American Association for Respiratory Care

Board of Directors Meeting

Courtyard Dallas DFW Airport North/Grapevine
2200 Bass Pro Court
Grapevine, TX 76051

March 11-12, 2017

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Executive Committee Meeting – March 10, 2017
Finance Committee and Board of Directors Meetings – March 11-12, 2017

Friday, March 10

5:00-7:00 pm Executive Committee Meeting (Committee Members only) Cowboys A

Saturday, March 11

8:00-9:00 am Finance Committee Meeting (BOD and HOD members are encouraged to attend) Silverlake C

9:00 am-3:00 pm **Board of Directors Meeting** – Silverlake C

9:00 am Call to Order
Announcements/Introductions
Approval of Minutes pg. 7
E-motion Acceptance pg. 31

9:30 am Lawrence M. Wolfish - Wolfish & Newman, P.C. (by phone)
Board Member Fiduciary Responsibility & Conflict of Interest

10:00 am John Barrett & Nancy Bello – Merrill Lynch –Investment Report

10:45 am Bill Sims - Salmon, Sims, & Thomas - Auditor's Report

11:30 am Erika Miller & Zara Day – Cavarocchi, Ruscio, Dennis Associates, LLC (CRD) (by phone)

12:00 pm LUNCH BREAK (Daedalus Board Meeting)

1:30 pm RECONVENE

General Reports pg. 32
- President pg.33 (A)
- Past President pg. 36
- Executive Director Report pg. 37 (A)
- Government & Regulatory Affairs pg. 55
- House of Delegates pg. 67
- Board of Medical Advisors pg. 68
- President's Council pg. 75

2:00 pm Standing Committee Reports pg. 81
- Audit Subcommittee pg. 82 (R)
- Bylaws Committee pg. 83 (R) (A)
- Elections Committee pg. 85
- Executive Committee pg. 86
- Finance Committee pg. 87
- Judicial Committee pg. 88
- Program Committee pg. 89 (R)
- Strategic Planning Committee pg. 91 (A)

Specialty Section Reports pg. 92

- Adult Acute Care pg. 93
- Continuing Care-Rehabilitation pg.94
- Diagnostics pg. 95
- Education pg. 97
- Home Care pg. 100
- Long Term Care pg. 102
- Management pg. 103
- Neonatal-Pediatrics pg. 105
- Sleep pg. 106
- Surface to Air Transport pg. 107

2:15 pm Special Committee Reports pg. 108

- Benchmarking Committee pg. 109
- Billing Codes Committee pg. 110
- Diversity pg. 111
- Federal Govt Affairs pg. 112
- Fellowship Committee pg. 113
- International Committee pg. 114
- Membership Committee pg. 116 (R)
- Position Statement/Issue Paper Committee pg. 118 (R)
- State Govt Affairs pg. 126
- Virtual Museum Committee pg. 127

2:30 pm Nominations for Life & Honorary Membership

(see pg. 79 for criteria)

Nominations for Legends of Respiratory Care

(see pg. 173 for criteria)

3:00-5:00pm Committee Workgroups (Executive Boardroom available)

Sunday, March 12

8:00-9:00 am Committee Workgroups (Cowboys A available)

9:00 am-3:00 pm **Board of Directors Meeting**

9:00 am Call to Order

Special Representatives pg. 128
- AMA CPT Health Care Professional Advisory Committee pg. 129
- American Association of Cardiovascular & Pulmonary Rehab pg. 130
- American Heart Association pg. 133
- Chartered Affiliate Consultant pg. 134 (R)
- Coalition for Baccalaureate and Graduate Respiratory Therapy Education (CoBGRTE) pg. 135
- Comm. on Accreditation of Medical Transport Systems pg. 137
- Extracorporeal Life Support Organization (ELSO) pg. 138
- International Council for Respiratory Care (ICRC) pg. 140
- The Joint Commission (TJC) pg. 144-146
- National Asthma Education & Prevention Program pg. 147
- Neonatal Resuscitation Program pg. 148

9:30 am Roundtable Reports pg. 149

10:00 am Ad Hoc Committee Reports pg. 151
- Advanced RT Practices, Credentialing, and Education pg. 152 (A)
- Research Fund for Advancing Respiratory Care Profession pg. 153 (R) (A)
- State Initiatives pg. 154
- Student Website Enhancement pg. 155

Other Reports pg. 156
- ARCF Report pg. 157
- CoARC Report pg. 158 (A)
- NBRC Report pg. 159

12:00 pm LUNCH BREAK

1:30 pm RECONVENE

UNFINISHED BUSINESS pg. 162
- Floor motion – ECMO Specialist pg. 163
- Roundtable Policy Changes (A)

NEW BUSINESS pg. 164

Policy Review

- CA.002 – Chartered Affiliates – Chartered Affiliate Requirements and Responsibilities pg.165
- CA.003 – Chartered Affiliates – Chartered Affiliates Revenue Sharing Adjustments pg.166
- SS.003 – Specialty Sections – Leadership pg. 167

- Entry level BSRT (Walsh)
- AARC 70th Anniversary (Lewis)
- Developing strong career paths within associate degree programs to increase the number of baccalaureate degree RTs. (Becker) pg.169-170
- Adult Acute Care Section (Lamb) pg. 171

2:30 pm ARCF Achievement Award Nominations (see attached file "ARCF Nominations) pg. 172 (A)

Bird
Hudson
Petty/Invacare
Mike West
Mitch Baran

3:00-5:00pm Committee Workgroups (Cowboys A available)

ANNOUNCEMENTS

TREASURER'S MOTION

ADJOURNMENT

(R) = Recommendation
(A) = Attachment

Recommendations

(As of February 24, 2017)

AARC Board of Directors Meeting

March 11-12, 2017 • Grapevine, TX

Audit Sub-Committee

Recommendation 17-1-13.1 "That the AARC Board of Directors accept the audit report as presented."

Bylaws Committee

Recommendation 17-1-9.1 "That the AARC Board of Directors find that the Illinois Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."

Recommendation 17-1-9.2 "That the AARC Board of Directors find that the Nebraska Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."

Recommendation 17-1-9.3 "That the AARC Board of Directors find that the Idaho Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."

Recommendation 17-1-9.4 " That the AARC Board of Directors find that the Kentucky Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."

Program Committee

Recommendation 17-1-15.1 "That the AARC Board of Directors approve the following members of the 2017 AARC Sputum Bowl Committee: Renee Wunderley – Committee Chair, Sherry Whiteman - Score Keeper, Rick Zahodnic - Practitioner Moderator, Angie Switzer - Student Moderator, Julie Boganwright – Timekeeper."

Membership Committee

Recommendation 17-1-24.1 "That the AARC eliminate the free student membership program with appropriate notification of students and schools currently utilizing the program."

Position Statement and Issue Paper Committee

Recommendation 17-1-26.1 "That the AARC Board of Directors agree to suspend the "60-day comment period from AARC membership" required by AARC BOD Policy CT.008 for Position Statements and Issue Papers that are recommended for retirement during 2017."

Chartered Affiliate Consultant

Recommendation 17-1-67.1 "Expand the scope of services and financial support of the chartered affiliate consultant to support the chartered affiliates' business operations to ensure their continued viability."

Ad Hoc Committee on Research Fund for Advancing Respiratory Care Profession

Recommendation 17-1-30.1 "That the AARC BOD accept the renamed and revised research program guidelines so that the AARC sponsors research that examines relationships between clinical interventions by respiratory therapists and the outcomes of care.

Past Minutes

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

October 13, 2016 • San Antonio, TX

Minutes

Attendance

Frank Salvatore, RRT, MBA, FAARC, President
Brian Walsh, PhD, RRT-NPS, RRT-ACCS, AE-C, RPFT, FAARC, President-elect
George Gaebler, MSEd, RRT, FAARC, Past President
Cynthia White, MS, RRT-NPS, AE-C, CPFT, FAARC, VP External Affairs
Lynda Goodfellow, EdD, RRT, FAARC, VP Internal Affairs
Karen Schell, DHSc, RRT-NPS, RPFT, RPSGT, AE-C, CTTS, Secretary/Treasurer
Timothy Op't Holt, EdD, RRT, AE-C
Lisa Trujillo, DHSc, RRT
Doug McIntyre, MS, RRT, FAARC
John Lindsey, Jr., MEd, RRT-NPS, FAARC
Deb Skees, MBA, RRT, CPFT
Pattie Stefans, BS, RRT
Cheryl Hoerr, MBA, RRT, CPFT, FAARC
Keith Lamb, BS, RRT-ACCS, FCCM
Natalie Napolitano, MPH, RRT-NPS, FAARC
Ellen Becker, PhD, RRT-NPS, FAARC
Kimberly Wiles, BS, RRT, CPFT
Camden McLaughlin, BS, RRT, FAARC

Consultants

Mike Runge, BS, RRT, FAARC Parliamentarian
Dianne Lewis, MS, RRT, FAARC, President's Council President
Terence Carey, MD, BOMA Chair

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, MPH, Director of Government Affairs
Anne Marie Hummel, Director Regulatory Affairs
Kris Kuykendall, Executive Administrative Assistant

CALL TO ORDER

President Frank Salvatore called the meeting of the AARC Board of Directors to order at 8:00am CDT.

