show a concerted front for patients with chronic respiratory conditions. As a result, several significant wins for public health have taken place due to the diligence of the Coalition in lobbying Congress and others.

The court overturned a previous ruling in favor of the tobacco industry that buttresses FDA's ability to ban the sale of menthol cigarettes and protects its Scientific Advisory Committee from future attacks by industry. The President signed into law the Child Nicotine Poisoning Prevention Act which requires liquid nicotine containers to be sold in child-resistant packaging, similar to other common household products that are dangerous to children. The final language in the Omnibus Reconciliation Bill did not contain the detrimental policy rider proposed in the House Agriculture Appropriations Bill that would have weakened FDA's authority over e-cigarettes and cigars. The CDC received $210 million in appropriations for its Office on Smoking and Health which enables it to continue the "Tips from Former Smokers" media campaign.

Conclusion

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

House of Delegates Report

Jakki Grimball – Spring 2016

Recommendations

None

Report

- Continued working with the Executive Office, House Officers, House Committee Co-Chairs and Delegates to on house business.
- Developed 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 1st 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.
- Continued working with Immediate Past Speaker John Wilgis on transition of Speaker roles and responsibilities
- Appointed House Officers as committee liaisons.
- Joined the Medicaid COPD State Initiatives Workgroup and participated in the first teleconference.
- Participated in testing the on-line Delegate Assistance and Student Mentorship applications.
- Advised and assisted House Committees as requested.

I owe a debt of gratitude to the Executive Office, Board of Directors, House Officers and John Wilgis. Thanks also to the members of the House and Committee Chairs/Co-Chairs for the support, collaboration, and teamwork.

Board of Medical Advisors Report

Submitted by Terence Carey, MD – Spring 2016

Recommendations

None

Report

Below are the preliminary minutes that should be approved on our next conference call that is scheduled for April 25th.

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Medical Advisors Meeting

November 8, 2015 – Tampa, FL

Minutes

Attendance

Steven Boas, MD, Chair (AAP)
Russell Acevedo, MD, FCCP (ACCP)
Robert Aranson, MD, FACP, FCCP, FCCM (ACCP)
David Bowton, MD, FCCP (ACCP)
Kent Christopher, MD, RRT, FCCP (NAMDRC)
Lori Conklin, MD (ASA), Past Chair
Thomas Fuhrman, MD (ASA)
Janet Lioy, MD (AAP)
Neil MacIntyre, MD (ATS)
Harold Manning, MD, FCCP (ACCP)
Col. Michael Morris, MD, FACP, FCCP, USA RET
Paul Selecky, MD, FACP, FCCP, FAARC, FAASM (NAMDRC)

Excused

Robert Brown, MD (ATS)
Terence Carey, MD (ACAAI), Chair-elect
Ira Cheifetz, MD, FCCM, FAARC (SCCM)
Allen Dozor, MD (ATS)
David Kelley, MD, RRT-NPS, CRT (ASA)
Kevin Murphy, MD (ACAAI)
Peter Papadakos, MD, FCCM, FAARC (SCCM)
Ravi Tripathi, MD (ASA)

Guests

Frank Salvatore, Jr., RRT, MBA, FAARC
Tom Smalling, PhD, RRT, RPFT, RPSGT, FAARC,
Kathy Rye, EdD, RRT, FAARC
Gary Smith, BS, RRT, FAARC
Lori Tinkler, MBA
Carl Haas, MS, RRT, FAARC

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Cheryl West, MPH, Director of Government Affairs
Anne Marie Hummel, Director Regulatory Affairs
Kim Turner, Esq., Director Legislative Affairs
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER
Chairman Boas called the meeting of the AARC Board of Medical Advisors to order at 10:06am EST.

INTRODUCTIONS
Chairman Boas asked members to introduce themselves asked members to disclose any conflicts of interest.

David Bowton – consultant for Covidien
Kent Christopher – ventilator patent

CHAIRMAN'S REPORT
Dr. Boas gave an update of BOD meetings he has attended over the year. He informed the BOMA of AARC Bylaws changes that have gone thru a second reading at this Congress. Some BOMA members questioned why BOMA exists then if they no longer have to approve medical issues. Tom Kallstrom assured BOMA that this will not lessen the roles of BOMA.

CoARC (Commission on Accreditation for Respiratory Care) Report
Kathy Rye and Tom Smalling gave highlights of their submitted written report.

NATIONAL BOARD FOR RESPIRATORY CARE
Carl Haas, Gary Smith, and Lori Tinkler gave highlights of their submitted written report.

AARC PRESIDENT'S REPORT
AARC President Salvatore spoke about the APRT credential. There is a taskforce and Ad Hoc Committee working on this along with representatives from CoARC and NBRC. He assured BOMA that AARC will need their support for getting this credential.

In the 2020 HR survey 80% or more respondents will be at or above bachelor's level degree.

The Respiratory Therapist position statement has been revised and will be published soon.

FM15-3-7.1 Dr. Aranson moved that BOMA members request from their parent organizations a letter of support for HR 2948, The Medicare Telehealth Parity Act.
Motion carried

An email will be sent to BOMA in January from the AARC Executive Office that will provide the background and information to BOMA members in order to facilitate this initiative.

APPROVAL OF MINUTES
Dr. Christopher moved to accept the minutes of the June 27 conference call of the AARC Board of Medical Advisors.
Motion carried

EXECUTIVE DIRECTOR REPORT

Executive Director, Tom Kallstrom, gave highlights of his submitted report. Membership is flat, 5% increase in student members, and 12% increase in international members.

The Executive Office was contacted by David Knight, Leonard Nimoy's son-in-law, about assisting with a film about COPD with the hopes to give the respiratory therapist more exposure.

The AARC has been involved with the CDC regarding the ventilator stockpile.

Sherry Milligan is retiring after 35 years. Her position will be split between two new employees – social media coordinator and membership manager. A grants writer has been hired as well.

The Alliance for Patient Access asked RT state leadership and a physician to go to Washington, DC to meet with the working group. Tom Kallstrom and Dr. Christopher are going along with Anne Marie Hummel and Kim Turner.

LEGISLATIVE AFFAIRS REPORT

Ms. Kim Turner was introduced as the AARC's new lobbyist in Washington DC and noted that her continued work with the Asthma and Allergy Network will enhance our impact on pulmonary related legislation. Anne Marie Hummel detailed the 2017 implementation of the Medicare physician payment system, and discussed pending changes to Medicare coverage for ventilators. Ms. West provided an update on state RT related legislation and regulations.

RECESS

Dr. Boas recessed the meeting of the Board of Medical Advisors at 12:15pm EST.

RECONVENE

Dr. Boas reconvened the meeting of the Board of Medical Advisors at 12:50pm EST.

MEDICAL ADVISOR REPORTS

ACCP

Dr. Aranson gave a report as ACCP/CHEST's current senior representative to BOMA. As customary, most of ACCP/CHEST's activities, as they relate to the AARC and BOMA, emanate from ACCP/CHEST's Respiratory Care NetWork Steering Committee. ACCP/CHEST continues to support AARC, including its legislative initiatives, which continue to be aimed at improving the health of patients with respiratory disease by education and training, and its continuing edification of the standing of the Respiratory Care profession, whose members are considered colleagues in the care of the pulmonary patient. At this year's annual CHEST Convention in October in Montreal, it was fortuitous that ACCP/CHEST's CEO, outgoing president, and incoming president were all in attendance at the meeting of the Respiratory Care NetWork Steering Committee, where they heard, first hand, the importance of this NetWork and the working relationships it has with the many entities integral to the profession of respiratory care. The Respiratory Care NetWork is truly one of the most multidisciplinary NetWorks within ACCP/CHEST.

SPECIALTY SECTION REPORTS
The Specialty Section Reports were reviewed.

OTHER REPORTS
Tom Kallstrom gave highlights of the submitted ARCF report. The third annual ARCF Fundraiser, Night on the Bay, was held on Friday evening and was sold out.

AWARD NOMINATIONS
Dr. Boas spoke about the Bird, Hudson, and West award. Moving forward, at the winter AARC meeting, BOMA will select names for these awards for the following year and submit to AARC by June 1 of each year.

UNFINISHED BUSINESS
There was no unfinished business.

NEW BUSINESS
There was no new business.

ADJOURNMENT
Dr. Boas adjourned the meeting of the AARC Board of Medical Advisors at 1:45pm EST.

President`s Council

Submitted by Dianne Lewis – Spring 2016

Recommendations

None

Report

I am happy to announce this year the Council awarded the Jimmy A. Young Medal to John Hiser, MEd, RRT, FAARC. John is well known to most of you and very deserving of the award. It is the time for the BOD to nominate individuals for Life and Honorary membership. Criteria for nominations follow this report. Please keep in mind whoever nominates the BOD's final choice must submit a copy of the individuals resume and a statement as to why the individual desires the award. Please e-mail the information to Kathy Blackmon and myself.

Other

Next year is the AARC's 75th anniversary. I, as well as others, have been working with Trudy Watson to come up with ideas. I know she is also working with the Executive Office. I want to offer the services of the Presidents Council as a group or individually to assist. I know there have been some issues with the interviews done by the Past Presidents. So, I would like to ask the Presidents Council members to submit a couple of paragraphs summarizing their presidency. For our decreased members, I will ask assistance from other Council members who served with them and knew them. I am looking for BOD/EO input if this is a worthy idea to accomplish by next year's anniversary.

AARC Life and Honorary Memberships

YEAR	LIFE	*HONORARY*
1961		Alvin Barach, MD
1965	J. Addison Young	
1967	Arthur A. Markee	
1972	Don E Gilbert	
	Leonard Gurney	
	Jerome Heydenberk	
	Joseph Klocek	
	Brother Roland Maher	
	James Peo	
	P. Noble Price	
	Howard Skidmore	
	Leah W Theraldson	
	Virginia Trafford	
1973	Robert A Cornelius	
	Bernard M. Kew	
	James Whitacre	
1974	Louise H. Julius	John Brown MD
1975	R.J. Sangster	
1976		
1977	John J. Julius	H. Frederic Helmholz, MD
	Easton R. Smith	
1978	Robert H. Miller	Meyer Saklad, MD
	George A. Kneeland	
	Samuel Runyon	
1979	Robert A. Dittmar	Huberta M Livingston, MD
1980	George Auld	Albert Andrews, MD
	Hilaria Huff	Vincent Collins, MD
	Vincent D. Kracum	Donald F. Egan, MD
	Jack Slagle	Ronald B. George, MD
	Bernard Stenger	Hurley L. Motley, MD
1981	John Appling	Sister Bernice Ebner
	Wilma Bright	John H. Newell
	James A. Liverett, Jr	
	Sister Mary of Providence Dion	
1892	Gareth B Gish	John Haven Emerson
1983	Robert E. Glass	William F. Miller, MD
		Robert H. Lawrence, MD
1984	John D. Robbins	James Baker, MD
		Duncan Holaday, MD

YEAR	LIFE	*HONORARY*
1985	James S. Allen	Walter J. O'Donohue, MD
	Houston R. Anderson	
	Thomas A. Barnes	
	Julie S. Ely	
	David H. Eubanks	
	Glen N. Gee	
	Gary L. Gerard	
	Sam P. Giordano	
	Robert L. Knosp	
	Lillian Van Buskirk	
	John R. Walton	
	Robert R. Weilacher	
	George A. West	
1986	Richard W. Beckham	Hugh Matthewson, MD
	Paul Powers	
1987	Jeri E. Eiserman	John Hodgkin, MD
	Edward A. Scully	
1988	Michael Gillespie	Irvin Ziment, MD
	Melvin G. Martin	
1989	Gerald K. Dolan	Roger Bone, MD
	Ray Masferrer	
1990	Paul J. Matthews, Jr	Alan Plummer, MD
1991	Larry R. Ellis	William Galvin
	Jerome M. Sullivan	
1992	Patrick J. Dunne	Alfred Sofer, MD
	Phil Kittredge	
1993	Bob Demers	David J. Pierson, MD
	Bernard P. Gilles	
1994	Philip R. Cooper	Richard L. Sheldon, MD
	Dianne L. Lewis	
1995	Deborah L. Cullen	Forest Bird, MD, PhD, ScD
	Patricia A. Wise	
1996	Jim Fenstermaker	Neil R. McIntyre, MD
	Trudy J. Watson	
1997	Charlie G. Brooks, Jr.	Steven K Bryant, MBA
	Pat Brougher	
1998	Kerry E. George	Charles Durbin, MD
	W. Furman Norris	
1999	Dean R. Hess	Barry A. Shapiro, MD
	Cynthia J. Molle	
2000	Jerry Bridgers	James K. Stoller, MD
	Dianne Kimball	
2001	Robert Fluck	Michael T. Amato
	Garry W. Kauffman	
2002	Susan B. Blonshine	

William Bernhard, MD

Sherry Milligan

YEAR	LIFE	*HONORARY*
2003	Margaret F. Traband J. Michael Thompson	Cheryl A. West
2004	David C. Shelledy Karen J. Stewart	Patricia A. Lee
2005	Janet Boehm Richard Branson	Jill Eicher
2006	John Hiser Lucy Kester	Marsha Cathcart
2007	Doug MacIntyre Joseph L. Rau	Kent Christopher
2008	Susan Rinaldo Gallo Michael W. Runge	John W. Walsh
2009	Vijay M. Deshpande	Dale L. Griffiths
2010	William H Dubbs Toni Rodriguez	None awarded
2011	Patricia A. Doorley	Foster M. “Duke” Johns III
2012	Richard M. Ford Timothy R. Myers	Miriam A. O’Day
2013	Linda Van Scoder	Kathy Blackmon
2014	Debra J. Fox	Edna Fiore
2015	Fred Hill	Kris Kuykendall

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.

Standing Committee Reports

Audit Sub-Committee

Submitted by Keith Siegel – Spring 2016

Recommendations

That the AARC Board of Directors accept the audit report as presented.

Report

The Audit Sub-Committee met via telephone conference call on Monday, March 14, 2016 to review the Association's consolidated financial reports and the findings of the independent auditors' report as presented by Bill Sims and James Nash of the auditing firm Salmon, Sims, Thomas & Associates, LLC. All members of the AARC Audit Sub-Committee were present on the call, as was AARC Controller Tony Lovio.

The auditors and the Committee members introduced themselves prior to the audit review. The auditors and the Committee reviewed the consolidated financial statements and independent auditors report for the years ending December 31, 2014 and December 31, 2015. The auditors reported that all of the financial records of the Association were found to be in compliance with generally accepted accounting principles for the United States.

After reviewing each financial statement and answering questions from committee members, the auditors gave a "clean, unqualified opinion", complementing the manner in which the AARC manages and accounts for its financial obligations. The auditors did note that since peaking in 2011, revenue from membership dues has fallen in each of the last four years. The decrease in membership revenue was discussed briefly. New to the auditors' report for 2015 was "rent receivables". Tony Lovio and the auditors explained how rent receivables are accounted for to the committee.

The auditors' report included no management recommendations.

Other

I would like to thank the Audit Sub-Committee for their participation in this annual review. I also want to thank Tony Lovio and the staff of Salmon Sims Thomas, LLC for their participation and open discussion and explanation of the Committee's questions. I also want to thank HOD Speaker Grimball for her guidance and advice as I took on the role of Chair of this committee.

Members: Karen Schell (KS), Curt Merriman (MN), John Walton (IL) and Keith Siegel (ME)

Liaisons: Tony Lovio (TX).

Bylaws Committee

Submitted by: Raymond Pisani - Spring 2016

Recommendations

That the AARC Board of Directors find that the Oregon Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (See attachment 'Oregon Society for Respiratory Care').

That the AARC Board of Directors find that the Montana Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (See attachments '2015 MSRC – Montana Bylaws Revisions Summary and 2015 Bylaws Montana Revised').

That the AARC Board of Directors find that the South Dakota Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (See attachment 'Bylaws changes South Dakota 2016 Final' and 'Bylaws Reviewed AARC South Dakota approved July 2014').

That the AARC Board of Directors find that the Arkansas Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (See attachment 'ASRC Bylaws 2015 Revisions', 'Bylaws Cover Letter 2016', and 'Bylaws Chart and Rationale to ASRC Bylaws').

That the AARC Board of Directors find that the Mississippi Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (See attachment 'MSRC Mississippi Bylaws Proposed 2016').

That the AARC Board of Directors find that the MD/DC Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws. (See attachment 'MDDC Society Bylaws 2016 Update').

Report

Throughout the review process, the AARC Bylaws Committee considered the implications of all recommended Bylaws changes to respective affiliates and the AARC and the Committee has determined that the Bylaws presented are not in conflict with the AARC Bylaws. The AARC Bylaws Committee has therefore approved and submitted the Oregon, Montana, South Dakota, Arkansas, Mississippi, and MD/DC Bylaws and Amendments for review by the Board of Directors.

According to the HOD Calendar, there are thirteen (13) Chartered Affiliates due for review of their Bylaws in 2016. One (1) Affiliate, Idaho, was due in 2015. As Committee Chair, I have reached out to all Affiliate President's reminding them that their Bylaws are up for review. The 2016 States include Colorado, Delaware, Hawaii, Illinois, Kansas, Kentucky, Missouri, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, and Vermont-NH.

Elections Committee

Submitted by: Dan Rowley - Spring 2016

Recommendation

None

Report

The Nominations and Elections Committee has maintained close and open lines of communication with the AARC Executive Office (EO) and each other over the past quarter.

All committee charges have been completed as scheduled to date. In collaboration with the EO, officers of the Board of Directors, House of Delegates, Specialty Section members, and Affiliate Presidents were invited via email correspondence to nominate individuals as follows:

- **Board of Directors** were invited to nominate for the following positions:
  - *VP-Internal Affairs*
  - *VP-External Affairs*
  - *Secretary-Treasurer*

- **House of Delegates** were invited to nominate for the following positions:
  - *Directors* (2 seats)

  - **Specialty Sections** were invited to nominate for the following positions:
  - *Adult Acute Care*
    - Chair-elect for 1-year and Chair for 3-years.
    - Board seat
  - *Diagnostics*
    - Chair-elect for 1-year and Chair for 3-years.
    - Does not meet specialty section membership numbers for a Board seat.
  - *Education*
    - Chair-elect for 1-year and Chair for 3-years.
    - Board seat
  - *Management*
    - Chair-elect for 1-year and Chair for 3-years.
    - Board seat
  - *Continuing Care / Rehab*
    - Chair for 4-years. We have an interim Chair, so no Chair-Elect year.
    - Does not meet specialty section membership numbers for a Board seat.

Prior to soliciting nominations for the above positions, the Nominations and Election Committee's calendar was edited to extend nomination deadline in response to unsolicited membership feedback. Nomination deadline was set at February 23rd, and then extended further to encourage specialty

section nominations where appropriate.

The following two questions were submitted for nominees to answer:

- What AARC or Chartered Affiliate offices/positions have you held where you feel you made a significant contribution to our profession? What is the contribution and how will you apply it to your new position if elected?

- Please provide a personal reflection about the direction of the AARC's mission and vision and relate it to the position you have been nominated. Provide examples of how you will help to advance the AARC's mission and vision forward.

Election nominee profiles were posted on Nominations and Elections Committee AARC Connect communication platform on March 11th.

- Committee members are reviewing nominee profiles at this time.
- Committee conference call to discuss and make final selection of respective position nominees occurred on March 22nd; Final ballot is as follows:

Final Ballot	Order to appear on ballot (Random selection)	
[redacted]	First Candidate Listing	Second Candiate Listing
Adult Acute Care	Carl Hinkson, MS, RRT-ACCS, NPS, FAARAC (WA)	Maria Madden, BS. RRT-ACCS (MD)
Diagnostics	Ralph Stumbo, AAS, RRT, CPFT (WA)	Katrina Hynes, MHA, RRT, RPFT (MN)
Education Chair	Donna Gardner, DrPh(c), RRT-NPS, FAARC, FCCP (TX)	Georgianna Sergakis, PhD, RRT, CTTS (OH)
Management	Christy Clark, BSRT, RRT (FL)	Cherly Hoerr, MBA, BSRT, RRT, CPFT, FAARC (MO)
Director at Large 1	John Wilgis, MBA, RRT (FL)	[redacted]
Director at Large 2	Felix Khusid, BSRT, RRT-ACCS, RPFT (NY)	
Director at Large 3	Raymond Pisani, BS, RRT-NPS, RRT-ACCS (LA)	
Director at Large 4	Susan Rinaldo Gallo, Med, RRT, FAARC, CTTS (NC)	
Secretary/Treasurer	Karen Schell, DHSc, RRT-NPS, SDS, RPFT, RPSGT, AE-C, CTTS (KS)	Cynthia White, MSc, RRT-NPS, ACCS, AE-C, FAARC (OH)
VP Internal Affairs	Natalie Napolitano, MPH, RRT-NPS, AE-C, FAARC (PA)	Lynda Goodfellow, EdD, RRT, AE-C
VP External Affairs	Doug McIntyre, BA, RRT (LA)	Sheri Tooley, BSRT, RRT-NPS, CPFT, AE-C (NY)

I wish to thank the following committee members, in addition to Beth Binkley and Tim Myers, for their unwavering commitment and guidance related to committee operations and activities over the past quarter.