Parliamentarian Mike Runge swore in Camden McLaughlin as Bill Lamb's replacement.

Secretary/Treasurer Karen Schell called roll and declared a quorum.

DISCLOSURE

President Salvatore reminded members of the importance of disclosure and potential for conflict of interest. Board members noted any conflicts of interest on a sheet of paper that was distributed.

Frank Salvatore – SUNY Sullivan Comm College Advisory Board
Brian Walsh – Maquet, GE, Aerogen, Draeger, Vapotherm, SCCM member
Karen Schell – Advisory Board JCCC, RT Program Olathe, KS; FDA Pulmonary Advisor Board, consumer member; CoBGRTE member; Advisory Board KCKCC RT program, Kansas City, KS
Lisa Trujillo – CoBGRTE member; MSRT Advisory Board, Northeastern University
Lynda Goodfellow – NAECB Board member, CoBGRTE member
Ellen Becker – CoBGRTE member, Association Asthma Educators, Board of Directors Chicago Asthma Consortium
Tim Op't Holt – CoBGRTE member
Natalie Napolitano – Research relationships with Aerogen, Geno, Phillips/Respironics, Draeger, CVS Health; CoBGRTE member; Allergy & Asthma Network Chair
John Lindsey – Advisory Committee member National Park College and Seark College
Keith Lamb – Medtronic, Bayer, Masimo, Sunovian, Fischer Paykel
Cheryl Hoerr – Adjunct Faculty, Lindenwood University
Cyndi White – Advisory Board Northeastern, CoBGRTE, Phillips, Vapotherm
Kimberly Wiles – Advisory Board member – West Penn/IUP School of Respiratory Care
John Wilgis – American Hospital Association, Florida Hospital Association, HHS – Centers for Disease Control and Prevention, Asst Secretary for Preparedness and Response
Deb Skees – St. Paul College RT Program Advisory Board

APPROVAL OF MINUTES

Karen Schell moved to approve the minutes of the June 29, 2016 meeting of the AARC Board of Directors.

Motion carried

Karen Schell moved to approve the minutes of the June 30, 2016 2016 meeting of the AARC Board of Directors.

Motion carried

E-motions

There were no E-motions to ratify.

President Salvatore dismissed the Board of Directors at 8:25am to attend the House of Delegates meeting to witness the Color Guard presentation.

President Salvatore called the Board of Directors meeting to order 8:52am.

GENERAL REPORTS

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

Executive Office

FM 16-3-1.1 Ellen Becker moved that the Board of Directors approve up to $50,000 for the purposes of conducting a needs assessment for the advanced practice respiratory therapist (APRT) role. (In response to FM16-2-1.4)

Motion carried

FM16-3.1.2 Karen Schell moved to authorize the Executive Office to proceed with the pilot of the state society support. (In response to FM16-2-1.3)

Motion carried

Presidents Council

Lynda Goodfellow moved to accept Recommendation 16-3-8.1 "That some members of the Presidents Council be involved in the AARC 60th Anniversary planning."

Cyndi White moved to refer to the Executive Office.

Motion carried

President Salvatore made a friendly amendment to change to "70th".

Motion carried

Camden McLaughlin moved to accept the General Reports as presented.

Motion carried

RECESS

President Salvatore recessed the meeting of the AARC Board of Directors at 10:10am CDT.

RECONVENE

President Salvatore reconvened the meeting of the AARC Board of Directors at 10:30am CDT.

STANDING COMMITTEES REPORTS

Bylaws Committee

Cyndi White moved to accept Recommendation 16-3-9.1 "That the AARC Board of Directors find that the Kansas Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."

Motion carried

Karen Schell abstained.

Lynda Goodfellow moved to accept Recommendation 16-3-9.2 "That the AARC Board of Directors find that the New Jersey Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."

Motion carried

Deb Skees moved to accept Recommendation 16-3-9.3 "That the AARC Board of Directors find that the Vermont-NH Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws."
Motion carried

SPECIALTY SECTION REPORTS

Home Care Section
Lynda Goodfellow moved to accept Recommendation 16-3-54.1 "That the Board of Directors charge the Executive Office with the task of investigating the feasibility and financial impact of combining the home care section, long term care section, and continuing care section."

Karen Schell moved to refer to the Executive Office.
Motion carried

President Salvatore introduced four students who came to observe the Board of Directors meetings.

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

SPECIAL COMMITTEE REPORTS

Membership Committee
Karen Schell moved to accept Recommendation 16-3-24.1 "That the AARC Board of Directors add a student member to the AARC Membership Committee."

Karen Schell moved to refer to the president-elect.
Motion carried

Cyndi White moved to accept Recommendation 16-3-24.2 "That the AARC Board of Directors add a recent graduate who transitioned to an active member to the AARC Membership Committee."

Cyndi White moved to refer to the president-elect.
Motion carried

Tim Op't Holt moved to accept the Special Committee Reports as presented.
Motion carried

SPECIAL REPRESENTATIVES REPORTS

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

FM16-3-26.1 Natalie Napolitano moved that the Position Statement/Issue Paper Committee develop a resource for best practices to include licensure requirements for practice of the respiratory therapist as an ECMO specialist.

Lynda Goodfellow moved to table for new business.
Motion carried

ROUNDTABLE REPORTS

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

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

AD HOC COMMITTEE REPORTS

Ad Hoc Committee on Advanced RT Practices, Credentialing, and Education
Cyndi White moved to accept Recommendation 16-3-31.1 "Continue the work of the Ad Hoc Committee through the term of the incoming AARC President, Brian Walsh."
Motion carried

Cyndi White moved to accept Recommendation 16-3-31.2 "Revise the committee's membership based on the input from the committee chairs."

Karen Schell moved to refer to the president-elect.
Motion carried

Cyndi White moved to accept Recommendation 16-3-31.3 "Accept the committee's 'Project Status Report' and the committee's 'Needs Assessment Outline' as informational items."
Motion carried

Cyndi White moved to accept Recommendation 16-3-31.4 "Accept the 'Request for Proposal for Needs Assessment Study for the Occupation of the Advanced Practice Respiratory Therapist' as information to solicit services from an organization to conduct a needs assessment study for the occupation of an advanced practitioner in respiratory care."

Karen Schell moved to refer back to the committee for revisions.
Motion carried

Ad Hoc Committee on Research Fund for Advancing Respiratory Care Profession
Cyndi White moved to accept Recommendation 16-3-30.1 "That the president-elect consider tasking the committee with revising the application to include a structured call for proposals with timelines and with more detailed information as part of the application."
Motion carried

Ad Hoc Committee on State Initiatives
Cyndi White moved to accept Recommendation 16-3-33.1 "Continue the work of the Ad Hoc Committee through the term of the incoming AARC President, Brian Walsh."
Motion carried

Cyndi White moved to accept Recommendation 16-3-33.2 "Revise the committee's membership based on the input from the committee chairs."

Karen Schell moved to refer to the president-elect.
Motion carried

FM 16-3-29.1 Lynda Goodfellow moved that the Board of Directors accept the Taskforce on Competencies document and move to the Executive Office for publication.
Motion carried

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

RECESS
President Salvatore recessed the meeting of the AARC Board of Directors at 12:00pm CDT.

JOINT SESSION
Joint Session was called to order at 1:35pm CDT.

Secretary/Treasurer Karen Schell called roll and declared a quorum.

Jim Lanoha presented the elections report and results.

Cheryl West provided updates on state legislative issues, including those states that are undertaking legislative efforts to move to the "RRT only" as a state licensure requirement. Ann Marie Hummel provided more detail on various Medicare regulations impacting the profession as well as updating the status of the Telehealth Parity Act. The dates for the 2016 AARC Hill Advocacy event have been set for April 3-4, 2016.

Executive Session
Karen Schell moved to go into Executive Session at 1:56pm CDT.
Motion carried

Lynda Goodfellow moved to come out of Executive Session at 2:16pm CDT.

Raymond Pisani presented a second reading of the AARC Bylaws.

Joint Session ended at 2:23pm CDT.

RECONVENE
President Salvatore reconvened the meeting of the AARC Board of Directors at 2:40pm CDT.

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

Karen Schell moved that the Board of Directors accept the 2017 budget.
Motion carried

Karen Schell moved to accept the second reading of the bylaws changes**.**
Motion carried

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

OTHER REPORTS

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

Tim Op't Holt moved to accept the other reports.
Motion carried

UNFINISHED BUSINESS

President Salvatore gave the Board an update of recent conference calls with CoBGRTE and the progress of the bachelor degree programs.

RECESS

President Salvatore recessed the meeting of the AARC Board of Directors at 3:50pm CDT.

RECONVENE

President Salvatore reconvened the meeting of the AARC Board of Directors at 4:05pm CDT.

President Salvatore began a discussion about the new AARC Affiliate AARConnect Community policy and revenue sharing. In 2016 three states did not sign the revenue sharing and co-marketing agreements.

George Gaebler moved to approve the new AARC Affiliate AARConnect Community policy/procedure.
Motion carried
Cheryl Hoerr abstained.

FM 16-3-1.3 Lynda Goodfellow moved to direct the Executive Office, beginning in 2017, to withhold revenue sharing from those states that do not sign the revenue sharing agreement.

Lynda Goodfellow moved to withdraw her motion.

RECESS

President Salvatore recessed the meeting of the AARC Board of Directors at 5:00pm CDT.

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

_____ _____

Karen Schell Date
AARC Secretary/Treasurer

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

October 14, 2016 – San Antonio, TX

Minutes

Attendance

Frank Salvatore, RRT, MBA, FAARC, President
Brian Walsh, PhD, RRT-NPS, RRT-ACCS, AE-C, RPFT, FAARC, President-elect
George Gaebler, MSEd, RRT, FAARC, Past President
Cynthia White, MS, RRT-NPS, AE-C, CPFT, FAARC, VP External Affairs
Lynda Goodfellow, EdD, RRT, FAARC, VP Internal Affairs
Karen Schell, DHSc, RRT-NPS, RPFT, RPSGT, AE-C, CTTS, Secretary/Treasurer
Timothy Op't Holt, EdD, RRT, AE-C
Lisa Trujillo, DHSc, RRT
Doug McIntyre, MS, RRT, FAARC
John Lindsey, Jr., MEd, RRT-NPS, FAARC
Deb Skees, MBA, RRT, CPFT
Pattie Stefans, BS, RRT
Cheryl Hoerr, MBA, RRT, CPFT, FAARC
Keith Lamb, BS, RRT-ACCS, FCCM
Natalie Napolitano, MPH, RRT-NPS, FAARC
Ellen Becker, PhD, RRT-NPS, FAARC
Kimberly Wiles, BS, RRT, CPFT
Camden McLaughlin, BS, RRT, FAARC

Consultants

Mike Runge, BS, RRT, FAARC Parliamentarian
Dianne Lewis, MS, RRT, FAARC, President's Council President
Terence Carey, MD, BOMA Chair

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, MPH, Director of Government Affairs
Anne Marie Hummel, Director Regulatory Affairs
Kris Kuykendall, Executive Administrative Assistant

Guests

Steve Sittig, RRT-NPS, FAARC
Mike Madison, MBA, RRT

CALL TO ORDER

President Frank Salvatore called the meeting of the AARC Board of Directors to order at 9:10am CDT.

President Salvatore introduced 6 students who came to observe the Board of Directors meeting.

Secretary-Treasurer Karen Schell called roll and declared a quorum.

John Wilgis announced the House election results:
Speaker-elect – Teri Miller
Treasurer – Dana Evans
Secretary– Kerry McNiven
Bylaws Chair-elect – Brian Cayko
Bylaws Committee - Raymond Pisani
Elections - Ed Borza

OLD BUSINESS CON'T
George Gaebler began a discussion about the new AARC Affiliate AARConnect Community Policy/Procedure. (See Attachment "A")

FM16-3-1.3 Brian Walsh moved that the AARC Executive Office develop the means and methods to enforce the revenue sharing agreement by the end of 2016.
Motion carried

NEW BUSINESS
POLICY UPDATES

BOD.024 – Board of Directors – AARC Disaster Relief Fund
Karen Schell moved to accept with date change.
Motion carried

President Salvatore introduced 5 students who came to observe the Board of Directors meeting.

RECESS
President Salvatore recessed the meeting of the AARC Board of Directors at 10:15am CDT.

RECONVENE
President Salvatore reconvened the meeting of the AARC Board of Directors at 10:30am CDT.

BOD.027 – Board of Directors – Surveys Conducted by the Association
Natalie Napolitano moved to accept as amended and date change.
Motion carried

CT.009 – Committees – AARC Fellowship Selection Committee
George Gaebler moved to accept as amended and date change.
Motion carried

(See attachment "A" for amended policies.)

RECESS
President Salvatore recessed the meeting of the AARC Board of Directors at 11:15am CDT.

RECONVENE
President Salvatore reconvened the meeting of the AARC Board of Directors at 11:23am CDT.

John Wilgis provided the outcomes of House of Delegates resolutions.

67-16-2 "Resolve that the AARC HOD only meet once per year, prior to the fall AARC Congress. The AARC Bylaws state that only one HOD meeting per year is required." **Defeated**

John Wilgis moved to accept **67-16-3** "Resolve that the AARC develop a mechanism to encourage affiliates to become more involved with the mission of the AARC. Plan to include but not be limited to encouraging more affiliates to change their affiliate bylaws to allow their president to be seated as a delegate and attend HOD meeting." **Passed**

Natalie Napolitano moved to refer to president-elect.
Motion carried

John Wilgis moved to accept **67-16-4** "Resolve that the AARC work in concert with the HOD Officers and the Delegate Assistance Committee to increase the assistance offered to affiliates and the needs of the HOD." **Passed**

Brian Walsh moved to refer to the Executive Office.
Motion carried

President Salvatore reviewed the Board Self-Assessment Survey. The majority of the comments stated that mentors would be helpful for new Board members.

Strategic Workgroups gave updates of their work from this morning.

President Salvatore stated that $585 was collected for the disaster relief fund by the Board of Directors today.

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

MOTION TO ADJOURN
Karen Schell moved to adjourn the meeting of the AARC Board of Directors.
Motion carried

ADJOURNMENT
President Salvatore adjourned the meeting of the AARC Board of Directors at 12:50pm CDT.

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

_____ _____

Karen Schell Date
AARC Secretary/Treasurer

Attachment “A”

Policy No. CA.008 – Chartered Affiliates – Affiliate AARConnect Community Policy/Procedure
Policy No. BOD.027 – Board of Directors – Policy for Surveys Conducted by the Association
Policy No. CT.009 – Committees – AARC Fellowship Selection Committee

American Association for Respiratory Care
Policy Statement

SECTION: Chartered Affiliates

SUBJECT: **AARC Affiliate AARConnect Community Policy/Procedure**

EFFECTIVE DATE: October 14, 2016

DATE REVIEWED: October 14, 2016

DATE REVISED:

Definition of an AARC Affiliate AARConnect Community: A place for affiliate members to share information that supports the mission and vision of the state society and AARC. AARC staff provides oversight of the AARConnect platform. The Affiliate Communities by the nature of the discussions are a reflection of the Affiliate and its members and is monitored by the affiliate leadership. This document is subject to change, according to evolving membership consensus and interaction. The following guidelines cover all messages sent – whether to an entire discussion or to an individual community member.

1. **Have a clear topic in mind and state it in the subject line**. Clear subjects enable members to relate to content easier. It also makes messages easier to find when searching.
2. **Post only content that you are authorized to post**. When acting on behalf of the Leadership of the Affiliate, clearly state your position and who authorized the posting. If posting with a personal message, note that the post is not an authorized Affiliate post. Avoid posting copyright protected materials. Official posts should not include advertising events or products that compete with the AARC and/or affiliate.
3. **Safeguard privacy**. Participation is limited to AARC members and affiliate leadership. However, online forum security cannot be guaranteed and as such your posts may not remain private. Ensure posts meet HIPAA and other relevant guidelines and regulations.
4. **Stay on topic**. Posts should be relevant to the Affiliate forum. Posts are subject to moderation or deletion if found to be off topic, if reported as inappropriate, or if they fail to support the mission and vision of the affiliate or AARC.
5. **Be professional**. Discuss issues, not people. Posts should be professional. Discussions should not include political messaging.
6. **Follow guidelines for surveys**. If you are interested in surveying members for research purposes, please contact the affiliate leadership to receive permission to post surveys. Surveys posted without permission will be removed. Oversaturation of community members with surveys for industry or personal gain, often result in members removing themselves from the list.
7. **Do not post commercial messages**. This includes job postings, products, services, or meetings or events. Official affiliate sponsored events are allowed when posted by the appointed/elected leadership of the affiliate.