George Gaebler, MSED, RRT, FAARC
John Hiser, MED, RRT, FAARC
Jim Lanoha, RRT FAARC
Mary Roth, RRT

Executive Committee

Submitted by: Frank Salvatore - Spring 2016

Executive Committee Actions Needing Board Ratification:

1. **None**

Objective:

1. Act for the Board of Directors between meetings of the Board on all relevant matters as necessary.

Survey Proposals Reviewed:

1. Napolitano Survey – 11/16/15 – Approved
2. Miller Survey – 12/31/15 – Approved
3. Becker Survey – 1/11/16 – Approved
4. Gray Survey – 1/27/16 – Approved
5. CSRC Survey – 3/7/16 – Approved

Notes:

1. The Executive Committee will meet on Friday, April 8, 2016 in Washington, D.C. to review the agenda and prepare for the Board Meeting.

Finance Committee Report

Submitted by: Frank Salvatore - Spring 2016

Verbal report

Judicial Committee

Submitted by Anthony Dewitt – Spring 2016

Recommendations

None

Report

All policy guidance documents have been submitted to AARC Leadership.

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

Program Committee

Submitted by Ira Cheifetz – Spring 2016

Recommendations

None

Report

1. Prepare the AARC Congress Program, Summer Forum, and other approved seminars and conferences.

Status: The committee met in Dallas on Jan. 21-23, 2016 to review in excess of 650-700 individual lecture proposals submitted in ten different specialty areas and roundtables for presentation at the Summer Forum and Congress. Annissa Buchanan from the Executive Office has already begun communicating with those who submitted proposals informing them of the Program Committee's decision to accept or reject their proposal. The committee would like to express our gratitude to all the individuals (and groups) who submitted proposals and to those who support our many programs and activities.

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

Status: Summer Forum has been secured through 2018 following a BOD approved eVote for the 2018 meeting to be held in San Antonio. This vote will be ratified at the 2016 Spring BOD meeting.

The next open year for AARC Congress is 2019. The Executive Office is currently evaluating destinations for this meeting and in collaboration with the Program Committee; it is likely a recommendation will be presented to the BOD for this meeting this summer in Florida.

3. Solicit programmatic input from all Specialty Sections and Roundtable chairs.

Status: Proposals for the Summer Forum and the Congress were received from all Specialty Sections and Roundtables. Each specialty section/roundtable was appointed a liaison from the Program Committee, and this liaison worked closely with the Section Chairs to review the submitted proposals and ensure that a well-rounded representation of section interests are included in our programs. Most Section Chairs were very involved in this process and are to be commended for their initiative and effort.

4. Develop and design the program for AARC Congress to address the needs of the membership regardless of area of practice or location.

Status: A broad offering of topics presented by new and experienced presenters are included in the agenda for both the Summer Forum and Congress. The Program Committee dedicated a significant amount of time to discussing industry priorities and hot topics as well as reviewing membership feedback from previous meetings. As a result of these conversations, several changes will be made to

AARC Congress 2016, including, but not limited to marketing the meeting, programming, exhibitors, and exhibit hall.

5. Misc.

- New in 2015/2016 – The mobile event app created for Congress attendees also allowed for real-time tracking of CRCE. As part of this new process, attendees were required to answer 3-4 questions about the session in order the receive credit. The questions were primarily geared towards evaluating presenters. As such, the Program Committee was able to make far more accurate decisions on existing speakers because of the volume of feedback that was provided via the app.
- The length of Congress presentations will remain at 35 minutes in 2016 and it was unanimously decided that we would run fewer concurrent sessions (8 vs. 10). This will allow for a more focused curriculum and mitigate the potential for lesser-attended rooms during late afternoon and early morning hours.

Strategic Planning Committee

Submitted by George Gaebler – Spring 2016

Report will be handed out at the meeting.

Specialty Section Reports

Adult Acute Care Section

Submitted by Keith Lamb – Spring 2016

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 a biannual bulletin and quarterly newsletters. We have planned our first virtual meeting to be held during the first week of May.

Continuing Care-Rehabilitation Section

Submitted by Trina Limberg – Spring 2016

Recommendations

None

Report

Background and Future Considerations:

- Continue discussions with the leadership from the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) on the possibility of joint professional certification and/or chronic pulmonary disease educator opportunities.
- **Background:** The AACVPR has offered cardiac rehab (CR) professional certification for about 3 years now. A greater percentage of the membership is cardiac rehab providers. There has been a trend for CR programs to add PR service lines. CR and PR differ greatly as does the acuity and patient population. A membership survey was conducted and showed member interest in PR certification. I currently serve on the AACVPR task force which has been charged with assessing needs and exploring possible options for members. This is a unique and important opportunity for the AARC and the AACVPR to collaborate. AACVPR has published competencies specific to PR (2014).
- **Rationale:** There are substantial disparities in professional competencies and program quality. PR competencies and practices are applied to the transition care for chronic lung disease patients in all post-acute settings. PR professionals are amongst the few RTs that practice disease management on a daily basis, including exacerbation risk assessment and behavioral modification intervention. There are no formal training options for professionals at present. Please refer to the abstract below on the ATS/ERS position statement on Pulmonary Rehabilitation recently released.

Activities to date:

- Responding to connect inquiries
- Virtual Section Meeting scheduled for 4/1
  Members survey interests include:
  #1 ICD10 coding for billing and reimbursement
  #2 Documentation and use of the Individual Treatment Plan (ITP)
  #3 Assessing and managing patients with co morbid conditions
  #4 Marketing pulmonary rehab services
- Providing Bulletins 2 x yearly – First issue included an overview of an OIG audit of a New Jersey PR program. Findings included deficiencies with the ITP and meeting CMS required MD sign off within 30 days.

Other

An Official American Thoracic Society/European Respiratory Society Policy Statement: Enhancing Implementation, Use, and Delivery of Pulmonary Rehabilitation
Carolyn L. Rochester et al.

Rationale: Pulmonary rehabilitation (PR) has demonstrated physiological, symptom-reducing, psychosocial, and health economic benefits for patients with chronic respiratory diseases, yet it is underutilized worldwide. Insufficient funding, resources, and reimbursement; lack of healthcare professional, payer, and patient awareness and knowledge; and additional patient-related barriers all contribute to the gap between the knowledge of the science and benefits of PR and the actual delivery of PR services to suitable patients.

Objectives: The objectives of this document are to enhance implementation, use, and delivery of pulmonary rehabilitation to suitable individuals worldwide.

Methods: Members of the American Thoracic Society (ATS) Pulmonary Rehabilitation Assembly and the European Respiratory Society (ERS) Rehabilitation and Chronic Care Group established a Task Force and writing committee to develop a policy statement on PR. The document was modified based on feedback from expert peer reviewers. After cycles of review and revisions, the statement was reviewed and formally approved by the Board of Directors of the ATS and the Science Council and Executive Committee of the ERS.

Main Results: This document articulates policy recommendations for advancing healthcare professional, payer, and patient awareness and knowledge of PR, increasing patient access to PR, and ensuring quality of PR programs. It also recommends areas of future research to establish evidence to support the development of an updated funding and reimbursement policy regarding PR.

Conclusions: The ATS and ERS commit to undertake actions that will improve access to and delivery of PR services for suitable patients. They call on their members and other health professional societies, payers, patients, and patient advocacy groups to join in this commitment.

Diagnostics Section

Submitted by Katrina Hynes – Spring 2016

Recommendations

None

Report

2016 Diagnostic Section Charges

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section's members. Proposals must be received by the deadline Friday, January 8, 2016.
    a. *Charge met. All proposals were reviewed by the Chair and feedback provided to Thomas Lamphere for consideration by the program committee for the 2016 International Respiratory Congress.*

2. The section chairperson is responsible for arranging or leading a quarterly engagement activity for their section membership. This engagement activity may include online section meeting, journal discussions, initiation of discussion on AARConnect, posting of key materials to AARConnect libraries, AARC webpages, or highlighting AARC resources to members through social media. Documentation of such a meeting shall be reported in the April 2016 Board Report.
    a. *Section Specific web cast/chat – webcast topics and prospective speakers have been discussed with Ms. Strickland, Associate Executive Director - Education.*
    b. *Section Chair initiated discussion on Wednesday, March 9, 2016, via AARConnect requesting routine correspondences from membership to the Chair regarding professional accomplishments and newly appointed positions. This information will be noted on quarterly Board reports under Diagnostic Professional Representation.*
    c. *One virtual Diagnostic Section meeting has been scheduled in the second quarter; Wednesday, June 15, 2015, 13:00 CST. Agenda item –increasing section membership.*

3. Undertake efforts to demonstrate value of section membership, thus encouraging membership growth.
    a. *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.*
    b. *As a team, the Section Chair and Bulletin Editor are relentless in seeking out new talents through AARConnect List Serve interactions, or via warm-chatter during the International Congress, to author bi-annual 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 will be reported in the second quarter Board 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 2016 Board Report and updated for each Board report.
    a. *Review of the Diagnostic Section library and swap shop materials will be reviewed bi-annually and reported in the second and fourth quarter Board reports.*

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

Diagnostic Professional Representation:

1. Mrs. Katrina Hynes was elected AARC Alternate Representative to the Joint Commission Professional and Technical Advisory Committee (PTAC).
2. 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.

3. 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– Spring 2016

Recommendations

That the AARC develop a program to recognize outstanding clinical receptors in respiratory care education.

An education section member recommended that the AARC provide an inexpensive external recognition for individuals who complete the Clinical PEP program. The following proposal was outlined:

Process:

- Director of clinical education (DCE) nominates clinical preceptor annually into the programmed system (likely a summer nomination period)
    - Necessary information:
    - RRT number (verification on NBRC website)
    - Date of completion for Clinical PEP program
    - Hours of preceptorship in last calendar year (minimum number: 120 in 12 months)
    - AARC member number (verification at AARC)
    - Education section member verification (verification at AARC)
    - Bachelor degree or higher (degree, date, university)
    - AARC member number of DCE
    - AARC member number of program director
- AARC staff reviews and vets application
    - Programming verifies AARC member number, Education Section membership, AARC member number of DCE and AARC member number of program director
    - Staff (likely Shawna or a customer service rep, depending on time necessary) double-checks the nominee's NBRC status on the NBRC webpage
- AARC staff confers "clinical preceptor" status on nominee
    - AARC staff enters "clinical preceptor" into iMIS database record with expiration date
    - This can be done with a start date in iMIS so it pushes the data on a specified date – likely one that coincides with start of fall term
    - This will also have an end date one year later so the DCE has to nominate each year; not a one-and-done like FAARC
    - The pushed data goes into AARConnect where the preceptor's profile has a "clinical preceptor" ribbon that shows to everyone who looks at the profile
- AARC staff sends email notification to clinical preceptor congratulating him/her on the recognition
    - This can be programmed into Informz to eliminate staff time
- AARC posts "congratulations" announcement to the section (or to membership at large?)

Logistic questions:

- Who at AARC will "own" the process?
    - Likely Shawna
- What will be the cost? (staff time, programming, audit, respond to questions, marketing)
    - Up front cost: minimal programming, likely 10-20 hours of staff time developing materials, unknown for questions, audit is minimal if we use a system that can verify iMIS information automatically
- What programming will need to occur in iMIS to trigger ribbon in AARConnect?
    - Nothing-we have a field that can be repurposed for this information
- What will be the nomination period?
    - Likely June-July
- Will recognition be for calendar year or 365 days after recognition date?
    - Recognition will be for the calendar year of Sept 1-Aug 31 each year. Those who are not renominated or who don't receive recognition for the second year will simply fall off of the list and the ribbon will disappear from the AARConnect profile.
    - Those who are renominated and receive recognition for the next year receive an email for that calendar year and the ribbon remains on the AARConnect profile page
- Will schools be able to do something special for their preceptors?
    - Schools will be able to do whatever recognition process they wish for their preceptors.
    - The AARC furnishes a piece of art for "clinical preceptor" that the schools can use on certificates and such.
- Is this a certification?
    - No. This in no way "certifies" a preceptor through an AARC process. The AARC is recognizing quality preceptors by the information provided by the DCE and/or program director and is simply recognizing excellence (similar to QRCR).

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 2016.
Status: Completed

2. The section chairperson is responsible for arranging or leading a quarterly engagement activity for their section membership. This engagement activity may include online section meeting, journal discussions, initiation of discussions on AARConnect, posting of key materials to the AARConnect libraries, AARC webpages, or highlighting AARC resources to members through social media. Documentation of such a meeting shall be reported in the April 2016 Board Report.

Status: A survey from the last book club session was conducted to inform the current session. The survey results indicated that 28 individuals participated in the prior session and 38 survey respondents had not. An overwhelming majority found the prior book appropriate for their needs and received new ideas for their teaching. Six new chapter leaders volunteered to lead discussions for the new book, *Getting Started with Team-Based Learning*, which was initiated on February 29, 2016. An education section webcast is scheduled for Thursday, March 31, 2016. Lastly, individuals were recruited for the section's Resource directory to aid programs that transition from AS to BS degree programs.

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

Status: A membership subcommittee led by Karen Schell was established and five volunteers began a recruitment campaign in February. The team is addressing the educators in the six states where they reside to assess their AARC membership status as well as their education section status.

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

Status: Four nominations for the education chair-elect were submitted.

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: Member requests for clarification occurred within two business days. Suggestions for webpage resources related to the new education position statement were forwarded to the section AARC liaison.

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 2016 Board Report and updated for each Board report.

Status: Reviews for the AARC Connect library and section swap shop are slated for completion by June 20, 2016. If the current work groups are unable to complete the review by this deadline, additional volunteers will be recruited during the Summer Forum.

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 membership level is 1043. The section membership continues to decline. The progress of the membership subcommittee will be monitored and ideas solicited from other members of the education section.

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

Status: Educational topics that address practicing therapists and hospital-based educators were included in the programming for the International Congress, the meeting that attracts most members from this group. All communications and engagement programs such as the Book Club address topics relevant to this important target group.

Home Care Section

Submitted by Kim Wiles – Spring 2016

Recommendations

None

Report

CHARGES

1. Provide proposals for programs at the International Respiratory Congress and Summer Forum to the Program Committee to address the needs of your Specialty Section's members. Proposals must be received by the deadline in Jan 2016.
STATUS:

- Several proposals submitted. All proposals received were reviewed with the homecare section liaison to the program committee, Dr. Kent Christopher.

2. The section chairperson is responsible for arranging or leading a quarterly engagement activity for their section membership. This engagement activity may include online section meeting, journal discussions, initiation of discussions on AARConnect, posting of key materials to the AARConnect libraries, AARC webpages, or highlighting AARC resources to members through social media. Documentation of such a meeting shall be reported in the April 2016 Board Report.
STATUS:

- Virtual meeting held 3/8/16, poor attendance. Next meeting will need to consider different time slot. Several members contacted me after the meeting to find out how they could access the meeting. They seemed to be confused as to how to access. Some didn't register for the event.
- Section Bulletin produced
- Home Oxygen article written for AARC Times

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

- Spoke at local respiratory conferences and discussed importance of being part of the home care section regardless of whether they were working in homecare.
- Talked to students at local university to talk about homecare and the importance of becoming a member of specialty section.

4. Solicit names for specialty practitioner of the year and submit the award recipient in time for presentation at the Annual Awards Ceremony.
STATUS:

- This was an “assignment” at the virtual meeting. Requested the submission of nominees.

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

STATUS:

- I have been working closely with the incoming section chair, Zach Gantt. He helped with the section bulletin.
- We have regular phone contact discussing various home care topics, esp membership recruitment

6. 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:

- Current information is up to date, but information is limited.
- Discussed in virtual meeting. Requested that members think about useful tools that should be on our page.

7**. 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 2016 Board Report and updated for each Board report.**
STATUS:

- AARC Connect has been monitored and topics are relevant. Topics were used to create proposals for Congress.
- AARC respiratory home care position statement reviewed.
- Review of library will be completed quarterly. Next review will be in June 2016

8. **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:

- Membership continues to be a problem. Current membership is at 628 members.
- Postings have been put on various social media sites
- Discussions have taken place with large HME companies to provide homecare membership to their active AARC members
- Continued discussions on combining the homecare section and the long term care section are taking place. Spoke to Tom Kallstrom as to the how to proceed.

9**. Assist Federal Government Affairs committee in passing legislation which will recognize respiratory therapists under the Medicare home health services benefit.**

- Provide review and comment on paper submitted to CMS (i.e. discharge planning and ventilation)
- Participating in PACT meetings

Long Term Care

Submitted by Gene Gantt – Spring 2016

Recommendations

That the AARC BOD authorize the AARC president to work with the LTC Chair to draft a letter to the NAMDRC President requesting that NAMDRC formally review and endorse the AARC 2010 Position Statement "Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care" .

Report

On March 2-5 I attended the NAMDRC annual conference in Palm Springs. While there I had an opportunity to meet with the NAMDRC leadership to discuss the rapid growth and development of Respiratory Care in the long term care space. There has been a surge of growth in the provision of Respiratory Care in the Skilled Nursing Facility (SNF) industry. With hospital readmission programs hospital partnerships with quality SNFs have become essential to prevent readmissions and SNFs have recognized the need for specialized services in order to succeed. Additionally SNFs will be under pressure to avoid admissions in a new all cause-all admission program beginning in 2017. With this SNFs will have a 2% payment holdback from Medicare for the first year to create a pool. Then those with the lowest admissions will have the money redistributed as a bonus to incentivize reduced admissions and subsequent cost. This new CMS program has created fantastic opportunity for our profession.

Additionally there has been a 22% increase in the number of SNF vent beds over the last 5 years. Many of these new "superSNFs" are providing not only ventilator care but have become very successful in ventilator weaning to liberation. In 2010 the AARC published the position statement "**Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care".** This position statement has become the blueprint for development of these services in the SNF.

I requested 2 things while meeting with the NAMDRC leadership:

1. To broaden the educational exposure of LTC service offerings to the NAMDRC membership by offering LTC sessions at the 2017 annual meeting, and
2. For NAMDRC to review and endorse the AARC 2010 position statement "**Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care"**

The NAMDRC leadership was in agreement with both of these requests. For the first NAMDRC will work internally to add LTC to the program. For the second request I was asked to request the AARC president send a letter to the NAMDRC 2016 President to formally ask NAMDRC to review the position statement for possible endorsement. At that point their BOD will take action on the request. (See recommendation 1)

Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care

Skilled nursing facilities are increasingly becoming the venue for the management of patients who require the full array of respiratory therapy services, from oxygen therapy and inhalation medication management to pulmonary rehabilitation and ventilator management. Skilled nursing facilities should recognize the clinical value to the patient of utilizing a respiratory therapist to provide the complete spectrum of services that respiratory therapists are both educated and competency tested to provide.

The American Association for Respiratory Care recommends that the basic standard of care for skilled nursing facilities be to employ Respiratory Therapists to render care to patients. Additionally, the following basic standards are recommended to ensure the safe and efficient delivery of respiratory therapy services in skilled nursing facilities delivering ventilator and/or high acuity respiratory care:

1. A Certified, or Registered, Respiratory Therapist—licensed by the state in which he/she is practicing if applicable—will be on site at all times to provide ventilator care, monitor life support systems, administer medical gases and aerosol medications, and perform diagnostic testing.

2. A Pulmonologist, or licensed physician experienced in the management of patients requiring respiratory care services (specifically ventilator care), will direct the plan of care for patients requiring respiratory therapy services.

3. The facility will establish admission criteria to ensure the medical stability of patients prior to transfer from an acute care setting.

4. Facilities will be equipped with technology that enables it to meet the respiratory therapy, mobility and comfort needs of its patients.
5. Clinical assessment of oxygenation and ventilation—arterial blood gases or other methods of monitoring carbon dioxide and oxygenation—will be available on site for the management of patients receiving respiratory therapy services at the facility.

6. Emergency and life support equipment, including mechanical ventilators, will be connected to electrical outlets with backup generator power in the event of power failure.

7. Ventilators will be equipped with internal batteries to provide a short term back-up system in case of a total loss of power.

8. An audible, redundant ventilator alarm system will be located outside the room of a patient requiring mechanical ventilation to alert caregivers of a ventilator malfunction/failure or a patient disconnect.