Policy Amplification:

1. Affiliate President must agree to code of conduct, which will be sent annually with Affiliate Affirmation. State Societies who do not sign the affiliate affirmation will not be eligible to have an Affiliate Community.
    a. On the initial implementation, the AARC will provide an interim Affiliate Community Agreement that will cover the period between the implementation and the 2017 Affiliate Agreement completion date.
2. The Affiliate Community will replace listserv and/or the need to contact the AARC HOD Liaison in order to post to its members within the state.
3. Leadership of the affiliate must appoint a member of their executive committee or board to manage, create and monitor all posts for the affiliate.
    a. When officially posting as an affiliate officer, authors should identify themselves as acting on behalf of the elected officers. Personal opinions should be identified as such and it should be made clear that they are not the official statement of the affiliate. AARC urges caution when posting on the state forum in that capacity.
4. Job postings are not allowed. These types of posts constitute advertising which is not permitted on AARConnect.
5. No direct solicitation of any type for meetings, events, products or services is allowed, either through lists or direct messaging to other members. These types of posts constitute advertising which is not permitted on AARConnect. This is already stated in #7 above
6. Use caution when discussing any services or products. Information posted on the lists is available for all to see, and comments are subject to libel, slander, and antitrust laws.
7. **AARC reserves the right to modify postings**. Affiliate officers are held to a high level of excellence and accountability. Repeat offenders may be subject to moderation or restricted access.
    a. **Individual Violations (e.g. – allowing individuals to post non-sanctioned state affiliate events or inappropriate use/responses by individuals)**:
        i. First Violation – Depending on the severity, a message may be deleted. A message informing the poster will be sent.
        ii. Second Violation – Depending on the severity, a message may be deleted. The poster will be put on moderation, and messages will be reviewed before being potentially posted online.
    b. **State Affiliate Violations (e.g. – postings that violate the affirmation agreement between the state affiliate and AARC)**:
        i. First Violation – Depending on the severity, a message may be deleted. The state affiliate will lose their access to the AARConnect community for six months and forfeit their AARC revenue sharing for that time period.
        ii. Second Violation – Depending on the severity, a message may be deleted. The state affiliate will lose their access to the AARConnect community for a year and forfeit their AARC revenue sharing for that time period.
    c. Disposition of withheld State Affiliate Revenue sharing. The AARC will hold the funds in a holding account and at the end of the year will disburse the funds equally to the state affiliates that had no violations during the preceding year.
8. All affiliates are required to follow all policy amplication definitions for AARC Connect Community and revenue sharing requirements. Failure to follow these policy amplication definitions shall result in withholding of these affiliate benefits.
9. Section 7 a,b,c will be followed as written. The AARC has the right to rescind the community's right, revenue sharing and charted affiliates co-marketing.
10. The AARC BOD will be the determinate body when violations occur. The withholding of these revenues shall be reserved in a protected account.

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: Policy for Surveys Conducted by the Association

EFFECTIVE DATE: March 2001

DATE REVIEWED: October 2016

DATE REVISED: October 2016

REFERENCES: CT.0688b Revised

Policy Statement:
1. All surveys of the AARC membership must be reviewed by the Executive Office and approved by the Executive Board before permission will be granted for conducting them.

Policy Amplification:

***Definition of Surveys*:** For the purposes of this policy a survey is a document requesting information that may be used to comprehensively consider an area of subject matter for the purposes of gathering data where the analysis could be considered for academic pursuit, publishing ~~or corporate use.~~

Definition of Listserve Questionnaires: Any question or questions posed that would be considered for one's own personal/professional use as information gathering for projects in their area of interest, practice, or job. Information gathered in this way would not be used for publication outside of one's institution.

1. Questionnaires/Information requests occurring within AARC Section mail lists (AARConnect) do not require Executive review provided that they adhere to the rules governing them. *See attachment A below*

Survey Request Procedure

1. The requestor must be an AARC Member for > 1 year and in good standing.
2. The requester must submit a copy of the survey plus communication stating the intent of the survey to the AARC Executive Office, no less than 30 days prior to the requested distribution date. Incomplete applications will be rejected. Please include the following information within the request:

    a. A copy of the proposed survey, preferably a link to the actual survey.
    b. The membership group you wish to survey.
    c. The survey introduction.
    d. A description of how you intend to assure confidentiality of information supplied by members.

e. A description of how you intend to disseminate the findings to members who participated.
f. Definitions for abbreviations used in the survey.
g. A disclosure of possible conflict of interest.
h. Whether you have Institutional Review Board approval (if applicable)

Note: Surveys will be circulated only on groups that currently exist on AARConnect. These include all AARC Specialty Sections, Roundtables, and, if a cross section of respiratory therapists is needed, the Help Line. Special requests for segmentation of AARC members cannot be accommodated.

3. The Executive Director or designee will evaluate the survey based upon the following criteria:

a. Overall appearance.
b. Have similar surveys have been done within the last 24 months? If so, proponent of that survey will be shared with the requestor.
c. Clarity of questions and appropriateness of format.
d. No redundancy of questions.
e. No blatant disregard for the wellbeing of our members or association.
f. Have the appropriate questions been developed to draw reasonable conclusions.
g. Has a survey been sent to the same population of AARC members during the last six months? Duplicate surveys will be rejected.
h. Does the survey provide information about our members or organization that could be used by our competitors or negatively affects our members or business?

4. After Executive Office review and approval a designee will notify the Secretary/Treasurer of the AARC BOD and seek Executive Board approval. The requester will be informed of the decision. If revisions are needed, the requester shall resubmit. Unsatisfactory revisions will be rejected. Once approved, the survey will be labeled with the following "This survey has been approved by the AARC for distribution. Please contact the survey proponent, as indicated in the message below, with questions and comments."

5. Approved Surveys will be distributed using web based survey systems (ex: Survey Monkey) that direct participants away from AARConnect. AARConnect will not be utilized to respond to surveys, unless it is questionnaire.

6. A brief summary of survey results will be made available within one year to AARC members within the AARConnect library. Summary pdf files (output) provided by the survey tool are acceptable. Most summaries provide the response rate and percentages of responses for each question. If you plan on publishing, please check with the journal to ensure this is not considered a publication. If the journal considers this a publication, the surveyor can wait until publication to provide a citation.

7. The Executive Office can seek assistance from the Executive Committee of the Board of Directors at any time by the following method:

a. Request for Executive Committee support will be sent to the Secretary/Treasurer for distribution, discussion and vote.
b. The Executive Committee has the right to make exception to the survey policy on behalf of the Board of Directors.

Attachment A

AARC Participant Listserv (AARConnect) Rules

General

1. Message content must be clinically or operationally relevant to the intent of the AARConnect group.
2. The following are not permitted to be posted. Members posting or contributing to these postings will be notified of their violation, censored, and then removed if their inappropriate behavior continues. Continued violations will be reported to the judicial committee for additional action.
    a. Advertisements or motions for products, services, job
    b. Meetings and events not sponsored by AARC or affiliate
    c. Poems, jokes and other forms of personal expression, chain mail, virus warnings, etc.
    d. Copyrighted material from a source other than the AARC
    e. Inquiries and promotions related to products/services by consultants, manufacturers, marketing firms and other similar entities outside of the AARC.
    f. Discussions relating to pricing or cost of goods as this may be considered price fixing and is a federal offense.

3. The AARC reserves the right to remove anyone for any reason from the AARC electronic mailing list. This includes the archival entries on the Listserve that pertain to a subject considered inappropriate or in violation of the Listserve guidelines.

The Exchange of Information:

1. AARC members may use the Listserv to exchange information between other Listserv Subscribers.
2. When you post a question, or series of questions, be sure that you title it with a good, concise, explanatory title in the subject line to clearly differentiate the message from others being posted or responded to.
3. Regarding information requests posted by Listserv clients, the Section Chair or Executive Office determine if the Listserv posting represents a survey that requires approval. The following guidelines can be utilized to differentiate Listserv information requests from query requests.

    3.1 Surveys often include the capturing of user specific information and hospital/department demographics for comparison reporting.

    3.2 The creator of a survey will embed a separate link to ask specific questions so

participants do not have the option to view other responses. If the creator of this type of inquiry tool has not expressively indicated results will be shared and accessible to all Listserv participants, the Section Chair will refer the individual to the Executive Office as per Policy BOD 027.

4. The sender of the information request may instruct section participants to reply to the Listserv, click on a link or reply directly to their personal email.

4.1 In the event responses are sent directly to the personal email or automated survey service (e.g. SurveyMonkey) of the individual who posted the information request, a summary of those responses should be posted so all Listserv participants may share the information. These summaries can be placed in the AARConnect library for future reference.

4.2 If your reply is simply a request to receive a copy of what someone has offered to share, or simply to agree with someone (such as: “Me too”), please do not reply to the entire group. Instead, send your response directly to the person who posted the message.

American Association for Respiratory Care
Policy Statement

SECTION: **Committees**

SUBJECT: **AARC Fellowship Selection Committee**

EFFECTIVE DATE: January 1, 2011

DATE REVIEWED: October 2016

DATE REVISED: October 2016

REFERENCES:

Policy Statement: The AARC Fellowship Program was established to recognize active or associate members in good standing who have made profound and sustained contributions to the art and science of respiratory care and to the AARC.

Policy Amplification: This policy sets forth the eligibility requirements, criteria for nomination, the selection process and rules governing the AARC Fellowship Program.

Eligibility:

- Be an active or associate member of the AARC in good standing for at least ten consecutive years prior to the deadline for receipt of nominations.
- Possess the RRT credential issued by the NBRC and licensed within their state of employment or, be a licensed physician with a respiratory care-related specialty.
- First term members of the AARC Board of Directors or Officers of the House of Delegates are not eligible.

Criteria:

- Must be nominated by at least two AARC members, one of which is required to be a Fellow of the AARC with membership in good standing.
- Must have demonstrated national prominent leadership, influence and achievement in clinical practice, education or science.
- Must possess documented evidence of significant contribution to the respiratory care profession and the AARC.

Rules:

- All nominations for Fellow, and associated supporting documents, must be submitted online through the AARC website.

- Upon receipt of a nomination, the Executive Office will confirm each nominee satisfies the minimum criteria for 10 consecutive years of AARC membership, and that each nominator continues to maintain eligibility to submit nominations for Fellow.

- For those nominees not meeting the 10-year requirement, the nominator will be so informed and the nomination not accepted. Nominators not eligible to submit nominations will likewise be notified.

- Deadline for receipt of nominations and all supporting documentation will be the last working day of August of the calendar year in which the nomination is to be considered or, by pronouncement, an earlier deadline as determined by the dates of the AARC's Annual Congress. Nominations not received by the established date will not be accepted.

- The Fellowship Selection Committee, consisting of a Chair and up to six current Fellows appointed by the AARC President, will evaluate nominations annually.

- During the first week of September, Selection Committee members will be provided an electronic folder containing all accepted nominations and supporting documents in alphabetical order. Committee members will also receive a ballot to indicate which nominees they consider worthy of induction as a Fellow. Completed ballots will be returned to the Chair anonymously for final tabulation.

- Committee members are to evaluate each nominee independently and make their determination based upon the contributions of the respective nominee to the profession, and most importantly, to the AARC. Committee members will not collaborate with anyone during the selection process.

- Nominees receiving an affirmative vote from all five committee members will be inducted as a Fellow of the AARC.

- Nominees selected for induction will be formally notified upon completion of the selection process, with their nominators receiving a blind copy of the congratulatory letter.

- An overriding goal of the Selection Committee is to minimize any embarrassment or discomfort to members not selected for induction. Therefore, for those nominees not selected, a letter so stating will only be sent to the nominators.

- Once the final tabulation is completed, the results of the balloting for induction shall remain confidential and will not be subject to outside review or discussion.

- New Fellows will be inducted during the Awards Ceremony held in conjunction with the annual AARC International Respiratory Congress.

- Newly inducted Fellows will receive a pin, a certificate suitable for framing and will have their names added to the list of Fellows on the AARC website.

- Upon induction, Fellows are expected to maintain their AARC membership in good standing.

Addendum

- Examples of profound and sustained contributions may include but are not limited to;
    - Specific evidence of outstanding contributions to the improvement of respiratory care at the national or international level or illustration of how regional impact demonstrates potential for national application.
    - Evidence includes but is not limited to documentation of the following:
        - Consistent outstanding contributions over time
        - Contributions with significant, measurable impact
        - Dissemination of important information about the contributions
        - Substantive honors, awards, and recognition by AARC or affiliates
        - Adoption of research findings and/or innovations that guide changes in education, research, administration, policy, or respiratory care practice

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting

October 18, 2016 • San Antonio, TX

Minutes

Attendance

Brian Walsh, PhD, RRT-NPS, RRT-ACCS, AE-C, RPFT, FAARC, President
Frank Salvatore, MBA, RRT, FAARC, Past President
Sheri Tooley, BSRT, RRT-NPS, CPFT, AE-C, VP External Affairs
Natalie Napolitano, MPH, RRT-NPS, AE-C, CTTS, FAARC, VP Internal Affairs
Karen Schell, DHSc, RRT-NPS, RRT-SDS, RPFT, RPSGT, AE-C, CTTS, Secretary/Treasurer
Timothy Op't Holt, EdD, RRT, AE-C
Keith Lamb, RRT
Doug McIntyre, RRT, FAARC
Deb Skees, MBA, RRT, CPFT
Steve Sittig, BSRT, RRT-NPS, CPFT, AE-C
Cheryl Hoerr, MBA, RRT, CPFT, FAARC
John Lindsey, Jr., MEd, RRT-NPS, FAARC
Pattie Stefans, BS, RRT
Kim Wiles, BS, RRT, CPFT
Lisa Trujillo, DHSc, RRT
Ellen Becker, PhD, RRT-NPS, FAARC

HOD Officers

Keith Siegel, BS, RRT, CPFT, Speaker
Kerry McNiven, MS, RRT
Dana Evans, MHA, RRT-NPS

Consultants

Camden McLaughlin, BS, RRT, FAARC, Parliamentarian
Jakki Grimball, MA, RRT, AE-C, Past Speaker

Excused

Robert Aranson, MD, BOMA Chair
Dianne Lewis, MS, RRT, FAARC, President's Council President
John Wilgis, MBA, RRT
Susan Rinaldo Gallo, MEd, RRT, CTTS, FAARC

Staff

Tom Kallstrom, MBA, RRT, FAARC, Executive Director
Tim Myers, MBA, RRT-NPS, FAARC, Associate Executive Director
Doug Laher, MBA, RRT, FAARC, Associate Executive Director
Shawna Strickland, PhD, RRT-NPS, AE-C, FAARC, Associate Executive Director
Steve Nelson, MS, RRT, FAARC, Associate Executive Director
Kris Kuykendall, Executive Administrative Assistant
Amanda Feil, Membership

Guests

Mike Madison, MBA, RRT

CALL TO ORDER
President Brian Walsh called the meeting of the 2017 AARC Board of Directors to order at 3:05pm CDT.

INTRODUCTIONS AND DISCLOSURES
President Walsh asked members to get to know another Board member and introduce them. Board members were also asked to report their disclosures.

President Walsh gave a brief overview of how he plans to manage Board meetings during his presidency. He proposed that the Board meetings take place from 9am-3pm with work groups meeting before and/or after. Conflicts of Interest will be done electronically and provided in the Board book.

2017 GOALS AND OBJECTIVES
President Walsh reviewed his written executive summary of the 2017 Goals & Committees Book that was emailed to the Board earlier in the day.

President Walsh reviewed the 2017 Goals and Committees. (See Attachment "A")

FM16-3-10.1 Natalie Napolitano moved to nominate Pattie Stefans as Board member for the Elections Committee.
Motion carried
Pattie Stefans abstained

FM 16-3-51.1 Ellen Becker moved to ratify the appointment of Crystal Kraddock as chair of the Continuing Care Rehabilitation Section for a two year term.
Motion carried

FM16-3-58.1 Natalie Napolitano moved to ratify the appointment of Katherine McKay (Turner) as chair of the Sleep Specialty Section for a three year term.
Motion carried

RECESS
President Walsh recessed the meeting of the AARC Board of Directors at 4:50pm CDT.

RECONVENE
President Walsh reconvened the meeting of the AARC Board of Directors at 5:00pm CDT.

FM 16-3-4.1 Karen Schell moved to approve the 2017 appointments, goals and objectives with revisions as presented.
Motion carried

President Walsh discussed expectations from the Board, i.e. attire, read Board book before the meeting, get reports in on time.

TREASURER'S MOTION

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

Motion carried

ADJOURNMENT

President Walsh adjourned the meeting of the AARC Board of Directors at 5:30pm CDT.