9. A backup ventilator will be available at all times that mechanical ventilation is being provided to a patient.

Developed: 10/2009

Management Section

Submitted by: Cheryl Hoerr – Spring 2016

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 were provided with information regarding proposal submission for 2016 programs. 132 individual proposals were submitted under the management section. Section Chair collaborated with the Program Committee Liaison to review submitted proposals. 19 presentation slots are available in the Summer Forum programing; these slots have been filled with presentations on current topics of interest to RT leadership.

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

   Status: The winter 2015 Bulletin was published as scheduled in January and included the announcement of Garry Kauffman as the Management Section Specialty Practitioner of the Year. The spring Bulletin will be published in April and includes articles on documenting value and creating value in tough times. The contributing authors to the spring Bulletin are two of the same authors who contributed to the winter Bulletin; it has become increasingly difficult to recruit writers and we will re-visit the decision to continue the Bulletin at the end of 2016. A management section meeting was held on Monday, November 9 as part of the International Respiratory Convention and Exhibition and was well attended. A web-based section meeting was held on Thursday, February 25 with approximately 35 members in attendance. A section meeting is planned for Wednesday, June 28 during the Summer Forum.

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. A management focused webcast is scheduled for March 29: Telehealth and the Respiratory Therapist. As part of the last two management section meetings each member was challenged to recruit just one new member.

4. Identify, cultivate, and mentor new section leadership

   Status: The International Convention offered an outstanding opportunity to network with section members and discuss the opportunities available through the AARC. Five section members expressed interest in becoming more involved and have committed to helping with the review of posted materials in the management section library. These members were also encouraged to (1) attend the Summer Forum in order to meet other RC leaders, (2) join the Leadership Book Club to grow their skills, (3) to write an article for the section newsletter, and (4) to submit a proposal for the Summer Forum and/or International Convention.

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. Between 35 and 40 unique threads are started each month. Recent hot topics included:

   - October – Jet Neb Cleaning
   - November – Tracking Missed Therapy
   - December – Billing for 94640
   - January – Pentamidine Treatments
   - February – E_TCO_2 vs S_pO_2 Monitoring

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: Six management section members have been recruited to help in reviewing and updating the reference materials that are currently posted on the management section web page. These volunteers are: Christy Clark, Karsten Roberts, Jeffrey Hodges, Amanda Richter, Joy Hargett and Mary Lou Guy. The first round of reviews is scheduled to be completed by the end of June.

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 1,522 total management specialty section members. This is an 8% decrease in membership numbers from this time last year; however, this number has increased by 10 members since it was report at the reported at the November 2015 BOD meeting. No action is currently planned for the management specialty section as of this posting.

Neonatal-Pediatrics Section

Submitted by Natalie Napolitano – Spring 2016

Recommendations

None

Report

- Worked with program committee liaison to grade topics submitted for conference
- Next Webinar meeting schedule for March 23rd
- Working with AARC staff and small group of section members to redesign Journal Club, survey being sent out to section to assist with decisions
- Working with Shawna on Neo/Peds prep course, all lectures dues in March to begin taping this spring
- Spoke at 3 day Neonatal Mechanical Ventilation conference in Cairo, Egypt (10 talks)

Sleep Section

Submitted by Marilyn Barclay - Spring 2016

Recommendations

That the AARC BOD allow the Sleep Section Chair to work with interested members to develop a Sleep Section specific Mission and Vision Statement to serve as a guide for section's future activities.

Justification: These statements would create a platform from which the section and AARC can build future activities and direction to support the needs of the members and the sleep profession.

Report

- Relaxed section meeting at the Tampa AARC with approximately 30 people present
- Increased posting on AARConnect
- Virtual section meeting Feb 4, 2016
    - 39 registrants
- Results of the Sleep Survey posted on AARConnect and discussed on the virtual section meeting
- Sleep newsletter sent Feb, 2016
- Sleep bulletin is to be published in April and October
- Review of the sleep library has begun and Russell Rozensky has been asked to update some of the outdated materials
- 13 people submitted 29 proposed lectures for the 2016 AARC International Congress
- Approximately 665 members
- Website library and AARConnect library will be reviewed and updated by September, 2016

Other

I would like clear direction from the AARC Board of Directors as to how they would like to approach the sleep profession. I believe that we should become the premiere association for Respiratory Therapists working in sleep. Other sleep organizations come to mind when many people ponder the sleep profession, some AARC members do not support the association of sleep and respiratory care. Until the AARC defines a position for sleep within the organization it will be difficult to increase membership or advance the field within our ranks.

Surface to Air Transport Section

Submitted by Tabatha Dragonberry - Spring 2016

Recommendations

None

Report

- Transport Bulletin completed
    - It is still difficult to find people to contribute for bulletins

- Membership could be better for this section
    - I do notice transport questions on the Neo/Peds boards
    - We will do a virtual meeting in May for the first time
    - Trying to think of ways that members feel they get value from being a section member

- Already soliciting for nominations for SPY

NOTE: Please let me know if there is anything else I can do further to promote the section and provide value to members

Special Committee Reports

Benchmarking Committee

Submitted by: Chuck Menders – Spring 2016

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 – Spring 2016

Recommendations

None

Report

Anne Marie and I continue to field questions about changes in code 94640- *Pressurized or nonpressurized inhalation treatment*

In 2014 the *National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services*, CPT code 94640 should only be reported once during a single patient encounter regardless of the number of separate inhalation treatments that are administered. This applies to outpatients only; clinics, the ED and observation units.

Medicare defines a hospital outpatient encounter as "a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient."

Anne Marie wrote and received response from CMS to verify the above. This information is listed in the Coding Guidelines on AARC.org.

A new development that occurred in January 2016:

Medically Unlikely Edit (MUE) –will allow only **2** units of service for 94640 per day under most circumstances

Ø Medically Unlikely Edit: 'An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.' MUEs prevent payment for an inappropriate number/quantity of the same service on a single day. This was established by CMS to lower the Medicare Fee-For-Service Paid Claims Error Rate.

Ø Medically Unlikely Edit (MUE) was previously **10** units of service per day under most circumstances (1/10/15-12/31/15)

It gets complicated and subject to different interpretations by carriers and hospital coding personnel. Once again, Anne Marie has written requesting clarification. CMS is continuing to explore opportunities to provide further guidance on how to report this code.

Diversity Committee

Submitted by: Frank Salvatore – Spring 2016

Recommendations

None

Report

This committee is under renovation. It was identified in November 2015 that we needed new leadership and a better direction (goals/objectives). It was also identified that this committee needed to be a special committee and be removed from the "Ad Hoc" status. Unfortunately, due to time constraints, I dropped the ball on this one. There were quite a few recommendations made by the 2015 committee that fell short of what needs to be done. I believe that is totally due to the fact the objectives were too broad and open for interpretation. I'm going to address this issue in an communication to the State President's/HOD AARConnect site to engage in dialogue and hopefully find individuals who are passionate about this subject to be members of the committee. So for the first ½ of 2016, the committee will be under renovation and a new list of objectives and members will be presented to you in either an e-vote if it should come about before June or it will be in the June 2016 Board report.

Federal Government Affairs Committee

Submitted by John Lindsey – Spring 2016

Recommendations

None

Report

The AARC will hold its annual Capitol Hill Advocacy Day immediately after the conclusion of the Spring BOD meeting on April 12, 2016. As this Report is written we will have RT representation from 45 states and the District of Columbia represented by over 130 Respiratory Therapists. Local respiratory therapy students and several patient advocates are also slated to participate. In addition for the first year nearly 17 members of the BOD/HOD Officers will stay on post Board meeting and accompany their state PACT reps on their Hill visits.

We continue to support HR-2948 – the Medicare Telehealth Parity Act that was reintroduced in July 2015 by Representatives Mike Thompson (D-CA) and Gregg Harper (R-MS). As you recall this bill will include among other, provisions recognize respiratory therapists as Medicare 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 the time this Report is submitted there are currently 28 co-sponsors of HR 2948. The list of co-sponsors is at the end of this report. We expect to increase the number of co-sponsors as our Virtual Lobby Week efforts get underway.

As you know Virtual Lobby Week is slated to begin on March 28, 2016 and last through April 15, 2016. The AARC Executive Office has used a variety of methods, including social media to make our members and outside supporters aware of VL Week and encourage participation. We also thank our state societies as many of them made a push on their own websites to participate in VL Week. We believe our efforts in sending many messages to the Hill over a short span of time will in some part be responsible for getting an increase in the number of co-sponsors for HR 2948.

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.

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
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

Cosponsor	Date Cosponsored
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
Rep. Boustany, Charles W., Jr. [R-LA-3]	10/06/2015
Rep. Clarke, Yvette D. [D-NY-9]	10/22/2015
Rep. Sewell, Terri A. [D-AL-7]	11/02/2015
Rep. Wilson, Frederica S. [D-FL-24]	11/02/2015
Rep. Kilmer, Derek [D-WA-6]	11/02/2015
Rep. Hinojosa, Ruben [D-TX-15]	02/03/2016
Rep. Swalwell, Eric [D-CA-15]	02/24/2016

Fellowship Committee

Submitted by: Patrick Dunne – Spring 2016

Recommendations

None

Report

The work of the Fellowship Selection Committee does not begin in earnest until the actual selection process commences later in the year. Please note that, due to the mid-October dates of the AARC Congress, the 2016 deadline for receipt of online nominations for Fellow will be Monday, August 1st. The Selection Committee will then commence review of all nominations received by the established deadline. The selection process will be completed by mid-August with notification letters being sent shortly thereafter.

International Committee Report

Submitted by John Hiser – Spring 2016

Recommendations

None

Report

1. **Administer the International Fellowship Program.**

   As of today March 10, 2016 we have 2 applicants for International Fellows and 5 applicants for City Hosts. The deadline for applications to be received was June 1st. The committee will meet on Tuesday, June 28th during the Summer Forum. I'll be sharing the final selection of fellows and hosts with BOD and HOD at your June meetings.

   We surveyed the Fellows and Hosts again this year. All of the comments were with minor exceptions, positive. The results of the surveys are being used to further improve the operations of the committee.

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

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

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

   We continue to be on the look-out for other educational materials that may be translated in the future.

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

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

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

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

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

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

Membership Committee

Submitted by Gary Wickman – Spring 2016

Recommendation

None

Report

Gary and Amanda conferenced to review what has been done in the past, including sending thank you cards to long term members, webinars with students, survey to Program Directors, the Alpha and Omega campaign, and the Visit Project. We decided to set up our first Membership Committee meeting in February 2016.

The agenda for the committee included getting to know Amanda, review what has been done in the past, review current data, brainstorm how we should approach membership this year, and get an update from Tom Lamphere on the works of the Ad Hoc Committee working to review and revise the student web site.

We met on 2/9/2016 with good attendance from the committee. The data remains flat varying between 37,500 and 39,000 each month. We discussed the Visit Project from last year and the year before. While we still think that grass roots efforts are the best way to connect with potential members, we will focus most of our energy on students.

Another area we are focusing on is to take an inventory of what each Affiliate has done for their members over the last year. The idea here is to evaluate how well we support the membership on a local level. We are starting with each committee member going back to their own Affiliates and push for that reflection. We will then use this information on a local level to see how we can enhance what is offered to members so people will realize the value of the AARC. We will then push this out the rest of the Affiliates and help support them to perform their own self-evaluation.

We will continue to commit to meet with students on the local level at their schools, at state conferences, etc. We also asked Amanda and Shawna to dig into how many students there are currently enrolled in educational programs and to evaluate how many graduate each year.

We currently have 7,795 student members. There are approximately 17,000 to 18,000 students enrolled. That means that only about half of students enrolled are student members. We think that this potential is where our best opportunity is to increase membership. Another caveat is that some student members have paid out of pocket to become members while the vast majority of student members are in the free category, signed up by their faculty. Since these student members have been dues paying, the question is, what can we do with them to help incentivize them to transition to active members? We will discuss options at our next meeting.

We are still finishing up the output from the Program Director Survey to see how they engage their students in the AARC. Asha is putting together the final touches on this project and then we will provide this to all Program Directors to give them tools to help engage their students in the AARC activities.

Amanda had an ask of the committee after the first meeting to reach out to Affiliates to make sure their Membership Chairs are up to date on our Officiary.

Next Steps:

The committee plans to meet again at the end of March to continue our work and hopefully will have recommendations for the Board in the Summer Meeting. WE have a lot of energy in this committee and I look forward to working hard on membership this year. We know that grass roots will continue to be our best avenue to reach the potential members. Asha and Amanda will share the student numbers with the Leadership meeting this spring.

I want to thank our committee members for their engagement in this process: Garry Kaufman, Karen Schell, Adrian Childers, Janelle Gardiner, Sheri Tooley, Jeff Davis, Ray Pisani, Sarah Varekojis, John Priest, Tom Lamphere, Kari Woodruff, Miki Thompson, Amanda Feil, Shawna Strickland, and Asha Desai

Position Statement Committee

Submitted by Colleen Schabacker – Spring 2016

Recommendations

Recommendation #1: That the Board of Directors approve the Position Statement "Cultural Diversity" with no revisions. This paper is submitted for your review as attachment #1.

Justification: After review, it was felt this position statement is still pertinent.

Recommendation #2: That the Board of Directors approve the Position Statement "Delivery of Respiratory Therapy Services in Long Term Care Skilled Nursing Facilities Providing Ventilator and/or High Acuity" with no revisions. This paper is submitted for our review as attachment #2.

Justification: After review by the Home Care and Long Term Care Sections, it was felt this position statement is still pertinent.

Recommendation #3: That the Board of Directors approve and publish the Position Statement "Home Respiratory Care" with no revisions. This paper is submitted for your review as attachment #3.

Justification: After review by Kim Wiles and Zach Gantt, it was felt this position statement is still pertinent.

Recommendation #4: That the Board of Directors approve and publish the Position Statement "Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialist" with no revisions. This paper is submitted for your review as attachment #4.

Justification: This position statement was reviewed by Donna Taylor. She felt it is still pertinent.

Recommendation #5: That the Board of Directors approve and publish the newly developed Position Statement "Respiratory Disease Manager". This paper is submitted for your review as attachment #5.

Justification: At the November 2015 Board meeting, the Board approved a recommendation to create this position statement.

Recommendation #6: That the Board of Directors add the goal of reviewing/revising all White Papers on the same three (3) year schedule the committee reviews all position statements.

Justification: The idea of reviewing/revising White Papers has been discussed in the past but there has never been any direction. These papers need to be looked at in a timely fashion to make sure they are not outdated.

Recommendation #7: That the Position Statement Committee submit the Position Statement

"Administration of Sedative and Analgesic Medications by Respiratory Therapists" to BOMA for their recommendations of revising or retiring this statement. This paper is submitted for your review as attachment #6.

Justification: This paper has not been reviewed since 2010. When it was brought up for review in 2013, it was put on hold because the ASA had written a new statement in 2011, Section II,A: "Statement on Granting Privileges for Administration of Moderate Sedation to Practitioners Who are Not Anesthesia Professionals" that excluded RTs. We forwarded it to Lori Conklin, who was at that time the BOMA chair, but never heard back on this topic. We either need to confirm this position statement is still pertinent, or retire it.

Report

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 are in the process of developing two new position statements. We will continue as directed.

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

The following Position Statements will be reviewed this year:

- Cultural Diversity
- Delivery of Respiratory Therapy Services in Long Term Care Skilled Nursing Facilities Providing Ventilator and/or High Acuity
- Guidance Document on Scope of Practice
- Hazardous Materials Exposure
- Home Respiratory Care
- Respiratory Care Scope of Practice
- Respiratory Therapists as ECMO Specialists
- Respiratory Therapists in the Emergency Department
- Respiratory Therapy Protocols
- Telehealth
- Transport of the Mechanically Ventilated

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 is attachment #7

Other

A sincere thank you to the members of this committee for their input: Kathleen Deakins, Deryl Gulliford, Linda Van Scoder and Tony Ruppert. I would also like to thank Kim Wiles, Zach Gantt and Donna Taylor for their input. And extra recognition to Linda Van Scoder for always being the one who steps forward to help with the most difficult of statements.

Excerpt from the November 2015 Board meeting:

Joint Taskforce on a White Paper Regarding Safe Initiation and Management of Mechanical Ventilation
The AARC was asked by UHC to work with them on a white paper because they needed an organization such as ours to create this document. Shawna Strickland spearheaded this project. The Board of Directors was asked to review and offer changes/comments.

FM 15-3-26.4 Sheri Tooley moved to refer to Position Statement Committee for review and comments.
Motion carried

On behalf of co-chairs Dario Rodriquez and Lisa Stampor, the final document (below) is submitted to the Board of Directors for consideration.

AARC/UHC White Paper

March 1, 2016

SAFE INITIATION AND MANAGEMENT OF MECHANICAL VENTILATION

This paper provides guidance for Best Practices for safe initiation and management of mechanical ventilation. It helps define the 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 were 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 patient harm. Inappropriate setting changes, failure to change alarms when ventilator settings are changed, changing settings without appropriate orders, and failure to communicate changes to the interdisciplinary team are under reported.

This White Paper is intended to provide additional guidance to acute and long term health care facilities, home care/durable medical equipment organizations (DME), and 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 and 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 ventilatory support for the patient based on physiologic response as measured by invasive and non-invasive monitoring. Therefore, it is imperative that each HCP who initiates and manages mechanical ventilation demonstrate competency before participating in this type of patient care.

Competency

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 as well as home care/DME providers require annual competency testing 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 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 completion and documentation of competency or skills review for anyone making ventilator adjustments.[4] Any HCP initiating and caring for home ventilators in a post-hospital setting should also maintain regular competency evaluations.

Though there is wide support for regularly timed competency demonstrations by HCPs who initiate and manage mechanical ventilation, a standardized competency assessment tool has not been developed. Many organizations develop their own assessment tool to be specific to the ventilator models used in that organization. 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 their 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] Using expert consensus, Goligher et al. developed a list of 56 learning objectives required to develop core ventilator management competencies. These objectives address 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 HCPs 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 residents to initiate and manage mechanical ventilation.[10] Cox et al. identified that a significant percentage (46%) of surveyed 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 and 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 improve the knowledge and skills required for 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 operational settings. Depending on the patient's needs, the default settings may present a hazard to the patient. Many institutions use disease driven ventilator protocols that help to reduce the risk of barotrauma or pneumothorax by using lung protective strategies.

Anytime a HCP 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.

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 HCPs who make changes to mechanical ventilators should be able to demonstrate the same level of competency and training as that of the respiratory therapist. Each change made to the patient's ventilator settings warrants an assessment of the patient to determine the effect of the change. 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 the 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 physicians are well trained in pathophysiology, they may not be adequately 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 appropriately trained and has 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. This has resulted 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 interdisciplinary 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, but 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 of 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

among manufacturers is non-existent, necessitating equipment specific training to familiarize staff with what alarm features are available, how to modify alarms, the sounds associated with various alarms including 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 and alarm fatigue, while creating an environment that is the safest and most responsive to patient care needs. When available, professional organization recommendations should be incorporated into policy and procedure guidelines in support of best practice.

Ventilator Failure

Each facility and home care/DME provider should ensure that a plan for backup ventilation is provided. An example of this would be establishing a set number of back up ventilators on hand at a facility to accommodate equipment failure and federal and local emergency preparedness plans in the event of a natural disaster.

A backup ventilator should be placed in the home setting of any home ventilator patient who lives greater than a 2 hour drive from the home care/DME provider, and a plan should be communicated to the patient, caregiver, and physician of how to handle equipment failure situations and natural disaster situations in the home setting.

Documentation, orders, and protocols

Orders

In this era of electronic medical records (EMRs) 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 facilities once developed. Development should be a broad base collaboration between respiratory therapy providers, midlevel providers and physicians. They should be built upon evidence-based recommendations of professional societies and have acceptance 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 be easy to be signed by the supervising mid-level provider or physician based on the privileging standards of a facility. These order sets and protocols should be reviewed and edited based on ongoing recommendations and evolving medical literature.

Home care/DME orders should be detailed and certify continued medical necessity for long term mechanical ventilation in the home. The details of this order should include a list of all required supplies and appropriate interface and mode of home ventilation. The certification of medical necessity must document the patient prognosis and plan of care, along with documentation of the consequences to the patient if ventilator support is withdrawn.

Documentation

The EMR has had its greatest advantage in its ability to share information across the continuum of care both at the bedside and through remote access. Therefore, it is imperative that physiologic parameters and the settings of the support technology be entered into the EMR. 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.

It is equally important for home care/DME providers to document patient home assessments and ventilator changes/settings at every patient visit so this documentation can be shared with treating physicians and other HCPs as appropriate to ensure continuity of care.

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 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 other internal or external providers 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.

It is often difficult to manage assigned workloads and unexpected emergencies. However, activities that are integrated into the institutions may help guide the caregiver into promoting safety first and above all other concerns. Having all caregivers of an organization use a standard tool should improve communication efforts.
Utilizing a standard communication tool may enhance effectiveness. A common tool is SBAR (Situation, Background, Assessment and Recommendation), where the caregivers use concise communication techniques.–

Some institutions may use multidisciplinary rounds to 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 mechanical ventilation.