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

_____ _____

Karen Schell Date

AARC, Secretary/Treasurer

E-Motions

(Since Last Board Meeting in October 2016)

E16-3-31.1 "That the AARC Board of Directors approve the outline for a Request for Proposal (RFP) for a needs assessment study exploring the status of advanced practice provider employment density and sufficiency of educational background in the care of patients with cardiopulmonary disease."

Results – December 12, 2016
Yes – 15
No – 0
Abstain – 0
Did Not Vote – 3

E17-1-4.1 "That the AARC Board of Directors agree to increase the State Affiliate Grant from $500.00 to $750.00."

Results – February 16, 2017
Yes – 14
No – 0
Abstain – 0
Did Not Vote – 3

General Reports

President Report

Submitted by Brian Walsh– Spring 2017

Recommendations

None

Report

This past quarter has been very busy as I establish my goals while promoting, advocating and advancing the profession. I have given a few comments according to my goals of quality, safety and value. I'm excited for the closeout of some strategic goals and the creation of new ones. We will discuss many of the opportunities to advance our great profession in the coming hours.

Quality:
I remain concerned about the quality of respiratory care given nationally. Like past presidents, I feel this poor quality might limit our value and lead to our elimination. Everyone knows what needs to be done, yet we have a culture of letting someone else do it for us. We don't share best practices and we are often not team players. If we shared information without any advances, we would be ahead. We need an injection of urgency into our mindset as straight forward things aren't being done.

Safety:
Preventable harm is occurring and I see few solutions from the RT community. We lack personal responsibility. Everyone thinks it's someone else's job. We have pockets of folks doing great things that give me hope, but a culture of safety not pumping through our blood. Again, we need urgency and must be unwilling to postpone progress. We need to focus on prevention, research, knowledge sharing and supporting standardization.

Value:
I believe simply, that if we show higher quality of respiratory care by delivering appropriate therapy better and safer than anyone else, we will be worth our weight in gold. I'm excited for the changes to the URM and Benchmarking as well as the Quality Respiratory Care Program.

> "It is important that an aim never be defined in terms of activity or methods. It must always relate directly to how life is better for everyone. The aim of the system must be clear to everyone in the system. The aim must include plans for the future. The is a value judgment." W.E. Deming

Advocacy:
I could not do the advocacy without Anne Marie, Cheryl, Tom, Shawna, Tim and the whole Executive Office. Below and attached to this report (see attached file "Walsh") is the letter sent out on behalf of our membership.

- Partnership with ATS – Creation of ICD-10-CM codes for e-cigarettes and other electronic nicotine delivery systems (ENDS)
- CMS-1656-FC and IFC: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs
- NIH - COPD National Action Plan
- HHS – Advocating for respiratory therapist and smoking cessation programs
- Submission of comments for IMPACT Act
- Endorsement of "The American Telemedicine Association's Operating Procedures for Pediatric Telehealth"
- Senate Finance Chronic Care Working Group – Comments of draft of the "The CHRONIC Act of 2016"

Appointments:
- COARC – Nominations of Lindsay Fox, Diane Flatland and William Galvin
- NBRC – Appointment of Brady Scott and Russ Acevedo
- ARCF – Appointment of Frank Salvatore

Committee Personnel Changes:
- Michael Madison – Government Affairs Committee
- Dr. Cohn – Membership Committee
- Mandy DeVries – Membership Committee (Student)
- Hanna Donato – Membership Committee (New Grad)
- Lisa Trujillo – IMMR
- Colleen Schabacker – Billing Codes Committee
- Kimberly Wiles – Issues Paper and Position Statement Committee
- Program Committee
    - Renee Wunderley – Committee Chair
    - Sherry Whiteman - Score Keeper
    - Rick Zahodnic - Practitioner Moderator
    - Angie Switzer - Student Moderator
    - Julie Boganwright as Timekeeper
- Ad Hoc Committee on State Initiatives
    - Jakki Grimball
    - Zach Gantt
    - Steve Sittig
- Ad Hoc Committee on Advanced RT Practices, Credentialing, and Education
    - Dr. David Kelley (BOMA)
    - Dr. Kathy Rye
    - Robert Joyner – Co-Chair

Supporting Letters:
- COARC – Letter of support for standard 1.01

Travel (Promoting):
October 28th – NYDART Conference
November 12th – COARC

November 19-20th – NBRC
January 20th – SCCM (Largely for my job and not for AARC)
February 2nd – 5th – Patient Safety Movement Summit
March 10th – COARC Meeting

Lectures:
February 17th – Journal Cast

Writing:
March – AARC Times - Article of Diversity
March – Respiratory Care – Editorial "The Respiratory Therapy Profession is at the Crossroads!"

Conference Calls:
Weekly calls with Frank, Tom and Ad Hoc AEDs
November 4th – Vision Research Grant proposal
Nov. 7th, Dec. 5th, Jan.2nd, Feb 6th, Mar. 6th – Executive Committee Update Calls
November 15th – Program Committee Call
November 22nd – APRT Committee Call
November 23rd – AS to BS Executive Committee Call
November 29th – Patient Safety Chair Call
Dec 1st, Jan 5th, Feb. 2nd, Mar. 2nd– House Speaker Monthly Calls
December 1st – Quality Effectiveness Call
December 5th – Specialty Section Chair orientation
December 8th – AAMI Conference Call
January 3rd – Committee Chairs orientation
January 9th – NN2 Conference Call
January 13th – Position Statement Committee Call
January 16th – National COPD Readmission Institute Summit Conference Call
January 19th - Membership Committee Conference Call
January 24th – APRT Committee Call
January 31st, Feb 9th, Feb. 28th – Presidents Call (NBRC/AARC)
February 9th – CPG Forecasting Conference Call
February 17th – ACCP / AARC CPG Exploratory Partnership Conference Call
February 23rd – Membership Committee Conference Call
February 27th – APRT Committee Meeting

Past President Report

Submitted by Frank Salvatore– Spring 2017

Recommendations

None

Report

The following is an accounting of my activities done prior to and around the March 2017 Board meeting:

- Participated in Bylaws and Elections Committees as per AARC Bylaws/Past President's role.
- February 8-10, 2017 – Florida Society for Respiratory Care Conference – Daytona Beach, FL.

The following are the items that were referred to me at previous board meetings:

- Nothing.

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

Executive Office

Submitted by Tom Kallstrom – Spring 2017

Recommendations

None

Report

Welcome back to Dallas. We look forward to a very productive meeting. Below is a summary of our activities since the October Board Meeting.

(See attachment "Executive Office Update April 2017")

MEETINGS & CONVENTIONS

AARC Congress 2016, held in San Antonio, TX was very successful for the Association in meeting the education needs of our members and in **exceeding all financial drivers in our budget**. Content was outstanding and the Open Forums delivered another strong year with more than 250 original research posters presented in 12 Open Forums over 4 days, including poster only format (exhibit hall), traditional poster presentation and Editor's Choice in which the top abstracts are selected by the RESPIRATORY CARE editorial team where presenters are given 10 minutes to present their research findings utilizing a PowerPoint presentation.

The Keynote Address delivered by JR Martinez was moving, inspirational and left attendees with the important message of caring for the patients' emotional needs as well as physical needs. The closing ceremony also had rave reviews as Richard Picciotto delivered a moving 1-hour presentation highlighting his experience on Sept. 11, 2001 after being trapped in the rubble of the World Trade Center collapse (and his subsequent escape). Picciotto was sure to thank those in attendance on behalf of all first-responders for the work they do (and did on 9/11) in caring for those with respiratory complication.

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 23 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. Attendance figures for San Antonio suggest that despite these obstacles, the AARC continues to create world-class educational programming that people want to experience. The location of our meeting (in a warm weather climate and in a very walkable city) suggests we must continue to find attractive destinations that people want to travel to.

AARC Congress 2016 hosted the Speaker Academy (held every other year). As a result, 6 new, first-time presenters will be given the opportunity to present at the 2017 meeting.

2017 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 moderate decrease in the number of proposals that were submitted for the '17 Congress with between with roughly 550 proposals submitted for consideration. This is a decrease of 100-150 proposals from previous years. It is suspected that the new electronic RFP site in addition to an earlier deadline may have contributed to this. While thoroughly tested, the RFP site did prove to have some issues that will need to be resolved in 2017; most notably an automatic email reply once someone successfully submits a proposal.

The $2^{1/2}$ day meeting concluded with a full program developed for both Congress and Summer Forum. Based on high demand from exhibitors, there will be no AARC hosted pre-demand and feedback from the 2016 meeting, the Program Committee elected to once again offer industry-sponsored pre-courses. With that said, the Program Committee felt unanimously that stronger efforts should be taken to segregate these sessions (including breakfasts and lunches) from actual AARC Congress programming. It was felt by the committee that without doing so, it suggests to attendees that these courses are in fact offered by, created by and endorsed by the AARC.