Some EMRs may have advanced tools, such as notes, that can be used to communicate concerns or ideas. While face-to-face communication is always best, individuals working on other shifts may not be able to participate in direct communication. This may be more apparent in smaller facilities, long-term ventilator units, home care/DME providers, or where a respiratory therapist may not be present

for all respiratory care activities. If institutions use a note-type function in an EMR or 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 others 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 for all healthcare providers who initiates and maintains mechanical ventilation. These educational opportunities should incorporate interactive environments.
2. Completion and documentation of competency or skills review should be performed annually and when new equipment is introduced.
3. All parameter and alarm changes on ventilatory support devices should be clearly recorded, documented, and communicated to the entire health care team.
4. Policies and procedures for ventilator alarms should be evidence-based, include clinical targets, directives regarding permission to modify alarms settings, identify the 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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Attachment #1

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

Position Statement

Cultural Diversity

The AARC professional community embraces diversity and multi-culturalism in all of its forms and promotes respect and cultural competence in every facet of its mission. The AARC is enriched by the unique differences found among its diverse members, their patients/clients, and other stakeholders. The AARC values and incorporates equal opportunity, and promotes the use of personal and cultural backgrounds to enhance our profession. The AARC accomplishes this by:

- Demonstrating sensitivity to all forms of diversity and multiculturalism including, but not limited to: age, gender and gender identity, race, color and ethnicity, nationality and national origin, ancestry, religious affiliation and creed, sexual orientation, socioeconomic status, political affiliation, physical and mental abilities, veteran and active armed service status, job responsibilities and experience, education and training.

- Acknowledging the varied beliefs, attitudes, behaviors and customs of the people that constitute its communities of interest, thereby creating a diverse and multicultural professional environment.

- Promoting an appreciation for communication between, and understanding among, people with different beliefs and backgrounds.

- Accommodating the needs of the physically disabled at events and activities.
- Using multicultural content and gender-neutral references in documents and publications.

- Promoting diversity education and cultural competence in its professional education programs.
- Recruiting candidates from under-represented groups for leadership and mentoring programs.

Effective 12/94
Revised 12/07, 04/13
Reviewed 07/10

Attachment #2

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

Position Statement

Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care

Skilled nursing facilities are increasingly becoming the venue for the management of patients who require the full array of respiratory therapy services, from oxygen therapy and inhalation medication management to pulmonary rehabilitation and ventilator management. Skilled nursing facilities should recognize the clinical value to the patient of utilizing a respiratory therapist to provide the complete spectrum of services that respiratory therapists are both educated and competency tested to provide.

The American Association for Respiratory Care recommends that the basic standard of care for skilled nursing facilities be to employ Respiratory Therapists to render care to patients. Additionally, the following basic standards are recommended to ensure the safe and efficient delivery of respiratory therapy services in skilled nursing facilities delivering ventilator and/or high acuity respiratory care:

1. A Certified, or Registered, Respiratory Therapist—licensed by the state in which he/she is practicing if applicable—will be on site at all times to provide ventilator care, monitor life support systems, administer medical gases and aerosol medications, and perform diagnostic testing.

2. A Pulmonologist, or licensed physician experienced in the management of patients requiring respiratory care services (specifically ventilator care), will direct the plan of care for patients requiring respiratory therapy services.

3. The facility will establish admission criteria to ensure the medical stability of patients prior to transfer from an acute care setting.

4. Facilities will be equipped with technology that enables it to meet the respiratory therapy, mobility and comfort needs of its patients.

5. Clinical assessment of oxygenation and ventilation—arterial blood gases or other methods of monitoring carbon dioxide and oxygenation—will be available on site for the management of patients receiving respiratory therapy services at the facility.

6. Emergency and life support equipment, including mechanical ventilators, will be connected to electrical outlets with backup generator power in the event of power failure.

7. Ventilators will be equipped with internal batteries to provide a short term back-up system in case of a total loss of power.

8. An audible, redundant ventilator alarm system will be located outside the room of a patient requiring mechanical ventilation to alert caregivers of a ventilator malfunction/failure or a patient disconnect.

9. A backup ventilator will be available at all times that mechanical ventilation is being provided to a patient.

Developed: 10/2009
Revised: 04/2010
Revised: 07/2013

Attachment #3

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

Position Statement

Home Respiratory Care Services

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

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

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

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

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

It is the position of the American Association for Respiratory Care (AARC) that the respiratory therapist—by virtue of education, training, and competency testing—is the most competent health care professional to provide prescribed home respiratory care. The complexities of the provision of home respiratory care are such that the public is placed at a significant risk of injury when respiratory care services are provided by unqualified persons, either licensed or unlicensed, rather than by persons with appropriate education, training, credentials, and competency documentation.

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

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

Revised 07/13
Attachment #4

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

Position Statement

Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists

The American Association for Respiratory Care endorses the use of qualified and appropriately educated Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists.

ECMO is a modified cardiopulmonary bypass technique used for the treatment of life threatening cardiac or respiratory failure. An ECMO Specialist is the technical specialist educated to manage the ECMO system including blood pump, tubing, artificial oxygenator, and related equipment. The ECMO Specialist, under qualified medical direction and supervision, is also educated to be responsible for the clinical needs of the patient on ECMO which can include: (1) maintenance of normal acid-base balance, oxygenation, and ventilation, (2) administration of blood and blood by-products, (3) medication delivery, and (4) maintenance of appropriate anticoagulation.

The Respiratory Therapist's education provides extensive training in maintenance of normal acid-base balance; oxygenation and oxygen delivery; ventilation; and cardiorespiratory anatomy, physiology, and pathophysiology. These fundamentals of Respiratory Care education make the Respiratory Therapist uniquely qualified to undertake further education as an ECMO Specialist. Additionally the Respiratory Therapist's ability to function in multiple clinical settings among all age groups enhances his/her value as an ECMO Specialist, allowing for care of all patient populations in a variety of critical care environments.

The requisite qualifications for educating a Respiratory Therapist to be an ECMO Specialist should include: (1) the successful completion of an accredited respiratory care educational program, (2) an earned Registered Respiratory Therapist (RRT) credential from the National Board for Respiratory Care (NBRC), (3) a state license (where required), and (4) clinical experience in critical care. Education as an ECMO Specialist should be in accordance with the Extracorporeal Life Support Organization's (ELSO) document entitled "Guidelines for Training and Continuing Education of ECMO Specialists."

Effective 8/3/98
Revised 07/07

Attachment #5

American Association for Respiratory Care

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

Position Statement

Respiratory Disease Manager

An expanding role for healthcare professionals today is in the position of Respiratory Disease Manager.

Hospitals, managed care organizations, public health organizations and government entities are increasingly recognizing the importance of comprehensive and well-organized Disease Management for patients with chronic cardiopulmonary conditions such as asthma, emphysema, chronic bronchitis, bronchiectasis, pulmonary fibrosis, cystic fibrosis, congestive heart failure and other disorders.

Disease Management includes educating patients, counseling patients, and coordinating their care in a variety of ways:

- Serving as Health Coach for patients with chronic respiratory challenges

- Making independent recommendations regarding the patient's respiratory care needs

- Performing assessments on new Disease Management participants to determine their clinical needs, clinical risks and readiness for positive change

- Serving as Case Manager in integrating and coordinating care among multiple providers at various levels along the continuum of care

- Disease Managers must continually enhance their assessment, teaching and counseling skills through active participation in professional seminars and conferences, and they should seek advanced credentials in fields such as Asthma Education, COPD Education and/or Case Management.

It is the position of the American Association for Respiratory Care that among all healthcare providers, the professionals best qualified for the role of Respiratory Disease Manager are Registered Respiratory Therapists credentialed by the National Board for Respiratory Care and prepared academically at the bachelor's level.

Effective: April 2016

Attachment #6

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

Position Statement

Administration of Sedative and Analgesic Medications by Respiratory Therapists

The American Association for Respiratory Care (AARC) recognizes the fact that Respiratory Therapists are called upon to assist physicians with the administration of sedative and analgesic medications during diagnostic and therapeutic procedures and patient transportation.

"Sedation" and "analgesia" describe a physical state in which the patient is able to tolerate unpleasant procedures, while maintaining adequate cardiorespiratory function, and the ability to respond purposefully to verbal commands and tactile stimulation. This is commonly referred to as moderate sedation. The AARC believes that Respiratory Therapists working under qualified medical supervision can assist physicians during diagnostic and therapeutic procedures and patient transportation, and help to minimize risks by administering prescribed medications and closely monitoring the patient.

The AARC recognized and acknowledges the following:

- The American Society of Anesthesiologists (ASA) has published the document "Practice Guidelines for Sedation and Analgesia by Non-anesthesiologists." Reference: Anesthesiology, 2002; 96: 1004-1017
- The purpose of the ASA document is to allow clinicians to provide their patient with the benefits of sedation and analgesia while minimizing associated risks.
- The ASA Guidelines should be followed by all Respiratory Therapists called upon to provide this service.
- The clinicians and their facilities have the ultimate responsibility for selecting patients, procedures, medications, and equipment.
- Respiratory care education programs approved by the Commission on the Accreditation of Allied Health Education Programs/Committee on Accreditation for Respiratory Care (or their successor organizations) provide appropriate pharmacologic and technologic training to enable Respiratory Therapists to safely administer sedatives and analgesics by following the ASA Guidelines.

Following successful completion of a specialized education and competency assessment program the Respiratory Therapists must:

- Be knowledgeable about the techniques, medications, side effects, monitoring devices, response or untoward effects of medications, and documentation for any specific procedure.

- Meet qualifications to be certified as competent, in accordance with her/his facility's and Respiratory Care Department's policies, to administer sedatives and analgesics under qualified medical direction.
- The AARC affirms the Respiratory Therapists who have successfully completed a specialized education and competency assessment program on sedation and analgesia based on the ASA's Guidelines, and who have been certified as competent by the appropriate medical director and department head or governing body, should be permitted to provide the service in accordance with ASA's Guidelines, facility policies, procedures, protocols, and service operations, as well as with Joint Commission and state requirements and policies.

Effective: 12/97
Revised: 07/07

Attachment #7

Position Statement Review Schedule
Originally Proposed: 02/20/2007
Last Update: 01/2016

Statement Title	Original Statement Date	Most Recent Review/ Revision	Years Since Last Review/ Revision	Schedule Review 2016	Schedule Review 2017	Schedule Review 2018	Schedule Review 2019
AARC Statement of Ethics and Professional Conduct	1994	2015	1			X	
Administration of Sedative and Analgesic Medications by Respiratory Therapists	1997	2007	9	X			
Best Practices in Respiratory Care Productivity and Staffing	2012	2015	1			X	
Competency Requirements for the Provision of Respiratory Services	1998	2014	2		X		
Continuing Education	1990	2015	1			X	
Cultural Diversity	1994	2013	3	X			
Definition of Respiratory Care	1987	2015	1			X	
Delivery of Respiratory Therapy Services in Long Term Care Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care	2009	2013	3	X			
Electronic Cigarette	2013	2015	1			X	
Guidance Document on Scope of Practice	2013		3			X	
Hazardous Materials Exposure	2002	2013	3			X	
Health Promotion and Disease Prevention	1985	2014	2		X		
Home Respiratory Care Services	2000	2013	3	X			
Insertion and Maintenance of Arterial Lines by Respiratory Therapists	2015	2015	1		X		
Insertion and Maintenance of Vascular Catheters by Respiratory Therapists	2015	2015	1		X		
Interstate Transport Licensure Exemption	2014		2		X		
Licensure of Respiratory Care Personnel	1990	2015	1			X	
Statement Title	**Original**	**Most**	**Years**	**Schedule**	**Schedule**	**Schedule**	**Schedule**

	Statement Date	Recent Review/ Revision	Since Last Review/ Revision	Review 2016	Review 2017	Review 2018	Review 2019
Pre-Hospital Mechanical Ventilator Competency	2007	2014	2		X		
Pulmonary Rehabilitation	1973	2015	1			X	
Respiratory Care Scope of Practice	1987	2013	3	X			
Respiratory Therapist in the Emergency Department	2012		4	X			
Respiratory Therapist Education	1998	2015	1			X	
Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists	1998	2013	1	X			
Respiratory Therapy Protocols	2001	2013	1	X			
Telehealth	2001	2013	1	X			
Tobacco and Health	1991	2014	2		X		
Transport of the Mechanically Ventilated, Critically Injured or Ill, Neonate, Child, or Adult Patient	2009	2012	2				
Verbal Orders	1990	2015	1			X	

State Government Affairs Committee

Submitted by: Raymond Pisani - Spring 2016

Recommendation

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. We will join forces for the launching of Virtual Lobby Week 2016 and AARC Capitol Hill Advocacy Day.

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

Several states are going through the process of RT Licensure Sunset. Fortunately Alabama and Tennessee went quickly through the legislative process and RT licensure has been continued. In 2015 Hawaii RT licensure received a very positive report from the State Auditor and in the 2016 legislative session it appears that the bill to continue RT licensure is moving swiftly through the legislature. Arizona RT licensure law is in the midst of having its state audit. We are unsure at this time what the outcome will be, but unofficial word is that the recommendation should be positive. AARC Government Affairs continues to work with each State Society during the legislative process.

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 Committee

Submitted by: Trudy Watson- Spring 2016

Recommendation

None

Report

The Virtual Museum Committee members continue work on development of new galleries for the Virtual Museum. We plan to launch a minimum of three new galleries in 2016: Resuscitation Equipment, Diagnostics, and Adult ICU Ventilators (1980-1999). In addition several other galleries are in the early stages of development and may be ready later this year if additional content can be obtained. We also have been collecting images for a special gallery to highlight the AARC's upcoming 70th Anniversary (2017). We would welcome your suggestions for future galleries to be added to the virtual museum and would especially appreciate your assistance in obtaining images for new or existing galleries.

In February, Asha Desai was invited to deliver a presentation on the AARC's Virtual Museum to the respiratory care program faculty and clinical preceptors at Collin College. As you may recall, some of their respiratory care students have assisted with scanning some of the AARC's early serial publications and have been very interested in the virtual museum project.

Several requests have been received over the past year from agencies requesting permission to use images that appear in the Virtual Museum. As a result, the virtual museum photo release was revised to grant permission for third party requests to republish images from the virtual museum for educational purposes as long as the photo contributor and AARC Virtual Museum are identified in the credits.

In early March, the Chairs of the boards of the nominating agencies were invited to nominate up to five individuals for consideration as the 2016 Legends of Respiratory Care. A nominations form was distributed to the nominating agencies to summarize key information regarding each individual nominated for the Legends designation. We look forward to receiving and reviewing your nominations along with those from the NBRC, ARCF, and CoARC. The deadline for the return of the completed nomination forms to me is June 30, 2016.

The committee is appreciative of the support and guidance provided by the Executive Office staff.

Special Representatives Reports

AMA CPT Health Care Professional Adv Comm

Submitted by: Susan Rinaldo Gallo – Spring 2016

Recommendations

None

Report

Code 94620 (Stress Test Simple) currently covers two different procedures:

- 6 – minute walk
- Prolonged exercise test for bronchospasm with pre and post spirometry and oximetry

It is easy to see that the two procedures are very different in terms of time, equipment and complexity.

It is not surprising that CMS has identified CPT code 94620 as a potentially miss valued. CMS bases this on the volume and year it was last surveyed. The Pulmonary Medicine organizations (ATS and ACCP), along with the AARC's input, decided the CPT descriptions and codes would benefit from revisions prior to the CMS RUC survey. So what was proposed at the last meeting was to break 94620 into three codes. A code for 6 minute walk, another code for Exercise test for bronchospasm with pre and post spirometry and oximetry, and a third code for Cardiopulmonary exercise stress test; complex (includes measurements of minute ventilation, CO2 production, O2 Uptake, and ECG recordings). As stated above, this will result in a re-evaluation of the 6 minute walk. This is al primary information and should NOT be discussed outside the BOD meeting until finalized.

Another area that received a large amount of attention at the February meeting was telemedicine care. Currently there is an E & M code for non-face to face chronic care management. There was discussion on creating an E & M code for non-face to face acute care, ie tele medicine ICUs.

Additional discussion revolved around coding for telehealth services/procedures. One proposal was to create a modifier that could be used with existing codes, if performed via telemedicine. Another proposal is to identify the procedures that be provided via telemedicine and create new codes for these.

Integrated medicine was also discussed at the HCPAC portion of the meeting. Discussion revolved around encouraging integrated care and increasing communication among HCPs.

Am Assn of Cardiovascular & Pulmonary Rehabilitation

Submitted by Gerilynn Connors - Spring 2016

Recommendations

None

Report

1. AACVPR Pulmonary Expert Committee member, this committee is chaired by Trina Limberg

    A. Involved in discussion with AACVPR about collaboration with AARC for a Pulmonary Rehabilitation Staff Certification/Credential, using the template of the Chronic Disease Certification developed by AARC

    B. current AACCPR BOD is lacking pulmonary rehabilitation representation and volunteers from the Pulmonary Expert Committee is attending all BOD meetings

    C. Dr. James Lamberti is the Pulmonary MD being recommended for the AACVPR BOD; Dr. Lamberti is my currently Pulmonary Rehab. Medical Director who is active on NAMDRC, NBRC and received the ATS Clinical Award 2015

2. AACVPR MAC 11 Reimb. Committee member, Pulmonary Rehabilitation audits continue in MAC M – Virginia, West Virginia, North Carolina and South Carolina

    A. committee wants to reopen dialogue with MAC M medical director, Dr. Feliciano about audit status and continuing issues to share with our membership – face to face meeting will be requested in April/May

    B. committee reported that Veteran's Administration problems with pulmonary rehabilitation referrals exits in Virginia, North Carolina and South Carolina

    C. Karen Lui Legislative Advocate for AACVPR will bring the VA concern to the national AACVPR board and also question Day on the Hill attendees to determine if other PR programs in the U.S. have problems with the VA referral process for pulmonary rehabilitation

3. ATS/ERS Policy Statement: Enhancing Implementation, Use and Delivery of Pulmonary Rehabilitation published Dec. 1, 2015: Am J Respir Crit Care Med. Vol 192; 11, ppgs1373-1386.

4. Attended 2016 COPD TOWN HALL MEETING hosted by NIH and COPD Foundation; all 6 working groups had Pulmonary Rehabilitation as a goal.

A. question to the competency of staff was brought up and program certification

**AACVPR has program certification

**enforces the need for the collaboration of AARC/AACVPR for a staff certification program for pulmonary rehabilitation staff

Other

AACVPR would like to continue discussions with AARC to build a Pulmonary Rehabilitation Staff Certification Program.

AACVPR currently offers a Cardiac Rehabilitation Staff Credential. Staff competency in Pulmonary Rehabilitation is critical. A credential/certification program would support competency. AARC has a successful structured Chronic Disease Management Program Certification that would be a starting template for staff competency plus needed pulmonary rehabilitation specific criteria.

RT Department Directors should be challenged to support/start pulmonary rehabilitation programs at their medical centers.

Pulmonary Rehabilitation is a standard of care for chronic lung disease and COPD readmission is being addressed by every RT Department.

American Heart Association

Submitted by Keith Lamb – Spring 2016

Recommendations

None

Report

Please see attached 2015 AHA CPR and Emergency Cardiovascular Care updates ("2015 AHA CPR Guidelines"). I will provide minutes of our recent teleconference when I receive them. Next meeting is planned for April 13th through April 15th 2016.

American Society for Testing and Materials

Submitted by Thomas Kallstrom – Spring 2016

Recommendations

That the ASTM be removed from the list of AARC Special Representatives.

Justification: ASTM has morphed to Association for the Advancement of Medical Instrumentation (AAMI) and in our talks with them we were told that there is not an interest for a liaison as this is not a process that they have in place. The AARC remains in close communication and is participating with AAMI on a number of other initiatives.

Report

AAMI has been taking the lead in an ISO/TC/AG01 advisory group that is looking at connectors for respiratory therapy devices. Of particular concern internationally is the accidental attachment of respiratory therapy devices that provide oxygen to patients being accidentally attached to an air flowmeter. They are in final stages of making recommended manufacturing changes to the proximal end of the delivery tubing such that it would be impossible to attach a device intended for oxygen administration to an air flowmeter. As this information becomes available I will share with the Board. I have asked Jerome Sullivan to keep the International Respiratory Community aware of the proposed change as well.


AIR
VACUUM
HUDSON RCI
340 mL
STERILE WATER
AQUAPAK
PRE-FILLED HUMIDIFIER
Teleflex
MEDICAL

Chartered Affiliate Consultant

Submitted by Garry Kauffman – Spring 2016

Recommendations

None

Report

I have remained in contact with and support those chartered affiliates with whom I have worked 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, George, Iowa, New Jersey, Washington State, and Utah.

As requested by the Chartered Affiliate and approved by AARC President Frank Salvatore, I facilitated a strategic and operational planning session with the New York State Society for Respiratory Care (NYSSRC) in January 2016. With the combined outgoing and new board members together for this meeting, I created a customized format to facilitate this important session. In addition to seasoned leaders, there are a number of folks new to leadership and new to NYSSRC leadership and the combination of leaders produced a successful session and refreshed mission statement and operational plan. As promised to NYSSRC leadership, I am committing more of my personal time to assist them in this restart of their operational planning and to make their organization of more value to both members and non-members whom we seek to recruit. It is clear to me in facilitating the strategic and operational planning sessions and m ongoing support of the Chartered Affiliate that the value of the AARC is largely determined by the visibility, voice, and value that the Respiratory Therapists see in their district and Chartered Affiliate. As such, I firmly believe that this support role, in addition to the myriad other support services provided by the AARC, is critical to the future viability and success of our Chartered Affiliates and the AARC.

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 for our Chartered Affiliates and the AARC.

Committee on Accreditation of Air Medical Transport Systems

Submitted by Steve Sittig – Spring 2016

Recommendations

None

Report

The yearly meeting schedule for the CAMTS BOD is set for the year. Our next meeting is April 7th - 9th in Denver. This will be a very busy meeting with over 30 deliberations scheduled. On Wednesday evening of the 6th, the CAMTS executive committee will meet. I will be taking part in both meetings as I serve as secretary on the executive committee. We as a board have continued to take in comments on the newly released 10th edition Standards. New applicants continue to apply for CAMTS accreditation.

Extracorporeal Life Support Organization

Submitted by Donna Taylor – Spring 2016

Recommendations

None

Report

The 32nd Annual Children's National Symposium: ECMO and the Advanced Therapies for Respiratory Failure occurred in Keystone Colorado this month. Topics discussed at the Steering Committee meeting of note to Respiratory Therapists were:

- ELSO Individual Membership

An individual membership category has been created by ELSO as is offered by other organizations which will allow ECMO Specialists to become invested on a personal level and take advantage of offerings for discounted courses and materials for these members.

- ELSO Collaboration with Other Organizations

The Chairman of the Steering committee, Jim Fortenberry, was pleased that the AARC accepted the recommendation to collaborate with the AARC. He is open to this type of collaboration and welcomes ideas for ways in which the AARC and ELSO may work together. ELSO has been approached by several groups interested in partnering around data sharing and research. The ELSO data base has a rich bank of information about ECMO cases since 1980. ELSO is very interested in facilitating requests for this information while remaining the source for ECMO data collection.

- ELSO Courses

ELSO continues to provide training courses in extracorporeal life support, both in the US and around the world. However, the demand exceeds what can be accomplished with the ELSO team of volunteers who have been the ones providing the personnel for the course. An “ELSO Endorsed” program may be the way to provide for the demand for ECLS training. Children’s Medical Center Dallas will undergo an evaluation and be a beta test site for to gain ELSO endorsement during our next course. By having ELSO endorse established programs, the demand for this training can remain under the ELSO umbrella and provide standardized training based on ELSO guidelines.

Extracorporeal Life Support is a therapy that is rapidly growing. Programs are emerging throughout the world. I continue to encourage the use of Respiratory Therapists and their unique skill for this advanced therapy.

International Council for Respiratory Care

Submitted by Jerome Sullivan – Spring 2016

Recommendations

That the AARC Board of Directors include in the 2017 budget and subsequent budgets funding for two US ICRC delegates to participate in the international meetings and activities associated with the AARC International Congress and the ICRC Annual Business Meeting.

The details of the funding are as follows and is based on 2016 AARC rates:
Round trip domestic airfare: $381
Lodging @ $216/day x 3 days: $648
Per Diem @ $50/day x 3 days: $150
Registration fee*: $390
Total for 1 individual: $1,569

Total request @ 2 individuals: $3,138 *This amount may be reduced by $780 for Registration fees if representatives are Life Members.

Background & Justification: This recommendation is being made with eventual succession planning in mind and to insure continued stability of AARC representation on the Council.

The ICRC was formally established in December of 1991 and will celebrate its Silver Anniversary in San Antonio on the occasion of the AARC 62nd International Congress in October , 2016. For the better part of the last 10 years expenses to attend and participate in the Annual Congress and associated international meetings and activities have been absorbed at an approximate total in excess of $10,000 as "out of pocket" by the principals involved. As changes of AARC representatives occur in the future this continued practice cannot be consistently relied upon. There needs to be systemic financial support to insure the stability of Council representation into the future.

The ICRC and our Council representatives play a critical role in fostering the public partnership of the AARC with the international community of respiratory practitioners and respiratory care equipment and service providers. Our representatives need to be directly involved in multiple international activities at the Congress including; The Awards/Opening Ceremony for the International Awards and Fellows, the ICRC Executive Committee Meeting (2nd day of Congress), all day ICRC Annual Business Meeting and International Reception (3rd day of Congress). Beyond these obvious commitments the President of the Council meets with individual delegations from the member countries and with industry representatives to address their interests and to gain support from them regarding projects and goals of mutual interest to the AARC and the international community.

Your consideration of this request is greatly appreciated.

Report

I. **Respiratory Care Division West China Medical School of Sichuan University:** West China School of Medicine, West China Hospital of Sichuan University was established in 1914. West China Hospital (WCH) is one of the largest single-site hospitals in the world and the leading medical center of West China, treating complicated and severe cases with 4,300 beds, 44 clinical departments and16 non-clinical/ laboratory departments. WCH is ranked 2nd in the Most Popular 3A Hospital List and in 2014 over 4.9 million patients visited the outpatient department, 130,000 operations were performed and 220,000 patients were discharged from inpatient departments. The Hospital has the largest student clinical skills training base in China supervising 165 PhD candidates and 325 Master Degree students. In the past two years, WCH has established long-term cooperative relationships with more than 30 internationally renowned institutions, including Harvard University, Massachusetts General Hospital and The Mayo Clinic. Professor Liang Zongan of WCH in 1997 with the help of former Chairman, Dr. Sawyer, and Loma Linda University launched a 4-year Respiratory Care (RC) training program. Currently Professor Liang is responsible for the RC Program and is Chairman of the RC Division. In 2000 WCH officially enrolled undergraduate students in a 4 year Respiratory Care Program awarding a Bachelor of Science Degree upon graduation. Admission to the RC Program is limited to 20 students per year. This is the only undergraduate teaching institution in China offering a BS Degree in Respiratory Care and the curriculum is basically in accordance with that taught in the USA. Students complete general medical courses, specialized courses such as *lung function and respiratory physiology*, *mechanical ventilation* and conclude with a clinical practice course lasting 48 weeks.

II. **Update on Respiratory Care Hôpital Sacré Coeur Milot, Haiti:** After completing a progressive didactic respiratory care training curriculum delivered by volunteer registered respiratory therapists from the United States, we have transitioned to clinical education where respiratory therapists work directly with Hôpital Sacré Coeur (HSC) physician and nursing staff to help them develop skills and confidence with applying the art and science of respiratory care practice. Hôpital Sacré Coeur offers medical care and treatment to infant, pediatric, and adult patients. Specialty service where respiratory care is provided includes neonatal intensive care, pediatric acute care, and a combined pediatric and adult intensive care unit. Over the past couple of years, respiratory therapists have been committed to improving respiratory care by training HSC staff basic and intermediate clinical skills for administering oxygen therapy, bubble CPAP, airway management, and how to identify when non-invasive positive pressure ventilation (NIPPV) and invasive mechanical ventilation may be beneficial to relieve respiratory distress and hypoxemia. Daniel D. Rowley, MSc, RRT-ACCS, RRT-NPS, RPFT, FAARCUniversity of Virginia Medical Center Charlottesville, VA and Natalie Napolitano, MPH, RRT-NPS, AE-C, FAARC Children's Hospital of Philadelphia, Philadelphia, PA have largely been responsible for the progress in this project.

III. **Cairo, Egypt: Experts Gather at Ain Shams University for Internationally Recognized Neonatal Respiratory Care Conference:** Soon after the unanimous vote by the International Council for Respiratory Care (ICRC) to welcome Egypt as a member of the Council, Ain Shams University has sponsored an International Education

Recognition System (IERS) approved Neonatal Respiratory Care Conference. The seminar was convened February 7 - 9, 2016 and offered an intense educational experience with 14 contact hours of lecture demonstrations and 4 hours of animal laboratory hands-on teaching/learning activity. The Level I IERS program featured an experienced cadre of distinguished Egyptian physicians and professors specializing in neonatal and pediatric medicine. Two leaders of the American Association for Respiratory Care (AARC) were prominently featured as contributing faculty in the clinical program. The first American professor was AARC President Elect, Brian Walsh, MBA, RRT-NPS, RRT-ACCS, AE-C, FAARC, Harvard Medical School Research Coordinator, Department of Anesthesia, Division of Critical Care. The second was AARC Board of Director & Neonatal/Pediatric Specialty Chair, Natalie Napolitano, MPH, RRT-NPS, AE-C, FAARC, Children's Hospital of Philadelphia Specialist for Research.

IV. Taiwan Celebrates RTSROC Annual Meeting & Associated Activities: On December 13, 2016 The Respiratory Care Association of the Republic of China (RCAROC) held its Annual Professional Congress to correspond with the recognition and celebration of Respiratory Care Week activities promoting respiratory therapy. This rich tradition dates back to December 21, 2001 the inaugural date of the third reading of the Respiratory Therapist Law by the Taiwan Legislature which established official government recognition of the RC profession. This recognition was not accomplished without the tireless, decade-long hard work and effort of the RCAROC. The Association was established in April 1, 1991as a professional society committed to quality improvement in clinical care and the promotion of the respiratory therapy profession. Recognition by the government was an immense and significant step forward in ensuring the improvement of respiratory care for patients in Taiwan afflicted with pulmonary disease. Therefore, by Decree, the anniversary of the event is recognized as Respiratory Therapist Day in Taiwan. Every year the RTSROC Annual Meeting is held in conjunction with the celebration of this day, and the Respiratory Therapy Department of China Medical University (CMU) also organizes Respiratory Care Week activities to promote the profession. For 2016 the President of the International Council for Respiratory Care, Jerome M. Sullivan, PhD, RRT, FAARC, was invited to participate in the RTSROC Annual Meeting, celebrate Respiratory Therapist Day, and to partake in Respiratory Care Week activities.

Joint Commission - Ambulatory PTAC

Submitted by David Bunting - Spring 2016

Recommendations

None

Report

There was a call on March 15th that I was unable to be on. However, Tom Kallstrom was on the call and his comments are below.

I was on the call with the Joint Commission on the 15th. The discussion that mostly impacted us was a proposed change in the competencies of the interpreting physician, under **Proposed Standards and Elements of Performance for Sleep Centers** as noted below**.**

Before granting initial or revised privileges to physicians responsible for interpreting sleep studies, the organization verifies that they have at least one of the following qualifications: - Certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM) or the American Board of Internal Medicine (ABIM) or,

- *A completed fellowship in sleep medicine or, - Demonstrated competence through the interpretation of a random sample of 10 sleep studies of varied type and complexity that have been reviewed and approved by a physician who is board-certified in sleep medicine*

My only comment to JC on the call was a concern I had about the competence of physicians who do pediatric sleep studies. I wanted assurance that both ABIM and ABSM offer that level in their certification programs. JC indicated in the affirmative but I am trying to get that confirmation and should have it before the board meeting.

Joint Commission - Home Care PTAC

Submitted by Kim Wiles – Spring 2016

Recommendations

None

Report

Nothing to report-The quarterly meeting was cancelled.

Joint Commission - Lab PTAC

Submitted by Darnetta Clinkscale– Spring 2016

No report submitted as of March 24, 2016.

National Asthma Education & Prevention Program

Submitted by Natalie Napolitano – Spring 2016

Recommendations

None

Report

I attended a Webinar on December 17th. Update on the progress of the next revision to he guidelines. Below are the 6 topics that will be reviewed:

1. Role of Adjustable Medication Dosing in Recurrent Wheezing and Asthma

2. Role of Long Acting Anti-Muscarinic Agents (LAMAs) in Asthma Management as Add-on to ICSs

3. Role of Bronchial Thermoplasty in Adult Severe Asthma

4. Role of Fractional exhaled Nitric Oxide (FeNO) in Diagnosis, Medication Selection, and Monitoring Treatment Response in Asthma

5. Role of Remediation of Indoor Allergens (e.g., House Dust Mites/Animals/Pests) in Asthma Management

6. Role of Immunotherapy in Treatment of Asthma

Neonatal Resuscitation Program

Submitted by John Gallagher – Spring 2016

Recommendations

None

Report

The Neonatal Resuscitation Program Steering Committee (NRPSC) met at the American Academy of Pediatrics headquarters in Elk Grove, IL on March 7-8, 2016. The AARC liaison contributed to discussion, planning, and program development in addition to providing an update on AARC initiatives.

Update from NRP: The NRPSC discussed an ongoing study named VentFirst: A Multicenter RCT of Assisted Ventilation During Delayed Cord Clamping for Extremely Preterm Infants. It involves 8 different children's hospitals and has a goal number of nearly 1,000 subjects. It will be running through March of 2021.

The 7th Edition course material is on schedule for a late April 2016 launch. Not only has there been an update on the science of the content (previously provided via AARC Connect by this liaison), the textbook has been redesigned and the framework of the program's systems have been updated. For example, the NRP provider database and Learning Management System has undergone significant redesign. The NRP has partnered with HealthStream to launch a new Database and Learning Management System in Spring 2016. All 7th Edition courses will be recorded in the new system. Features include:

- Course creation and roster management
- Portable/mobile eCards
- One location for web-based learning (Online Examination, eSim, Instructor Course, Instructor Toolkit)
- Individual user accounts for both Instructors and Providers
- Increased course and demographic reporting capabilities

All 6th Edition rosters should be recorded utilizing the existing (6th Edition) NRP database. The existing database will remain open to instructors until 2/1/2017.

One large change to the format of NRP has been the introduction of E-Sim, a high tech computer-based simulation module that allows providers / learners to conduct resuscitation in a safe, simulated environment. The NRPSC and liaisons were integral to the planning and design of the product.

The next NRP Steering Committee meeting will be held onsite at the annual AAP meeting in San Francisco, CA in October of 2016. In addition, the Steering Committee hosts a Current Issues Seminar, a one-day conference for providers which highlights new concepts and reinforces clinical skills. The AARC liaison has been asked to assist in the difficult airway workshop portion of the seminar.

Roundtable Reports

(I)	*ROUNDTABLES*	Chair	Staff Liaison	BOD
37	Patient Safety	S. Sittig/K. McQueen	T. Myers	C. White/B. Lamb
38	Simulation	J. Perretta	S. Strickland	L. Trujillo
39	Disaster Response	C. Friderici	S. Strickland	L. Goodfellow
40	Neurorespiratory	G. Faulkner	D. Laher	C. Hoerr
41	Tobacco Free Lifestyle	G. Sergakis	S. Strickland	K. Wiles
42	Pulmonary Disease Mgt	S. Tooley	T. Kallstrom	N. Napolitano
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	S. Nelson	E. Becker
47	Informatics	C. Mussa	S. Nelson	TBD
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 Advanced RT Practices, Credentialing, and Education

Submitted by John Wilgis - Spring 2016

Recommendations

That the AARC Board of Directors Adopt the CoARC proposed revision to the APRT working definition to read:

> "The Advanced Practice Respiratory Therapist (APRT) is a ~~trained,~~ credentialed, ~~and~~ licensed respiratory care practitioner ~~who is employed to~~ trained 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 advanced, evidence-based, ~~complex~~ diagnostic and therapeutic clinical practice and disease management."

That the AARC Board of Directors adopt the revised committee objectives to read:

Objectives: (In priority order)

7. Create the framework for the needs assessment, retain a third party consultant to conduct the needs assessment, conduct the needs assessment, and evaluate completed needs assessment to determine appropriate next steps.
8. General - Licensure - identify states where passage of APRT licensure or certification would have the greatest chance of success.
9. General - Identify at least one educational institution to offer an educational pilot program(s) for APRT.
    a. Identify possible mechanisms to provide funding through the ARCF or other stakeholder(s) (e.g., employers) to support the pilot program(s).
10. AARC - Reimbursement issues - Clearly define the pros and cons of both an "incident to" and "independent practice" approach related to APRT reimbursement and provide information that assists in determining the best approach to establish for future use.
    a. Include information related to direct billing versus salaried positions from a physician or hospital/ facility and level of supervision.
11. Align work of the committee with the Taskforce on Competencies for Entry into Respiratory Care Professional Practice, the Ad Hoc Committee on AARC Research Fund for Advancing the Respiratory Care Profession, the Ad Hoc Committee on Respiratory Therapists and Disease Management, and with the work of specific AARC Goals Committees.
12. NBRC – Upon formal request from the AARC, develop the credential for the APRT.

Report

The committee meets regularly via conference call and web meeting to conduct its work.

- Working Definition:

  Following the AARC Board of Directors meeting in November, CoARC, at its November Board meeting, reviewed suggested revisions to the APRT Standards. During this review, there were some suggested edits to the AARC-approved working definition (as outlined above). The CoARC respectfully requested the Ad Hoc Committee consider these edits. The committee accepted them and agreed to refer the changes to the AARC Board of Directors at its next scheduled meeting.

- Committee Objectives:

  The committee was originally charged with the following objectives:

  1. Develop a plan to address the creation and implementation of a needs assessment survey regarding the APRT.
  2. General - Identify an institution (or institutions) to be pilot programs and provide funding through ARCF or other source (this should also tie into #3 since it would obviously not be prudent to start a pilot program in a state where there's no chance at all of having licensure to support it).
  3. General - Licensure - identify states where passage of APRT licensure would have the greatest chance of success.
  4. AARC - Reimbursement issues
     a. The APRT workgroup supported an 'incident to' approach versus an 'independent practice' approach; and,
     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.

  Following discussion, the committee agreed the objectives needed to be prioritized to effectively accomplish each objective and related tasks. The changes were made and shared with the committee and President Salvatore. The committee accepted the changes and agreed to submit the proposed revisions to the AARC Board of Directors at its next scheduled meeting.

- Needs Assessment:

  Several members of the committee submitted information related to developing Request for Proposal (RFP) to an outside agency / organization to conduct a needs assessment for APRT. This information was reviewed and discussed. An RFP outline was developed (Attachment 1) based on the submitted information. Working groups were established to address each section of the outline. The working groups are occupied in gathering data, resources and information to be

included for consideration in the final outline. This outline will serve as the framework for a RFP for a needs assessment.

- AARC Position Statement on Respiratory Therapists Education and Related Responses:

  The AARC Revised its Position Statement on Respiratory Therapists Education in November 2015. The Position Statement was shared with the committee as an informational item.

  Following the release of the revised AARC Position Statement, CoARC communicated its response to their communities of interest. CoARC's response was also shared with the committee as an informational item.

  The Coalition for Baccalaureate and Graduate Respiratory Therapy Education (CoBGRTE) released its "Response to Historic AARC and CoARC Announcements" in *The Coalition Chronicle*, [February 29, 2016 Volume 5 (2), pg. 9 ff]. This was shared with the committee as an informational item.

Other

The Co-Chairs are very grateful for the opportunity to share this report with the AARC Board of Directors and wish to extend their appreciation to the entire committee, of which, this work would not be possible without their input.

Committee members include:

AARC Representatives: Dr. Ellen Becker, Chuck Menders, John Wilgis (Co-Chair), and Dr. Shawna Strickland (Executive Office Liaison).

CoARC Representatives: Dr. Kevin O'Neil, Dr. Shane Keene (Co-Chair), Dr. George Burton, and Dr. Tom Smalling (CoARC Executive Office Liaison).

NBRC Representatives: Dr. Robert Balk, Kerry George, Dr. Robert Joyner, Carl Haas, and Gary Smith (NBRC Executive Office Liaison).

Respectfully submitted – John Wilgis and Dr. Shane Keene.

ATTACHMENT 1 – RFP NEEDS ASSESSMENT FOR APRT OUTLINE

REQUEST FOR PROPOSALS (RFP) FOR

NEEDS ASSESSMENT STUDY

FOR THE OCCUPATION OF

ADVANCED PRACTICE REPSIRATORY THERAPIST (APRT)

-OUTLINE-

I. PURPOSE OF RFP (Small working group)

a. This language is linked to the QUESTION-BASED OUTCOMES described in the last bullet point of this list. This section should include a description and rationale for the deliverables for this RFP.

b. Determine whether current and projected health care provider services are adequate to provide access to patients with acute and chronic respiratory illnesses across all care settings.

c. If a gap between needs and services exists, identify the services a new provider should provide to address the gap(s).