2016 AARC Summer Forum

The 2017 Summer Forum will be held June 25-27 in Tucson, AZ. The meeting will be held at the JW Marriott Starpass 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 targeted toward Educators titled; "Laying the Foundation". This course will be held in collaboration with the CoARC and NBRC and is aligned with the AARC Strategic Plan in aiding 2-year Associate's Degree programs to transition to a 4-year bachelor's degree (or articulation agreement). There will be a nominal fee associated with this course.

AARC Congress 2017

Progress is well underway for the logistical planning for AARC Congress 2017 to be held in Indianapolis, IN from Oct. 4-7^{th}. 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 2016 regarding session length (35 minutes) with one additional hour of unopposed exhibit hours (from 8 hours to 9 hours). As in 2016, the Program Committee has opted to run fewer concurrent lecture rooms (8). This will slightly reduce overall costs, but will in turn provide a more focused, better-attended curriculum.

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 San Antonio 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.

Advertising and Marketing

Grants

AARC has been working with our per diem Grants Strategist since AARC Congress concluded. We are starting to realize the benefits of this role and the relationships being developed. We are in the process of actualizing over $200,000 in grant proposals/sponsorships that will see revisions to Aerosol Guides, a new Pulmonary Hypertension Guide, A brochure for Pulmonary Fibrosis patients that require oxygen (in collaboration with Pulmonary Fibrosis Foundation), and support of the 2nd Annual Patient Advocacy Summit in San Antonio prior to AARCongress.

MEMBERSHIP

At the end of January 31, 2017, our membership numbers were 47,348. We will have a more current number to report at the board meeting in March. The retention rate through January was 78.9% and there were 781 new members in January. A membership dashboard is attached to this report.

Early Student Renewals

We are preparing for the large group of May graduates. Outreach efforts have included contacting Program Directors, posting messages on AARConnect, and the automated early student renewal emails.

Senior Membership

We ended January with 181 members on the senior membership tier. This is the highest number of senior memberships since the program's inception. We will continue to pilot an outreach program for members eligible for the senior membership tier.

Leadership Workshop
Plans are underway for the 2017 State Chartered Affiliate Leadership Boot Camp. It will be held the weekend of April 7-9, 2017. We plan to cover topics such as membership, financial stability, and engagement strategies.

Specialty Sections
The membership department has been working with the specialty section chairs on way to engage their members. An orientation meeting was held in December 2016. We have also created a community on AARConnect for specialty section chairs and chair-elects to communicate with each other and share ideas.

State Society Liaison
The AARC Board of Directors directed the Executive Office to proceed with the state society support pilot program. The purpose of the program is to provide contracted state affiliates with basic administrative assistance to improve their member communication, engagement, and retention. At this time, states that previously expressed interest have been contacted regarding continued interest in committing to the 1-year pilot.

SPECIAL PROJECTS

Life & Breath
The Life & Breath public relations and recruitment video is planned for revision in 2017. The new product will have multiple types of video for various audiences and purposes.

Higher Logic
The AARC continues to participate 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 continue to be 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 12-14 months. Higher Logic has also featured the AARC's success in automation rules in a recent webinar.

CDC Tips from Former Smokers Campaign
The AARC completed work with the CDC to promote the 2016 Tips from Former Smokers campaign in September 2016 and signed a new agreement for the 2017 campaign through June 2017. The AARC's 2016 successes were highlighted in a January 2017 Tips from Former Smokers partner webinar.

Student Engagement Book
Mentoring Excellence: AARC & Lifelong Learning is a collection of tips and ideas for incorporating AARC resources into the classroom and curriculum from respiratory care educators that was released in early fall 2016. The AARC will place a call for new ideas and tips on AARConnect in late spring to update the resource for 2017. Future editions of this book will be electronic only.

Clinical Practice Guidelines
The AARC has begun the preparations to explore tracheostomy safety as a topic for an upcoming clinical practice guideline. Organizations such as Chest and ATS have expressed interest in working together toward a collaborative guideline. The Executive Office has begun discussions toward completing this goal.

Advertising, Marketing, Communications and Business Development

Advertising

With Beth Binkley's retirement at the end of 2016, AARC conducted a CQI assessment of the advertising program from Sales to Billing. The processed allowed us to maximize our efficiency and productivity for advertising eliminate some duplicative steps, inefficiencies and antiquated software. It also allowed us to create a visual dashboard of the advertising product presales as well.

Print advertising is tracking close to budget at the time of this report (end of 2 months). Our ability to look at both real time sales and sales across 2017 allows us to see we are tracking pretty close to budget for all of 2017 in print publications. We will see a bigger push when we get closer to Summer Forum and Congress for additional print sales.

Digital advertising continues to be an area that we are keeping a close eye on for 2017. 2016 was a banner year for AARC in the digital arenas (websites and newsletters) and we are hoping to see an increase interests in 2017. Maybe unnoticed by many, RESPIRATORY CARE website was converted to a new platform in mid-November. This new layout optimized new opportunities for us to highlight "box ads" (instead of skyscrapers that ran down the page too far and implement "retargeting" on this website like aarc.org.

Newsletters are off to a slow start in Jan/Feb, but this is not unusually for the first 3-4 months of the calendar year. However; 2016 was a record-breaking year in sales and our sales rep Phil Ganz has a nice methodology moving forward for sales with industry. We are also adding and modifying opportunities. We are preparing to change *NewsNow* to a responsive design to make it mobile-friendly and this will provide some unique ad placement opportunities.

With a proposed redesigned website, we are considering other potential opportunities on Your Lung Health website in the latter part of 2017, but we will need time to build traffic once this has been redesigned.

Recruitment ads have gotten off to a fantastic start again in 2017 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 >$100,000 in revenues and 2017 is off to a comparable start. We have just created an agreement with a large agency (JobTarget) that should bring us more recruitment ads from them and their clients. This agreement creates a volume basic discount for JobTarget to incentivize them to list more ads with us.

Corporate Partners
We had a very successful year of revenue and sponsorships from our 2016 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 again as we begin 2017 (outside of AARCongress).

2017 Partners: Vyaire, Masimo, Medtronic, Monaghan, Philips/Respironics, Drager, Getinge Group, Teleflex, Boehringer Ingelheim, Astra Zeneca, Mallinckrodt, ResMed and Fisher-Paykel.

We will be meeting with the Corporate Partners in Dallas on February 27th and 28th just prior to the Board meeting. A verbal update can be provided at that time if needed.

MarCom
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 2017. 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 reinvigorated our relationship with Geico Insurance and have seen a boost in revenues from that program in 2016. We also continue our relationship with the malpractice insurance group for our members. We are also currently investigating a travel affinity program as well as one that offers optimized and consolidation of student loans.

We are also current looking to hire a Communication Coordinator to fill a vacancy created by Beth Binkley's retirement. This new role will be primary focused on multimedia communications and public relations endeavors. As AARC (and the world) gravitates to a digital world, we are looking for an individual with a skillset in digital writing/communications. We hope to have someone hired and into the role by 2nd quarter.

Products
We approach our current vendor, Devore Technologies in "rebuilding" the Benchmark database system and received a very high quote for this work. We began work in late 2016 on developing our Benchmarking 2.0 program internally. We have hired a new .NET programmer to finalize the work and hope to have the new product ready for 2nd quarter of 2017. The new system will start to venture into patient outcome metrics on quality and safety.

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 2 years. And will look to continue and hopefully enhance these sales for RC Week in 2017, but is not as popular as this once was 5-10 years ago.

In 2017, we will look to update some products that have served the membership and professional well over the last decade. First, we will look to revise and update the Competency and Orientation Manual. We are considering not only the full spectrum manual, but also smaller "niche" manuals that concentrate in specific disciplines (diagnostics, Sleep, Neo-Peds).

We are also looking to update the Uniform Reporting Manual (URM). The new manual will not only look at time standards and productivity/efficiency standards, but will also look to address value-based care concepts and metrics.

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.

EDUCATION

NBRC Collaboration

The AARC and NBRC implemented the NBRC CRCE information-sharing program in September 2015. As of September 7, 2016, over 2,100 different individuals uploaded their AARC transcripts to the NBRC Continuing Competency Program since the program launch. The NBRC is updating their database and this program will undergo minor edits for efficiency.

Recruiting for the Profession

The 2017 HOSA event will be held in Orlando, FL. Jamy Chulak has agreed to coordinate the event for this year. The next USA SEF event will be held in 2018 in Washington, D.C.