II. REQUESTING AGENCY

a. American Association for Respiratory Care

III. DESCRIPTION OF THE RESPIRATORY CARE PROFESSION (2016)

a. There is most likely standardized language for this section. What is the current status of the profession statement from the AARC?

IV. DESCRIPTION OF CURRENT PROFESSIONAL HIERARCHY (Small working group)

a. This will require some work as the professional hierarchy is not standardized across credentials or education. There are leanings toward more education and credentials means more authority and higher pay, but this will need to be presented in generalities. This may also be reflected in more autonomy to make diagnostic and therapeutic decisions.

b. The beginning of this can be found within the document developed by this group in 2015.

V. CURRENT WORKING DEFINITION OF THE APRT (Done)

a. What has been accepted by the AARC BOD should to be placed here.

VI. LITERATURE REVIEW (Small working group)

a. Literature-based gap analysis of current "mid-level/advanced-practice" provider education, capabilities, and existing provider needs. Does the literature demonstrate a gap in current provider capability and current industry needs?

VII. RESPONDENTS NEEDED BY CATEGORY (Small working group).

a. Provide the suggested respondents to poll (is the current list sufficient – provide language to state why the final list contains all of the necessary groups)

b. Determine the proper sample size from each group.

c. Determine what the database of information from each group will look like (e.g., First Name, Last Name, Credentials, e-mail, street address, etc.)

d. Determine who will be responsible for soliciting this information from the group, how that information will be stored, and who will be responsible for maintaining that information.

e. Develop correspondence that will be used to solicit information from each group including confidentiality language to reassure solicited group there information is safe from retribution. May need to agree to destroy contact information after a period of time.

VIII. SAMPLE SIZE (Paired with VII)

a. This is linked with VII and separated into each group solicited and a total number of respondents across groups. A minimal sample size should be developed by working group based on results of work linked to VII.b.

IX. TIME LEVEL (This should be read as TIMELINE. It should contain short achievable goals and built to allow an estimate of completion. We should not set ourselves up for failure.)

X. COST OF NEEDS ASSESSMENT STUDY (We need to agree from the start not to cut corners. This will be expensive.)

a. We need to agree that any study being conducted will need 100% consensus from the group. There are long term implications here which include the validity and defensibility of study results. If there are doubts among members of this committee we need to agree to resolve those doubts before moving forward. This includes the entire process of data collection, analysis, interpretation, and distribution.

b. This project will be expensive. We need to know now whether to move forward. The AARC should provide guidance here. We should not develop something that results in grey data.

XI. CURRENT DATA SUPPORTING NEED FOR APRT (Small working group. This language should be changed to "CURRENT DATA SUPPORT THE NEED FOR THE TYPE OF PRACTITIONER DESCRIBED IN THE WORKING DEFINITION")

XII. ANSWERS NEEDED (Small working group)

a. This is more of a QUESTION-BASED OUTCOMES section. This should not be driven by a desire to find a desired outcome, but to determine if a gap exists between what health care provider services are currently available and what health care provider services are currently needed)

Ad Hoc Committee on RTs and Disease Management

Submitted by Claire Aloan – Spring 2016

Recommendations

None

Report

Updated plan:

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

2. Ask committee members to:
   a. Identify their areas of interest in disease management: survey sent, modest response, will resend
   b. Solicit and present any evidence-based information available on best practices for management of the selected disease process or other aspect of disease management (e.g., reimbursement) Not started

3. Solicit information on what role RT's are currently playing in management of identified disease processes. Information to be solicited by:
   a. Existing publications on the RT role: in process
   b. Review of existing materials on roundtables, e.g, asthma and COPD and in section libraries and discussions: in process
   c. Contact with RT's known to be involved in disease management programs to solicit their input: in process
   d. Solicitation of information from section and roundtable members, e.g, through survey: not started
   e. Ask state societies for assistance in identifying RT disease management experts and/or programs: not started

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

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

6. Work with AARC on best place to post and provide information from above actions to members: not started

Ad Hoc Committee on Research Fund for Advancing Respiratory Care Profession

Submitted by Frank Salvatore – Spring 2016

Recommendations

None

Report

This ad hoc committee is under renovation. In 2014 we learned that this committee was not only still active, but that it didn't appear in the goals/committee books of recent Presidents, including this one. We've worked to create attributes for the members of this committee which are:

- PI on one successful grant application (demonstrates understanding of grant process)
- At least 3 peer reviewed publications (demonstrates ability to construct research methodology appropriate to achieve research outcomes)
- AARC member

Unfortunately, due to time constraints, I dropped the ball on this one as well. We've gotten to the point where we're looking at possible candidates to be on this committee. At the time this report was due, the proposed members of the committee still had not been contacted so this publication will not have names attached. What you need to know, is this committee is one that makes the recommendations for funding to the AARC Board. They will not decide who gets the funding, that accountability will always lie with the board.

I promise that once the background work is done and I have the commitment of the members, I will update this report for the April or June board book and present to you the full slate and objectives for the committee.

Ad Hoc Committee on Student Website Enhancement

Submitted by Tom Lamphere – Spring 2016

Recommendations

None

Report

The committee worked during the early part of this year on reviewing the current content of the Student webpage and has begun creating a list of ideas for enhancement of the page. We then spent time creating a survey to ascertain if students are accessing the AARC Student webpage and if so, what interface they are using, how often they are accessing the page and if they found the information on the page applicable to their needs and/or interests.

The survey will also ask students to rate the importance of many types of content that either is or could be listed on the page. In addition, the survey also seeks input from students as to what they'd like to see on the site and asks them to list any other websites they have found helpful.

Once the survey is completed, these ideas will be reviewed along with the survey results to come up with a list of recommendations.

Charges

1. Review the AARC "student" website pages for current content.

2. Review other student web resources to see what's available outside the AARC

3. Survey students to solicit ideas what they believe would make the AARC website the #1 resource for students to visit.

4. Solicit ideas for site enhancement among committee members

5. Develop list of changes and additions for the website.

6. Work with the Executive Office Staff to evaluate new content

7. Create a sustainability model to ensure that content remains current

ARCF
CoARC
NBRC

American Respiratory Care Foundation

Submitted by Michael T. Amato – Spring 2016

Recommendations

None

Report

The American Respiratory Care Foundation (ARCF) has been very active since the last Board of Trustees meeting in July 2015, with our most recent quarterly call convening on September 21, 2015. The following are highlights of activities currently under taken by ARCF, which are all in addition to administering the extensive array of education recognition awards, fellowships, and grants.

As you are aware, the ARCF hosted its 3rd annual ARCF Fundraiser Reception "Night on the Bay" during the AARC Congress 2015. There were over 300 attendees and a net of $38,200 was raised; this does not include the donation received by Teleflex. Vapotherm's sole sponsorship and large amounts of tables purchased was a major benefactor of this event. Plans have begun for the 2016 ARCF Fundraiser Reception to be held on October 14th in San Antonio, Texas with expectations for it to be a bigger success than previous receptions. I hope that you will make it a point to attend this year's event, as we need the support of our peers to encourage the support from our AARC members.

The ARCF will be holding an awareness event and fundraiser raffle again this year during the welcome reception at Summer Forum in Ponte Vedra Beach, Florida. The goals of this event are to bring more awareness to the Foundation while also raising money to support our cause. Promotions for the raffle will began in March.

This June 10-11, ARCF will present the 55th Journal Conference focusing on "Pediatric Respiratory Care". The proceedings from this Conference will be published in a 2016 issue of RESPIRATORY CARE. As-to-date, we have not received funding at either of the sponsor levels, however, sponsorship request have been sent out and follow-up emails are taking place at this time.

Solicitation for the 2016 ARCF awards has begun. There are two new awards for 2016, which are the NBRC/AMP Gary A. Smith Educational Award for Innovation in Education and the Advanced Degree and Clinical Research Training Grant in Alpha-1 antitrypsin Deficiency.
We are honored to have these new additions to our awards.

Solicitations for sponsorship for the International Fellowship Program were sent out the middle of February. As-to-date, we have had three companies commit to sponsorship, Teleflex, Philips/ Respironics, and NBRC. Push for sponsorships will continue.

Summary

The ARCF Trustees have been in frequent communication through quarterly phone conferences as well as a face-to-face meeting last year. We will be holding our first face-to-face meeting of 2016 during Summer Forum this year. I want to thank all of you that gave to the Foundation in 2015 and urge all of you who haven't yet provided your support for the Foundation to consider making a tax-deductible donation. Your support is indispensable to our success. I look forward to presenting this report to you and entertaining any questions you may have while at the Board Meeting.

CoARC Report

Submitted by Tom Smalling – Summer 2016

See attachment “CoARC Update March 2016”

Date: March 8, 2016

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

From: Robert L. Joyner, Jr., PhD, RRT, RRT-ACCS, FAARC
NBRC President

Subject: NBRC Report

I appreciate the opportunity to provide you my first update as President on activities of the NBRC. Since the last meeting, the Board of Trustees met to discuss business related items pertinent to the credentialing system and made significant decisions related to its wholly owned subsidiary, Applied Measurement Professionals. The following information summarizes the current status of major activities in which the Board and staff are currently involved.

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 are now being reviewed and considered by the Board's Continuing Competency Committee.

Advanced Practice Respiratory Therapist/Competency Ad Hoc Committees

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

NBRC Sells Its Interest in Applied Measurement Professionals, Inc. (AMP)

On December 31, 2015, PSI Services of Burbank, CA acquired Applied Measurement Professionals (AMP), a wholly owned subsidiary of the National Board for Respiratory Care (NBRC). AMP was founded in 1982 by the NBRC to take better control of the testing process for credentialing respiratory therapists. Since then, AMP worked with more than 100 organizations

across a wide variety of professions to develop, maintain, strengthen and transition voluntary certification programs.

This is a bittersweet time for us. We are very proud of what AMP has accomplished over the past 30-plus years. The company it grew into now provides us an opportunity to focus on our core mission of serving the respiratory care profession. From this point forward, actual delivery of examinations will be outsourced to AMP, a PSI business. All other services performed by NBRC, including examination development, will remain unchanged.

Job Analysis Studies for Adult Critical Care and Neonatal/Pediatric Examinations

In 2016, the NBRC will begin the process of conducting job analysis studies for both the Adult Critical Care and Neonatal/Pediatric specialty examinations. At the request of the NBRC, AARC President Frank Salvatore appointed an AARC representative to serve on each of these Job Analysis Committees. Work for both will begin when the Board meets in April. New test specifications for these examination programs will be introduced in 2018.

2015 Examination and Annual Renewal Participation

For 2015, the NBRC administered 29,109 tests across all examination programs. 54,849 credentialed practitioners renewed their active status with the NBRC for 2015. Active status renewal notices for 2016 were mailed on October 1, 2015 and follow up notices were mailed on February 1, 2016.To date, 40,270 credentialed practitioners have renewed their active status for 2016.

Examination Statistics – January 1 –December 31, 2015

Examination	***Pass Rate***
Therapist Multiple-Choice Examination –14,316 examinations	
• First-time Candidates	Exceed High Cut-Score 76.5% Exceed Low Cut-Score –85.0%
• Repeat Candidates	Exceed High Cut-Score 34.2% Exceed Low Cut-Score –52.8%
Clinical Simulation Examination –12,332 examinations	
• First-time Candidates	55.8%
• Repeat Candidates	43.2%
Adult Critical Care Examination – 860examinations	
• First-time Candidates	79.0%
• Repeat Candidates	44.8%
Neonatal/Pediatric Examination – 1,082 examinations	
• First-time Candidates	78.3%
• Repeat Candidates	44.0%
Sleep Disorders Specialty Examination – 110 examinations	
• First-time Candidates	87.6%
• Repeat Candidates	61.5%

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 – 209 examinations

- First-time Candidates Exceed High Cut-Score 36.8%
  Exceed Low Cut-Score 77.1%
- Repeat Candidates Exceed High Cut-Score 12.5%
  Exceed Low Cut-Score - 46.9%

Your Questions Invited

I am honored to be serving as President of the NBRC in 2016 and look forward to 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 CoARC. 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

- CoARC/CoBGRTE
- State Initiatives Workgroup (see below)
- Taskforce on Competencies for Entry into Respiratory Care Professional Practice (see below)

To: AARC Board of Directors

From: John Wilgis, M.B.A., RRT, Chair – State Initiatives Working Group

Re: Report on State Initiatives Working Group

Date: March 8, 2016

Attn: Lynda Goodfellow
VP/Internal Affairs - AARC Board of Directors
American Association for Respiratory Care
9425 N. MacArthur Blvd.
Suite 100
Irving, TX 75063-4706

Recommendation: Appoint an Ad Hoc Committee for State Medicaid Initiatives for Pulmonary Patients

Throughout 2015 and this year, I have been privileged to be involved in an informal American Association for Respiratory Care (AARC) workgroup called the Medicaid Chronic Obstructive Pulmonary Disease (COPD) State Initiatives Workgroup. I was pleased to co-lead with Tom Kallstrom and Sam Giordano, a fantastic group of respiratory therapists to explore how the AARC could assist it's state affiliates partner with State Medicaid Programs and other state health care entities, as appropriate, to introduce cost efficient delivery models for patients suffering from COPD and other pulmonary diseases to improve care and increase access to treatment by respiratory therapists.

The participants of this workgroup included: Frank Salvatore, Tim Myers and Cheryl West (AARC); Jan Fields (Centers for Disease Control and Prevention); Gene Gantt (Eventa); Joe Goss (New Jersey Society for Respiratory Care); Jakki Grimball (BlueChoice Health Plan of South Carolina and Speaker, AARC House of Delegates); , Ken Alexander (Louisiana Hospital Association)Sam Giordano, and Tom Kallstrom.

Below is a summary of the group's activities in 2015:

- Congregated workgroup of subject matter experts to facilitate activity and action items.
- Examined data and information related to Medicaid COPD patients and other pulmonary conditions from federal and state government resources.
- Solicited and examined initiatives taken by state affiliates to improve access, affordability, outcomes and quality of care for Medicaid COPD patients and patients with other pulmonary conditions.
- State affiliates included: Tennessee, Missouri, North Dakota, South Dakota, California, Colorado, Rhode Island, South Carolina, New Jersey, Minnesota, Kansas, Texas, and Louisiana.

- Developed a template letter for AARC and state affiliate collaboration with State Medicaid Programs for COPD Delivery Improvement – including concept paper highlighting example pilot programs for consideration.
- Shared information with state affiliates through AARC House of Delegates and the President's and House listserv's, and other communication mechanisms.
- Began developing a state-by-state standard dataset that would support an affiliate's work to implement a pilot program.

This work has been met with a great deal of enthusiasm and interest by the respiratory care community, AARC affiliates and others advocates for those suffering from pulmonary disease but challenged by the common health care barriers of affordability and access to care. I've included our communication to the AARC President's and House of Delegates listserv (Attachment 1) which outlines the overarching goal to assist state affiliates engage in a collaborative effort with state Medicaid Programs to use and assess alternative care services for the Medicaid COPD patient and other patients with pulmonary conditions, utilizing Respiratory Therapists in a way we are not currently being used. I've also included the template letter for State Medicaid Directors, State Affiliate Presidents, and State Hospital Association Presidents we developed (Attachment 2) as a reference.

As the group continued into 2016, we realized we needed a set of clear objectives to guide our work. Primary to all of this is to formally find a place for this work within the structure of the AARC. Therefore, I am officially requesting the AARC Board of Directors (the Board) designate this workgroup as an Ad Hoc Committee and expand the membership to include key subject matter experts from state affiliates involved in delivery improvement programs for Medicaid COPD patients or patients with other pulmonary conditions.

As mentioned, we are leaning into our work for the year and have already identified several objectives we would like to achieve. I am also requesting the Board to consider the recommended objectives below as charges to the Ad Hoc Committee, and provide any additional objectives they deem appropriate. The 2016 recommended objectives include:

1. Categorize existing programs reviewed to determine similarities, lessons learned, potential gaps, and consideration of inclusion in concept paper as recommended pilot programs.
2. Develop a step-by-step, model program and strategic plan to introduce, manage and actively implement an initiative with a State Medicaid Office for COPD and other pulmonary conditions delivery improvement program(s).
    a. The plan should be replicable, and adaptive, and include relevant morbidity, cost per patient, and admissions / readmission information.
    b. The program should focus on expanded access and full utilization of licensed respiratory therapist scope of practice in each state, and include an emphasis on post-acute care settings.
    c. Support information should include clinical information and resources, resource utilization data, and economic projections for an innovative care delivery system.
3. Survey each state to identify: Morbidity and mortality rates for all COPD patients; and, utilization rates of health care resources by COPD patients.
    a. This would include: cost per COPD patient, hospital admission and readmission (within 30 days) rates, emergency department utilization, wait times for physician

appointments, medication adherence/compliance rates, and other information determined relevant by the committee.

4. Create a grant program to support state affiliates activities to develop, manage and implement a Medicaid COPD (or other pulmonary conditions) delivery improvement program and strategic plan.
    a. Grant program should include: contractual terms of business between the AARC and state affiliate requesting financial assistance; a set of deliverables tied to grant fund disbursements; and, a percentage or dollar match requirements for state affiliates.
5. Develop consultative services available to state affiliates to assist in the development, management and implementation of a delivery improvement program and strategic plan for Medicaid COPD patients (or patients with other pulmonary conditions).
    a. Consultant should be a subject matter expert in respiratory care, disease management for COPD and other pulmonary conditions, Medicaid and other payor methodologies, state licensure, government affairs and relations, and other skills as identified.

The workgroup realized early on that to make a difference and produce real results, we would need to position the work within the framework and structure of the Board and its committees and groups. The workgroup also believes that much of this work aligns with the Board's focus on advancing our profession into the 21st Century.

I appreciate your attention to this matter and ask that you refer our requests to the Board for their consideration at the next scheduled Board meeting. I am available for questions and information and appreciate your assistance in this matter.

Thank you!

John Wilgis, M.B.A., RRT
Chair – State Initiatives Working Group
Immediate Past Speaker, AARC House of Delegates
Florida Hospital Association

Cc: Tom Kallstrom, Sam Giordano, Frank Salvatore, Kris Kuykendall

TO: AARC State Affiliate Presidents and the House of Delegates

FROM: John Wilgis, M.B.A., RRT

SUBJECT: State Based Medicaid Initiative

DATE: September 1, 2015

Dear State Affiliate Presidents and Delegates:

One of the most significant goals in our nation's evolving health care system is the emphasis on lowering exacerbations amongst patients with chronic illnesses. Respiratory Therapists can play a more meaningful role to achieve this goal by working with chronic lung patients in other, less expensive, care settings, such as physician practices, skilled nursing facilities, and through home health. In short; Respiratory Therapists need to help their patients outside the hospital setting preventing more costly exacerbations that lead to avoidable hospital emergency room visits, admissions, and readmissions.

As Speaker of the AARC's House of Delegates (HOD), I'm sending this information not only to the HOD but the State Affiliate Presidents as well. AARC is launching a state based project that we believe will eventually create better access to respiratory therapists for the Medicaid COPD patient. Reaching out and engaging State Affiliate Presidents, and your Delegates, is essential to our success in this initiative. We need your help!

As each Delegate knows, the new project discussed in detail at the July Phoenix HOD Meeting was a State Based Medicaid Initiative. The goal of this project is to engage in a collaborative effort with state Medicaid Programs to use and assess alternative care services for the Medicaid COPD patient utilizing Respiratory Therapists in a way we are not currently being used. Please see the attached introductory letter and concept paper presented to the HOD in July as background information.

The first step in this collaborative is to gather as much state Medicaid data on COPD patients that is available. If we are to ask for Medicaid programs to entertain a change from current practice we need to provide them a baseline of data that will support our contention that the provision and coverage of Respiratory Therapy services to Medicaid COPD patients' needs to change, not just that we want it to change.

We believe the best path to achieving success is to gather state data (where available or accessible) on a number of COPD state Medicaid metrics. These may include:

- Number of physician office appointments;
- Emergency department visits;
- Access and use of outpatient services;
- Skilled nursing facility stays;
- Home care services;
- Long-term care services;
- Durable medical equipment usage;
- Hospitalizations; or,

- Hospital readmissions.

We understand this is a significant amount of information and some of it will not be accessible, but surely some will be.

There are also documents available that might serve as a source information for this collaborative. These references are:

- The COPD Foundation's Behavioral Risk Factor Surveillance Survey (BRFSS) data which shows the COPD prevalence rates for every state - http://www.copdfoundation.org/What-is- COPD/COPD-Facts/Statistics.aspx

- The Agency for Healthcare Quality and Research hospital readmissions data by diagnosis (including COPD) and payer (including Medicaid) - http://www.hcup-us.ahrq.gov/reports/statbriefs/sb153.pdf

- The Kaiser Family Foundation state health data - http://kff.org/statedata/

As I indicated, we need your help and there are many ways you can pitch in! You can:

1. Offer your assistance gathering information specific to any of the measures listed above and share them with the AARC.

2. Identify other example successful programs in your state that are different from the pilots featured in the concept paper; and, connect those professionals with the AARC for active engagement.

3. Volunteer your society to work with the Association exploring ways to partner with your State Medicaid Agency for COPD delivery improvement.

4. You may have other ideas that would propel this collaborative to the next level - please share them!

As we work together to move our profession forward, collaborative efforts like the State Based Medicaid Initiative lay the ground work for us to practice in new areas of care delivery. Help us help the profession! For questions and more information please contact me at jswilgis@gmail.com or 1-850-524-2037, or Tom Kallstrom, Executive Director and CEO of the AARC at kallstrom@aarc.org or 1-972-243-2272. We look forward to learning how your state can help all of us make a difference for the patients we serve.

Thank you!

John Wilgis, M.B.A., RRT
Speaker, AARC House of Delegates

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
9425 North MacArthur Blvd., Suite 100, Irving, TX 75063, (972) 243-2272, Fax (972) 484-2720
http://www.aarc.org, E-mail: info@aarc.org

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

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

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

DATE: <INSERT DATE>

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

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

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

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

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

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

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

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

Sincerely,

<SIGNATURE>

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

Attachment: Concept Paper

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

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

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

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

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

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

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

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

severity and challenges of providing care for COPD patients using traditional service delivery models.

Second, the AARC would like to collaborate on the development of alternative care delivery models. There is strong evidence suggesting admissions and readmissions for COPD patients may be reduced if patients are permitted access to the skills of a licensed respiratory therapist before and after being admitted and discharged from a hospital.[3] The AARC hypothesizes part of the problem generating a 25% readmission rate is the limited access to skills processed by licensed respiratory therapists.

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

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

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

- **Pilot Project 3**: Explore the development of a pilot program involving hospitals and participating or integrated providers or delivery systems (e.g., physician practices under hospital ownership, etc.) that provide services to a large volume of COPD Medicaid recipients. According to a recent American Medical Association Review Document,[4] over the last several years hospitals have been acquiring physician practices. It is has been estimated that as many as 50% of hospitals in the United States have at least some

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

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

ownership position in physician practices. Given these new structures of integrated care delivery, Pilot Project 3 would explore ways to leverage this structure to utilize licensed respiratory therapists employed by the hospital but practicing under an agreed arrangement to the hospital owned physician practices. As with the previous suggested pilot projects, an assessment of the costs, quality of life, and number of health care encounters as determinants of success, or lack thereof, would be performed.

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

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

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

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

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

Taskforce on Competencies for Entry into Respiratory Care Professional Practice

Goals:

1. The group will meet via conference call, and decide the structure of the "chair" role. It can be once chair but no more than three tri-chairs if it is decided to have one from each group.
2. Using data gathered through the 2015 and beyond conferences and later sub-groups, determine the competencies needed by practitioners who are entering into Respiratory Care Professional Practice.
3. If the data from goal #2 is not enough to complete a comprehensive list of competencies, the group can employ information gathering techniques so as to create a comprehensive list of competencies.
4. This group should have an initial report on their work prepared for the November 2015 AARC Board meeting.
5. The final report to the AARC Board of Directors is due in April 2016.

AARC Representatives
Bill Galvin - galvin.w@gmercyu.edu
Garry Kauffman – gwkauffman@hotmail.com
Kathy Moss - mossk@health.missouri.edu

Staff Liaison: Tom Kallstrom – Kallstrom@aarc.org

CoARC Representatives:

Brad Leidich – baleidic@gmail.com
Pat Munzer – pat.munzer@washburn.edu
Christine Hamilton – Chamilt5@tnstate.edu

Staff Liaison: Tom Smalling – tom@coarc.com

NBRC Representatives:

Todd Bocklage – bocklaget@health.missouri.edu
Katherine Fedor – fedork@ccf.org
David Vines – David_Vines@Rush.edu

Staff Liaison: Robert Shaw – rshaw@nbrc.org

Update

By Tom Kallstrom

The committee started their work and did so in a series of conference calls (at least twice a month) during the last half of 2015. No one on the committee offered to be the chair so I served as default chair until the President could appoint one. The committee did complete an agency specific (NBRC and CoARC) preliminary review of the competencies that had been prepared by Toni Rodriquez and Lynda Goodfellow to determine capability of their agency to assess competency earlier in the process.

The work of this committee is not yet complete. They are half way through adding and editing the current competencies so that the list can be comprehensive.

New Business

Policy Review

- BOD.002 – Board of Directors – Board of Directors Liaisons to Committees, Task Forces, Focus Groups, Panels, and Special Representatives
- BOD.008 – Board of Directors – Joint Session with House of Delegates
- BOD.013 – Board of Directors – Professional Attire
- RT.001 – Roundtables - Roundtables

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Board of Directors Liaisons to Committees, Task Forces, Focus Groups, Panels, and Special Representatives**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: November 2011 (on hold until changes to Bylaws have been made)

DATE REVISED: July 2005

REFERENCES: **Position Descriptions/Profiles for the offices of**: **Vice President of Internal and External Affairs**

Policy Statement:
The Vice President for External Affairs will serve as liaison to the BOD for all Special representatives while the Vice President for Internal Affairs will serve as liaison to the BOD for Standing Committees, Special Committees, Specialty Sections and Round Tables**.** Additional Board liaisons may be assigned to AARC Committees, Task Forces, Focus Groups, Panels, and Special Representatives, with the exception of the Finance and Executive Committees at the discretion of the President.

Policy Amplification:

1. When Board liaisons are assigned by the President in addition to the Vice Presidents for Internal and External Affairs, the responsibilities of the liaison and the group(s) to which the liaison is assigned shall be as contained within this policy.

2. It shall be the joint responsibility of the liaison, Vice Presidents for Internal and External Affairs and the Committee/Task Force/Focus Group/Panel chair or special representative to assure that regular communication is maintained.

3. The Vice Presidents for Internal and External Affairs and Board Members appointed as liaisons shall be directed to develop and maintain clear lines of communication between the Board and Committees, Task Forces, Focus Groups, Panels, and Special Representatives.

A. The objective shall be to identify an individual in addition to the President whose primary function is to serve as a resource to Committees, Task Forces, Focus Groups, Panels, and Special Representatives.

B. The Vice President for Internal and External Affairs shall serve as Committees, Task Forces, Focus Groups, Panels, and Special Representative Spokesperson during Board discussions and/or deliberations with comments solicited from Board members or AARC Staff Members that have served as liaisons as indicated.

4. The Vice Presidents for Internal and External Affairs as well as appointed liaisons shall contact the committee chair or special representative as soon as assignments are made and explain the role of the liaison.

   A. No Board liaisons to committees shall have the authority to issue committee charges, authorize changes in committee reporting schedules, approve committee member appointments, or represent the Board or President unless so directed by the President.

   B. Liaison, other than the Vice Presidents for Internal and External Affairs, shall not represent the Committees, Task Forces, Focus Groups, Panels, or Special Representatives without permission of the Committee/Task Force/Focus Group/Panel Chair or the Special Representative.

5. Each Committee/Task Force/Focus Group/Panel Chair or Special Representative shall keep the Vice Presidents for Internal and External Affairs informed of the progress in completing charges and seek assistance as to methods of operations and project completion which conforms to existing policies and procedures.

   A. Committee/Task Force/Focus Group/Panel Chair and Special Representatives shall provide their assigned Vice President for Internal and External Affairs with copies of all correspondence and with their reports prior to submission to the Board of Directors.

   B. The Vice Presidents for Internal and External Affairs shall review reports from assigned Committees, Task Forces, Focus Groups, Panels, or Special Representatives to assure clarity, completeness and consistency of construct, as well as compliance with the approved format.

6. The quality of communication between Committees, Task Forces, Focus Groups, Panels, and Special Representatives *and their assigned Vice Presidents for Internal and External Affairs and* liaisons shall be critical to the discussions and deliberations of the Board.

A. *The Vice Presidents for Internal and External Affairs* and liaisons must assure that they are fully informed of the activities of their assigned Committees, Task Forces, Focus Group, Panels, or Special Representatives and be prepared to represent both the word and the intent of the group(s) they represent to the Board.

B. The Vice Presidents for Internal and External Affairs should also be prepared to formally evaluate the performance of the Committee/Task Force/Focus Group/Panel Chair and Special Representatives.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Joint Session with House of Delegates**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: April 9, 2011

DATE REVISED: July 2005

REFERENCES:

Policy Statement:
Joint Session of the Board of Directors with the House of Delegates shall be planned and conducted by the President.

Policy Amplification:

1. The President, in consultation with the Speaker of the House of Delegates, shall determine those items to be addressed in joint session prior to each summer and fall meeting.

2. The Annual Budget shall be addressed in joint session at the fall meeting.

3. Other items which will facilitate functioning of the Association should also be presented in joint session.

    A. The Board of Directors may or may not vote on items presented in joint session, in accordance with direction from the President.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Professional Attire**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: July 2012

DATE REVISED: July 2012

REFERENCES:

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

Policy Amplification:

1. Unless otherwise determined by the President, the following dress is required at meetings:

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

This requirement shall also apply to invited guests.

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

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: RT.001

SECTION: Roundtables

SUBJECT: **Roundtables**

EFFECTIVE DATE: August 22, 2001

DATE REVIEWED: December 2014

DATE REVISED: December 2014

REFERENCES:

Policy Statement:

1. Roundtables are informally organized members of the AARC focused on specific topics of common interest.

2. A minimum of 25 members may propose a Roundtable by completing the attached *Roundtable Proposal Form* and submitting it to the AARC Executive Office.

3. The AARC Executive Office will communicate this request to the AARC membership using the appropriate methods and solicit their interest.

4. If the Executive Office determines that at least 50 members are interested in joining:
   a. A Roundtable within AARConnect community (listserv) will be established.
   b. All AARC members will be contacted and informed of the new Roundtable.
   c. The AARC President will appoint a section chair or BOD member liaison to monitor the activities of the roundtable and report as needed to the Board.

5. The Board of Directors may elect to dissolve a Roundtable at any time. In such case, the liaison will post an announcement in the Listserv stating the reason(s) for the dissolution of the Roundtable, and the Listserv will cease 30 days after the announcement. Examples of dissolvent include, but are not limited to:
   a. If the Roundtable has three consecutive months with no posts the AARC Board liaison will be notified of the lack of communication.
   b. If the Roundtable is no longer serving the original purpose for development.
   c. If the Roundtable grows large enough to become a section.

6. Through the Board liaison, the Roundtable is charged to:
   a. Promote and advance the interests of the Roundtable among its members;
   b. Work with the Board to advance the interests of the Roundtable through AARC resources other than the Listserv;

c. Encourage Roundtable members to submit program proposals to the AARC Program Committee;

d. Determine if the Roundtable growth meets the bylaws criteria for becoming an AARC Specialty Section.

Roundtable Proposal Form

Please read the *AARC Roundtable Policy* before completing this form.

Definition – *Roundtables are formally organized members of the AARC focused on significant topics of common interest, and who feel other groups within the organization are not addressing their special interest.*

Your Name _____

AARC Member # _____ E-Mail _____

Employer _____

City _____ State _____

Suggested name for proposed Roundtable _____

List reasons you and others feel justify the establishment of the Roundtable:

_____
_____
_____
_____
_____
_____

Before your proposal is submitted, at least 9 other AARC members must concur with you. E-mails to you will be accepted in lieu of their signatures; in such case, attach the e-mails to this form.

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Name _____ Signature _____ AARC Member # _____

Your Signature _____ Date _____

Please Send via US Mail to: **President, American Association for Respiratory Care**
9425 N. MacArthur Blvd #100
Irving, TX 75063

DEFINITIONS:
ATTACHMENTS:

ARCF Achievement Awards

Forrest M. Bird
Lifetime Scientific Achievement Award

Dr. Charles H. Hudson Award
for Cardiopulmonary Public Health

Thomas L. Petty, MD Invacare Award for
Excellence in Home Respiratory Care

Mike West, MBA, RRT Patient Education
Achievement Award

AMERICAN RESPIRATORY CARE FOUNDATION
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http://www.arcfoundation.org, E-mail: info@arcfoundation.org

Memorandum

DATE: February 2016

TO: Frank R. Salvatore, Jr., RRT, MBA, FAARC, AARC President
Robert Joyner, Jr., PhD, RRT, RRT-ACCS, FAARC, NBRC President
Brad Leidich, MSEd, RRT, FAARC, CoARC President
Terence Carey, MD, BOMA Chair

FROM: Michael T. Amato
ARCF Chair

SUBJECT: **Forrest M. Bird Lifetime Scientific Achievement Award 2016—*Solicitation of Nominations***

This award was established in 1983 to acknowledge "outstanding individual scientific contributions in the area of respiratory care of cardiopulmonary disorders." The annual award is funded by an endowment from Dr. Forrest M. Bird, founder of Bird Products Corporation, a developer and manufacturer of respiratory equipment. Dr. Bird has been not only an outstanding innovator of respiratory care equipment, but has inspired and encouraged many investigators to continue the search for methods of improving respiratory care. He is recognized as an international educator and promoter of excellence in respiratory care.

In recognition, the recipient will receive an inscribed plaque, monetary award, coach airfare, one night's lodging, and registration to attend the Awards Ceremony at the AARC Congress 2016.

Previous recipients of this prestigious award have been:

2015 John B. Downs, MD
2014 John J. Marini, MD
2013 Michael T. Newhouse, MD, FRCP©, FACP
2012 Patrick Dunne, MEd, RRT, FAARC
2011 Brian Carlin, MD, FAARC
2010 Louise Nett, RN, RRT, FAARC
2009 James K. Stoller, MD, MS
2008 Bruce K. Rubin, MD, FAARC
2007 Robert L. Chatburn, RRT-NPS, FAARC
2006 Robert M. Kacmarek, PhD, RRT, FAARC
2005 Richard D. Branson, MS, RRT, FAARC
2004 Joseph L. Rau, Jr., PhD, RRT, FAARC

2003 Robert Kirby, MD
2002 Charlie G. Durbin, Jr., MD, FAARC
2001 Neil R. MacIntyre, MD, FAARC
2000 Martin J. Tobin, MD
1999 Dean Hess, PhD, RRT, FAARC
1998 Walter O'Donohue, Jr., MD
1997 Alan H. Morris, MD
1996 David J. Pierson, MD, FAARC
1995 Leonard D. Hudson, MD
1994 John F. Murray, MD
1993 Peter Safar, MD
1992 George A. Gregory, MD
1991 Edward A. Gaensler, MD
1990 John W. Severinghaus, MD
1989 Roger C. Bone, MD
1988 William F. Miller, MD, FAARC
1987 H. Fredrick Helmholz, Jr., MD
1986 Thomas L. Petty, MD
1985 Claude Lenfant, MD
1984 C. Everett Koop, MD, Surgeon General

- Each year nominations are invited from the AARC Board of Directors, ARCF Board of Trustees, AARC Board of Medical Advisors, the National Board for Respiratory Care and the Committee on Accreditation for Respiratory Care.

- Nominees must have authored (or co-authored) at least 25 peer reviewed publications listed on Pubmed.gov that: a) clearly demonstrate the important contributions that the nominee has made to the science of respiratory care; b) provide evidence that the nominee was a principal investigator/author on the work; and c) shows a commitment to scientific process. Previous award recipients have generally been established investigators at either teaching institutions or non-profit organizations and usually have in excess of 150 PubMed citations.

    1. Your organization may nominate one candidate.

    2. In fairness to your nominee, you must submit a complete current curriculum vitae and biographical summary.

    3. We request that you tell us why you have made your choice, keeping the purpose of the award as designated by the donor. Your nominee must have made **"outstanding individual scientific contributions in the area of respiratory care of cardiopulmonary disorders."** This should include activities in research and education of physicians, therapists and nurses, through publications and lectures.

    4. Each organization must provide a personal statement from their nominee of interests and activities outside of medicine as well as the candidate's opinion of what their most significant contributions are.

    5. Remember, it is your job to sell your nominee to the selection group.

Any submission that does not meet the criteria of the award will be eliminated. The deadline for receipt of your nomination in the Executive Office is **June 1, 2016.**

cc: AARC Board of Directors
ARCF Trustees

Forrest M. Bird Lifetime Achievement Award

The award was established in 1983 to acknowledge "outstanding individual scientific contributions in the area of respiratory care of cardiopulmonary disorders."

The annual award is funded by an endowment from Dr. Forrest M. Bird, founder of Bird Products Corporation, a manufacturer of respiratory equipment. This award consists of a cash award, a plaque, coach airfare, one night's lodging and registration for the AARC Congress 2016.

Nominations are solicited from the AARC Board of Directors, the ARCF Board of Trustees, BOMA, NBRC, and CoARC. The recipient will be selected by September 1, and the award will be presented during the Awards Ceremony at AARC Congress 2016.

AMERICAN RESPIRATORY CARE FOUNDATION
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Memorandum

DATE: February 2016

TO: Frank R. Salvatore, Jr., RRT, MBA, FAARC, AARC President
Robert Joyner, Jr., PhD, RRT, RRT-ACCS, FAARC, NBRC President
Brad Leidich, MSEd, RRT, FAARC, CoARC President
Terence Carey, MD, BOMA Chair

FROM: Michael T. Amato
ARCF Chair

SUBJECT: **Dr. Charles H. Hudson Award for Cardiopulmonary Public Health 2016—*Solicitation of Nominations***

The American Respiratory Care Foundation (ARCF) has initiated this year's selection process for the Dr. Charles H. Hudson Award for Cardiopulmonary Public Health. We are requesting one nomination from each organization.

The purpose of this award is to recognize "**efforts to positively influence the public's awareness of cardiopulmonary health and wellness.**"

Previous recipients include:

- **William N. Rom, MD, MPH - 2015**
- Stanton A. Glantz, PhD - 2014
- COPD Foundation - 2013
- Melaine Giordano, MSc, RN, CPFT - 2012
- Congressman Mike Ross - 2011
- Not awarded in 2010
- John Kattwinkel, MD - 2009
- Ted and Grace Anne Koppel - 2008
- Senator Michael D. Crapo – 2007
- John W. Walsh − 2006
- Christopher Reeve Foundation - 2005
- Thomas L. Petty, MD, FCCP, FAARC - 2004
- Barbara Rogers - 2003
- National Lung Health Education Program (NLHEP) - 2002
- David Satcher, MD, PhD, Surgeon General of the United States - 2001

- Stephen Wehrmen, RRT, RPFT - 2000
- Mike Moore, Attorney General, State of Mississippi - 1999
- Jackie Joyner-Kersee - 1998
- William W. Burgin, Jr., MD, FACP, FACCP - 1997
- Respiratory Care Dept., Toledo Hospital - 1996
- American Lung Association - 1995
- Allergy & Asthma Network-Mothers of Asthmatics, Inc. - 1994
- Lansing Area Respiratory Care Practitioners - 1993
- Debra Koehl, RRT – 1992
- Senator Frank Lautenberg - 1989
- Congressman Richard Durbin - 1988
- Terry H. DuPont, CRT - 1987
- New York Society for Respiratory Care – 1986

The nomination procedure and other details concerning the award are included on the enclosed information sheets. Nominations are due in the Executive Office no later than **June 1, 2016.**

cc: Board of Directors
ARCF Trustees

Dr. Charles H. Hudson Award for Cardiopulmonary Public Health

The purpose of the award is to recognize "**efforts to positively influence the public's awareness of cardiopulmonary health and wellness**." The award is funded by an endowment from Hudson Respiratory Care Inc. and was established in 1986 in honor of the company's founder, Charles H. Hudson, DDS.

This award consists of a plaque, monetary award, coach airfare, one night's lodging, and registration for the AARC Congress 2016.

Nomination Procedure:

Please submit a typed letter of one thousand words or less that answers each of the following questions as appropriate for the nominee. Nominees may include individuals, groups or organizations whose primary effort has promoted cardiopulmonary health and wellness.

1. How has the nominee promoted cardiopulmonary health and wellness? Outline and describe major activities, events, research, or public policy the nominee has affected.

2. Describe how public cardiopulmonary health and awareness has been influenced through the efforts of the nominee.

3. Why is the nominee a role model for others in terms of public health?

4. How has the nominee promoted the objectives relative to *Healthy People 2010* (see attachment), the federal agenda for a healthier America?

Please include any supporting documentation and, in case of an individual, a curriculum vitae, if available.

Nominations will be accepted through June 1, 2016. Please submit nominations to:

ARCF Executive Office
Attention: Crystal Maldonado
9425 N MacArthur Blvd., Suite 100
Irving, TX 75063
(972) 243-2272
(972) 484-2720 FAX

The award will be presented by the American Respiratory Care Foundation during the Awards Ceremony at the AARC Congress 2016.

Fact Sheet
Healthy People 2010
National Health Promotion and
Disease Prevention Objectives

Healthy People 2010 Goals

- Increase quality and years of healthy life.
- Eliminate health disparities.

The Nation's progress in achieving these goals will be monitored through 467 objectives in 28 focus areas. Many objectives focus on interventions designed to reduce or eliminate illness, disability, and premature death among individuals and communities. Others focus on broader issues, such as improving access to quality health care, strengthening public health services, and improving the availability and dissemination of health-related information. Each objective with baseline data for tracking has a target for specific improvements to be achieved by the year 2010. As data sources are established for those developmental objectives currently without data sources or baseline data (see Data Tracking Volume of Healthy People 2010), targets will be set. Each objective is placed in only one focus area so that there is no duplication of objectives in Healthy People 2010. Each focus area, however, has a list of related objectives in other focus areas, indicating the linkages among the focus areas.

Healthy People 2010 Focus Areas

Access to Quality
Health Services
Arthritis, Osteoporosis, and Chronic Back Conditions
Cancer
Chronic Kidney
Disease
Diabetes
Disability and Secondary Conditions
Educational and Community-Based Programs
Environmental Health
Family Planning
Food Safety
Health Communication
Heart Disease and Stroke
HIV
Immunization and Infectious Diseases
Injury and Violence Prevention
Maternal, Infant, and Child Health
Medical Product Safety
Mental Health and Mental Disorders
Nutrition and Overweight
Occupational Safety and Health
Oral Health

Physical Activity and Fitness
Public Health Infrastructure
Respiratory Diseases
Sexually Transmitted Diseases
Substance Abuse
Tobacco Use
Vision and Hearing

Leading Health Indicators

The Leading Health Indicators, set forth in the publication "Healthy People 2010: Understanding and Improving Health," reflect the major public health concerns in the United States and were chosen based on their ability to motivate action, the availability of data to measure their progress, and their relevance as broad public health issues. They illuminate individual behaviors, physical and social environmental factors, and important health system issues that greatly affect the health of individuals and communities. Underlying each of these indicators is the significant influence of income and education. In addition, the Leading Health Indicators are intended to help everyone more easily understand the importance of health promotion and disease prevention and to encourage wide participation in improving health in the next decade. Developing strategies and action plans to address one or more of these indicators can have a profound effect on increasing the quality of life and the years of healthy life, and on eliminating health disparities – thus creating healthy people in healthy communities.

The Leading Health Indicators have been developed as a short list of measures that will monitor national success in targeting certain behaviors, environmental factors, and community health interventions that impact on health. The set of Leading Health Indicators addresses physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behaviors, mental health, injury and violence, environmental quality, immunizations, and access to quality health care. By tracking and communicating progress on individual indicators, it will be possible to spotlight both achievements and challenges in improving the Nation's health. It is hoped that the Leading Health Indicators will allow the public to more easily understand the importance of health promotion and disease prevention, and invite their participation and partnership.

The Office of Disease Prevention and Health Promotion (ODPHP), United States Department of Health and Human Services, is the Coordinator of the Healthy People 2010 Initiative.

Additional information can be accessed online at:
Healthy People 2010
http://www.health.gov/healthypeople

AMERICAN RESPIRATORY CARE FOUNDATION
9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063-4706
(972) 243-2272, Fax (972) 484-2720
http://www.arcfoundation.org, E-mail: info@arcfoundation.org

Memorandum

DATE: February 2016

TO: Frank R. Salvatore, Jr, RRT, MBA, FAARC, AARC President
Robert Joyner, Jr., PhD, RRT, RRT-ACCS, FAARC, NBRC President

FROM: Michael T. Amato
ARCF Chair

SUBJECT: **Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care 2016—*Solicitation of Nominations***

This award was established in 1992 with a grant from Invacare Corporation to recognize **"outstanding individual achievement in home respiratory care."**

Previous recipients include:

- **Kent. L. Christopher, MD, RRT, FAARC - 2015**
- Angela King, RPFT, RRT-NPS - 2014
- Patricia Blakely, RRT, FAARC - 2013
- Linda A. Smith, BS,RRT, FAARC - 2012
- Brian P. Wilson, RCP, EMT-I - 2011
- Louise Nett, RN, RRT, FAARC - 2010
- John R. Loyer, MS, RRT - 2009
- Nancy T. Martin, BS, RRT - 2008
- Claude Dockter, BS, RRT - 2007
- Robert M. McCoy, RRT, FAARC - 2006
- Vernon Pertelle, MBA, RRT - 2005
- Timothy W. Buckley, RRT, FAARC - 2004
- Gene Andrews, BS, RRT, RCP - 2003
- Robert Fary, RRT - 2002
- Joseph Lewarski, RRT - 2001
- David A. Gourley, BS, RRT - 2000
- Patrick J. Dunne, MEd, RRT, FAARC - 1999
- Regina D. Marshall, BS, RRT - 1998
- Robert J. Jasensky, RRT - 1997
- Linda Ann Farren, RRT - 1996
- Scott Bartow, MS, RRT - 1995

- Susan Lynn McInturff, RRT - 1994
- Linda Chapman Maxwell - 1993

We are now accepting nominations for this award. Please submit a one-page, typed description of how the nominee embodies excellence in home respiratory care relative to the following criteria:

- Must currently be working in home respiratory care.
- Must be a respiratory care practitioner.
- May not be employed by a manufacturer.
- May be involved in education as well as the management and organization of patient care.
- Should serve as an active patient advocate in home respiratory care, with specific achievements that demonstrate leadership.

In recognition, the recipient will receive an inscribed plaque, monetary award, coach airfare, one night's lodging and registration to the AARC Congress 2016.

Preference will be given to individuals who have participated in volunteer community efforts related to home respiratory care, in addition to meeting the medical needs of their patients.

A curriculum vitae is required and supporting documentation should be included, if available.

Nominations should be received by the Executive Office no later than **June 1, 2016.**

cc: Board of Directors
ARCF Trustees

Thomas L. Petty, MD Invacare Award for Excellence in Home Respiratory Care

The award was established in 1992 with a grant from Invacare Corporation to recognize "outstanding individual achievement in home respiratory care". The annual award includes a cash award of up to $500 and an engraved crystal sculpture, plus coach airfare and one night's lodging to attend the Awards Ceremony at the AARC Congress.

Nomination Procedure:

Please submit a one page typed description of how the nominee embodies excellence in home respiratory care relative to the following criteria:

1. Must currently be working in home respiratory care;

2. Must be a respiratory care practitioner;

3. May not be employed by a manufacturer;

4. May be involved in education, as well as the management and organization of patient care;

5. Should serve as an active patient advocate in home respiratory care, with specific achievements that demonstrate leadership;

6. Preference is given to individuals who have participated in volunteer community efforts related to home respiratory care, in addition to meeting the medical needs of their patients.

A curriculum vitae is required and supporting documentation should be included, if available.

Nominations will be accepted through June 1, 2016. Please submit nominations to:

ARCF- Thomas L. Petty, MD Invacare Award
Attention: Crystal Maldonado
9425 N MacArthur Blvd, Ste. 100
Irving, Texas 75063
(972) 243-2272

The award presented by the American Respiratory Care Foundation during the Awards Ceremony at the AARC Congress 2016.

AMERICAN RESPIRATORY CARE FOUNDATION
9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063-4706
(972) 243-2272, Fax (972) 484-2720
http://www.arcfoundation.org, E-mail: info@arcfoundation.org

Memorandum

DATE: February 2016

TO: Frank R. Salvatore, Jr., RRT, MBA, FAARC, AARC President
Robert Joyner, Jr., PhD, RRT, RRT-ACCS, FAARC, NBRC President
Brad Leidich, MSEd, RRT, FAARC, CoARC President
Terence Carey, MD, BOMA Chair

FROM: Michael T. Amato
ARCF Chair

SUBJECT: **Mike West, MBA, RRT Patient Education Award 2016—*Solicitation of Nominations***

This award was established in 2012 with an endowment from Philips Healthcare to recognize **"a Respiratory Therapist who has had a profound impact on patients as established by measurable outcomes as a result of patient education."**

Previous recipients include:

- Trina M. Limberg, BS, RRT, FAARC, MAACVPR - 2015
- Timothy Op't Holt, RRT, AE-C, FAARC - 2014
- Bill G. Galvin, MSEd, RRT, CPFT, AE-C, FAARC - 2013
- Mike West, MBA, RRT- 2012

We are now accepting nominations for this award. Nominations will be invited from the AARC Board of Medical Advisors, the Board of Directors of the AARC, the Trustees of the ARCF, National Board for Respiratory Care (NBRC) and the Committee on Accreditation for Respiratory Care (CoARC). The nominating group is responsible for submitting the following:

- A complete and current biographical report on their nominee (curriculum vitae). Only *one* nominee (who is *not* a past recipient of the award) is allowed from each group.
- A statement, including data which indicates the basis for the nomination, keeping the principle criterion of "promoting patient education" in mind. They should illustrate the nominee's impact on patient education through novel training and education programs,

adherence programs for patients, and improved outcomes of patients gained through education and feedback.

- A brief personal comment on their candidate's interests and activities outside of medicine (i.e. civic, family, hobby).

In recognition, the recipient will receive an inscribed plaque, monetary award, coach airfare, one night's lodging and registration to the AARC Congress 2016.

Please submit nominations to the Executive Office no later than June 1, 2016.

cc: Board of Directors
ARCF Trustees

Mike West, MBA, RRT Patient Education Achievement Award

Established in 2012, this award is named for Mike West, a Registered Respiratory Therapist, who recognized the importance of educating patients to help them manage chronic pulmonary diseases, and the profound impact such self-management has on patient respiratory quality of life. Mike West made it his quest throughout his career to ensure that patients, caregivers, and industry had the highest understanding of respiratory disease and the best solutions for treating these diseases.

An endowment has been established to recognize excellence in patient education by, American Respiratory Care Foundation's Trustees (ARCF), through a grant from Phillips Healthcare, to recognize a Respiratory Therapist who has had a profound impact on patients as established by measurable outcomes as a result of patient education.

This award includes a plaque, coach airfare, one night's lodging and registration for the AARC Congress.

Nomination Procedure

Nominations will be invited from the AARC Board of Medical Advisors, the Board of Directors of the AARC, the Trustees of the ARCF, National Board for Respiratory Care (NBRC) and the Committee on Accreditation for Respiratory Care (CoARC).

The nominating group is responsible for submitting the following:

1. A complete and current biographical report on their nominee (curriculum vitae). Only *one* nominee (who is *not* a past recipient of the award) is allowed from each group.
2. A statement, including data which indicates the basis for the nomination, keeping the principle criterion of "promoting patient education" in mind. They should illustrate the nominee's impact on patient education through novel training and education programs, adherence programs for patients, and improved outcomes of patients gained through education and feedback.
3. A brief personal comment on their candidate's interests and activities outside of medicine (i.e. civic, family, hobby).

All nominations must be received by the AARC Executive Office no later than June 1, 2016, and the award will be presented by the ARCF during the Awards Ceremony at the AARC Congress 2016.

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063-4706
(972) 243-2272, Fax (972) 484-2720
http://www.aarc.org, E-mail: info@aarc.org

March 4, 2016

Frank Salvatore, Jr., MBA, RRT, FAARC
President, American Association for Respiratory Care (AARC)
9425 N MacArthur Blvd
Irving, TX 75063

Dear Frank,

I am seeking your Board's nominations for the 2016 *Legends of Respiratory Care*.

As you may recall, the criteria for the designation of *Legends of Respiratory Care* includes, but shall not be limited to:

- Recognized professional achievements related to the clinical practice, education, or the science of respiratory care, publication of scientific articles or other activities bringing significant, sustained career recognition.
- Sustained personal service, representation, or advocacy on behalf of the respiratory care profession, and/or individual's creativity or ideas that resulted in historic advancement of the profession or its professional societies.
- Scientific achievements and/or inventions of historical significance that revolutionized, or remarkably enhanced delivery of respiratory care.
- Singularly distinctive individual actions during historic professional events, above and beyond reasonable expectations, that resulted in advancement of respiratory care and/or resolution of a significant crisis or issue facing the profession.
- Other sustained historic achievements as determined by the Boards of the AARC, ARCF, CoARC, and NBRC.

The Boards of the AARC, ARCF, CoARC and NBRC may each nominate up to five (5) individuals who have made a significant historic impact on respiratory care. Nominations must be supported by two-thirds (2/3) majority vote of the agency's board. Please summarize the activities and contributions for each of your agency's nominees using the attached nominations form. The nominations must be submitted by **June 30, 2016** to Trudy Watson at *tjwatson@mchsi.com*.

The recipients of this prestigious designation will be announced at the 2016 AARC Congress in October. They will be featured in the *Legends* of *Respiratory Care* gallery of the Virtual Museum along with the previous recipients: V. Ray Bennett, Dr. George Burton, Dr. Forrest M. Bird, Dr. Donald F. Egan, John H. "Jack Emerson, Sam P. Giordano, Dr. H. Fred Helmholz, Jr., Sister M. Yvonne Jenn, George A Kneeland, Dr. Robert M. Lawrence, Brother Roland Maher, Dr. William F. Miller, Dr. David Pierson, Dr. Thomas L. Petty, and Jimmy Young.

Sincerely,
Trudy Watson

2016 Legends of Respiratory Care Nomination Form

Nominating Board: _____ AARC _____ARCF _____ CoARC _____NBRC

Nominee _____

1. Has the nominee held continuous active, associate, life, or honorary membership in the AARC for 25 years or more?

_____Yes _____No _____ Not applicable. If no/not applicable, please

explain:_____

2. In which decade(s) was the nominee's primary service/contributions to Respiratory Care delivered?

_____Prior to 1970 _____ 1970 - 1980 _____1980-1990 _____after 1990

3. Which of the following awards/honors has the nominee received?

_____ AARC Jimmy A. Young Medal _____ AARC Life or Honorary Membership

_____ AARC Fellow (FAARC) _____ NBRC Albert H. Andrews, Jr. Award

_____ NBRC Robert H. Miller Award _____ NBRC Sister Yvonne Jenn Award

_____ Emeritus - Board ARCF, NBRC, CoARC _____ CoARC Bonner Smith Award

_____ARCF Hector Leon Garza, MD International Achievement Award

_____ ARCF Forrest Bird Lifetime Scientific Achievement Award

_____ARCF Charles Hudson Award for Cardiopulmonary Health Award

_____ARCF Thomas Petty Invacare Award for Excellence in Home Care Award

_____ARCF Mike West Patient Education Achievement Award

_____ARCF NBRC/AMP Gary Smith Innovation in Education Award

_____ ICRC Toshihiko Koga Medal, MD Medal

_____Lambda Beta Society National Honorary Member

_____Other (specify)_____

4. How many total years did the nominee serve as an elected/appointed member * of the Board(s) of:

_____AARC _____NBRC _____CoARC _____ARCF

*Do not include years as an elected officer

5. Did the nominee hold an elected office in any of the nominating agencies? If so, indicate the number of elected terms:

_____ President (includes President-elect, Past-President in presidential term)

_____Vice President _____Secretary _____Treasurer

_____ Secretary/Treasurer

6. How many years has the nominee served as a Chair* of any committee(s) of the nominating agencies?

_____10+ _____5-9 _____ <5 _____Unknown

*includes Chair of AARC Specialty Sections

7. How many years has the nominee served as a member of any committees of the nominating agencies? (Combine service years to single or multiple committees)

_____20+ _____10-19 _____<10 _____ Unknown

8. Does the nominee hold any patents for devices or inventions of historical significance to the respiratory care profession?

_____2 or more patents _____ 1 or more patent _____0/Unknown

9. Are any national scholarships, awards, or lecture series offered in this nominee's name?

_____Yes _____ No Please Specify _____

10. Has this nominee authored or co-authored a textbook related to respiratory care or contributed a minimum of 6 chapters to one or more respiratory care - related textbooks?

_____Yes _____ No _____ Unknown

11. Has this nominee presented at the AARC Congress or the AARC Summer Forum?

_____Yes _____No _____Unknown

If yes, list the approximate number of 30-50 minute presentations:

_____30+ _____20-29 _____<20 _____Unknown

12. Has the nominee authored 6 or more journal articles published in a peer-reviewed scientific journal?

_____ Yes _____ No/Unknown

If additional qualifications are known, please specify on an additional sheet.

March 8, 2016

Frank Salvatore, Jr., MBA, RRT, FAARC
President
American Association for Respiratory Care

Dear Frank:

As a member of the Board of Medical Advisors to the AARC, I would like to submit a nomination for the AARC's Legends of Respiratory Care Award. Since this honor can be awarded posthumously, I would like to submit the name of my late father, **Albert Aranson, MD**, as a candidate.

My father was the first formally trained pulmonologist in the State of Maine, whose career there spanned 45 years (1948-93). His career was characterized by so many firsts, that his colleagues bestowed upon him the title of Maine's pioneer of Pulmonary and Critical Care Medicine and Respiratory Therapy. In essence, he *was* the history of those fields in the State of Maine.

In 1947-48, after returning from the Pacific Arena in WWII, Dr. Aranson became the first Pulmonary Chief at the Cushing Veterans Administration Medical Center in Framingham, MA, right out of fellowship, a rarity in those days when the giants of medicine walked the Earth. There, he was one of the first pulmonologists in the country to use streptomycin for the treatment of tuberculosis (TB), charged with the responsibility of finding its optimum dosage.

Upon his arrival in 1949 at Portland's Maine Medical Center (MMC), the largest hospital in the State, Dr. Aranson founded Maine's first Pulmonary Division, Pulmonary Function Laboratory, and Inhalation Therapy Department (as it was called in those days). He hired Maine's first respiratory therapist, Robert H. Miller, RRT, for whom the NBRC Award is named, as well as Maine's first PFT tech, Virginia Charlton. As you may know, Bob Miller was the first respiratory therapist to become president of the NBRC.

In the 1950s and 1960s, Dr. Aranson obtained grant money from the federal government and from the York and Cumberland County TB & Health Associations to fund projects at MMC for the study of obstructive lung diseases and the measurement of pulmonary function in health and disease. These grant monies funded expansion of the then Inhalation Therapy Department, training of respiratory therapists and pulmonary function technologists, establishment of a new Intensive Care Unit (ICU), and development of the State's first TB Clinic in 1949, which he founded and directed until his retirement. He also created the Respiratory Therapy Department, Pulmonary Function Laboratory, and the State's first ICU at Portland's Mercy Hospital.

With his extensive expertise in TB, Dr. Aranson helped develop protocols for the modern antibiotic treatment of TB, as well as TB control and prevention protocols for the State of Maine Department of Health, for which he served as consultant during his entire medical career in Maine.

Dr. Aranson also had a long and prolific alliance with the American Lung Association of Maine, including involvement in anti-smoking campaigns and TB prevention and control. In the 1960s, Dr.

Aranson was responsible for the removal of cigarette vending machines at MMC, a movement ahead of his time that spread throughout the State.

As a medical educator, Dr. Aranson trained hundreds of students of respiratory therapy, nursing, and medicine, as well as residents and pulmonary fellows, many of whom, because of his encouragement, chose to settle in Maine, including in underserved areas, to care for the people of Maine. In the training of these students, Dr. Aranson inculcated care for the patient first and foremost - to listen to the patient, for the patient will give you the diagnosis, corroborated by a thorough physical examination - a legendary philosophy for which he is remembered by all who came under his tutelage.

Commensurate with his involvement in the aforementioned areas of Pulmonary and Critical Care Medicine and Respiratory Therapy in Maine, Dr. Aranson held numerous other positions of leadership in major local, state, and national medical organizations, including as Secretary/Treasurer of the Cumberland County Medical Society, Director of the Cumberland County TB & Health Association, Co-chairman of the Board of Consultants for the Division of TB Control for the State of Maine Department of Health, President of the Maine Thoracic Society, founder and President of the Maine State Chapter of the American Society of Internal Medicine, and Governor of the State of Maine for the American College of Physicians and the American College of Chest Physicians. In these roles, he organized, participated in, and lectured state wide at many hospital conferences and teaching symposia associated with these organizations, as well as with the Maine Medical Association.

In summary, I believe my father, Dr. Albert Aranson, was truly a legend as Maine's pioneer of Pulmonary and Critical Care Medicine and Respiratory Therapy. Thank you for giving him your strongest consideration as a candidate for the AARC's Legends of Respiratory Care Award, of which he is most deserving.

Thank you again.

Sincerely yours,

Robert Aranson, MD, FACP, FCCP, FCCM
Chair-Elect, Board of Medical Advisors
Associate Member
American Association for Respiratory Care