Respiratory Care Education Annual (RCEA)

The RCEA published issue 25 in September 2016. The call for papers for 2017 will be open until February 15, 2017. Dr. Dennis Wissing continues to serve as editor. Ms. Helen Sorenson retired from the publication team and Dr. Kathy Myers Moss and Dr. Kathy Rye have agreed to serve as assistant editors. Dr. Will Beachey, Dr. David Chang, and Dr. Doug Gardenhire have returned to the editorial board. Dr. Dave Burnett and Dr. Gregg Marshall have joined the editorial board for 2017.

Pulmonary Disease Educator course

The online pulmonary disease educator course was released in November 2016. Co-sponsoring organizations include the Cystic Fibrosis Foundation, COPD Foundation, Allergy & Asthma Network, American Association for Cardiovascular and Pulmonary Rehabilitation, American Lung Association, and Pulmonary Hypertension Association. An application for course certificate status is in development.

CDC Strategic National Stockpile Ventilator Workshops

The AARC has received confirmation that the CDC has approved an RFP for five SNS workshops in 2017. The five confirmed sites are the Sunshine Seminar in Daytona Beach, FL

(FSRC); the Respiratory Care Society of Washington Annual Conference in Seattle, WA; the Colorado Society for Respiratory Care Annual Conference in Vail, CO; AARC Congress 2017 in Indianapolis, IN; and the Massachusetts Society for Respiratory Care Annual Conference in Worcester, MA.

Preceptor Recognition Program
With the Board's approval, the AARC Preceptor Recognition program is under development. The program will provide the RT program with an opportunity to nominate a qualifying preceptor for recognition of quality clinical education. Qualifying preceptors will have at least a bachelor's degree, hold the RRT credential, have completed the AARC's Clinical PEP program, have precepted students at least 120 hours in the last 12 months, be an AARC member and education section member. Beta testing will commence in March 2017 with an anticipated call for nominations in May 2017.

Pfizer Grant
The AARC received a Pfizer grant for the development of "Clinician Training on Tobacco Dependence for Respiratory Therapists." The project included 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 included a study to determine the effectiveness of the intervention. A manuscript from this study has been submitted to the Respiratory Care Education Annual and the Smoking Cessation Leadership Center highlighted the AARC's tobacco cessation efforts in a webinar in January 2017.

Additions to Education
Several courses are new to AARC University in late 2016/early 2017. The Pulmonary Disease Educator course (14.5 CRCE) was released in November 2016. Three other courses were released in January 2016: Neonatal-Pediatric Specialist course (20 CRCE); Impact of Pulmonary Vasodilator Device Safety on Institutional Risk and Quality (1.0 CRCE); and Guiding Patients Through Decisions in IPF: The Respiratory Therapist's Role (1.0 CRCE). The national and California ethics courses will be revised in 2017 for release in 2018. Current sales are going well and, overall, are over budget.

2016 Educational Product Sales/Attendance Trends at a glance (as of 2/1/17)

	2017 YTD	2016	2015	2014	2013	Comments for 2017
Webcasts and JournalCasts	408	8,153 (340)	9,149 (410)	8,812 (383)	7,511 (442)	Per session attendance in parentheses
Asthma Educator Prep Course	22	246	183	268	203	On budget
COPD Educator Course	66	734	859	820	570	Above budget
Ethics	397	4,242	1,928	1,757	2,361	Above budget
RT as the VAP Expert	7	53	63	115	81	On budget
Alpha-1	4	75	74	125	98	Under budget

Exam Prep	2	189**	180*	39	40	*F&P grant (150) + 30 **F&P grant (150) + 39
Leadership Institute	6	99	68	89		Under budget
Asthma & the RT	450	604	446	172		Above budget
ACCS	21	164	121			Above budget
PFT: Spirometry	35	422	228			Above budget
PFT: Pediatrics	6	117	43			Under budget
PFT: Advanced Concepts	12	264	79			Under budget
Tobacco Training	16	259	85			Under budget
Congenital Heart Defects	14	122				Above budget
Pulmonary Disease Educator	40	32				Above budget
NPS	12					Above budget

As you may recall the Board authorized a survey looking at the role of the RT in pre and post discharge Oxygen management. Below is an abstract that has been submitted to CHEST

Respiratory Therapist Home Oxygen for Chronic Obstructive Pulmonary Disease (RIsOTTO) Study: A National Survey

List of authors:

Ai-Yui M. Tan, David Vines, Valentin Prieto-Centurion, Melissa Gutierrez-Kapheim, Jerry A. Krishnan, Thomas J. Kallstrom

Rationale: Patients hospitalized for chronic obstructive pulmonary disease (COPD) exacerbations and prescribed home oxygen therapy are at high risk for hospital readmissions, death and other adverse outcomes after discharge to home. Information on practices of respiratory therapists (RT) working in acute care settings could help to improve the care of this high-risk population during hospital to home transitions.

Methods: Cross-sectional analysis of data collected over a 90-day period from an online survey that was sent out from the American Association of Respiratory Care to its membership. RT who take care of patients with COPD exacerbations in acute care settings were included.

We asked them to report: 1) Their familiarity (Not at all, Somewhat, Very) with the Centers for Medicare & Medicaid Services (CMS) National Coverage Determination (NCD) for Home Use Oxygen; 2) The frequency with which they obtained pulse oximetry saturations (SpO2) or arterial blood gas (ABG) within 48 hours prior to hospital discharge at rest (oxygen evaluation at rest), with activity (oxygen evaluation with activity), and during sleep (oxygen evaluation during sleep); 3) The individuals responsible for making decisions regarding home oxygen equipment; 4) Whether they conduct home visits after hospital discharge; 5) Their familiarity

(Not at all, Somewhat, Very) with long-term oxygen devices (stationary and portable concentrators (SC and PC, respectively), oxygen conserving devices (OCD), home transfill system, liquid oxygen).

Results: Of 614 respondents, 492 RT met eligibility criteria. They indicated that 7.8% were not at all familiar with CMS NCD for Home Use Oxygen, 47.1% somewhat familiar, and 45.1% very familiar. Just over half (58.5%) reported conducting an oxygen evaluation at rest, 43.2% with activity, 14.8% during sleep every time or almost every time (76-100% of the time). Respondents indicated substantial variability regarding decisions about home oxygen equipment (27.8% physicians, 18.6% social workers, 17.3% RT, 16.8% Durable Medical Equipment company staff, 1.5% nurses, 17.9% "I don't know"/ "Other"). Very few (3.5%) conduct home visits to assess whether a patient is on appropriate oxygen therapy. Familiarity for home oxygen devices was highly variable with 66.2% very familiar with SC, 57.3% OCD, 56.0% PC, 45.4% liquid oxygen, and 32.2% home transfill system.

Conclusions: The RIsOTTO study has documented multiple opportunities for respiratory therapists working in acute care settings to play a more prominent role to improve the care and coordination of patients with COPD exacerbations who are prescribed home oxygen therapy at the time of discharge and after discharge.

The Great Flood

The AARC suffered yet another catastrophe in January when a portion of our building flooded out. Thankfully we were able to get this corrected and dried out. We will have a better idea of the costs that we will have as a result.

RESPIRATORY CARE Journal

Last November we rolled out a new and modern Journal website built on the Drupal open source software. The site is very clean and increases the design and theming options, it gives us more control over Journal configuration as well as more stability and responsiveness. It also enhances the user readability, social media access, and how to prioritize content.

The number of manuscripts received continues to be robust. This has also resulted in a lessening of the acceptance rate. It is good that we receive so many manuscripts, but because of limitations on our resources, we are not able to keep up the same rate of acceptance. For example, in 2010 we received 194 original research manuscripts and accepted 87 (45%), while in 2016 we received 545 manuscripts and accepted 182 (26%).

Working with and through the Program Committee, the Journal will again present the Open Forum at the Indianapolis Congress. Accepted submissions will be presented in one of three formats: Editors' Choice, Poster Discussions, and Posters Only. Deadlines for submissions May 1st.

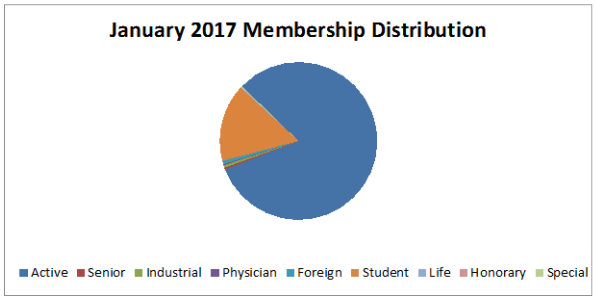
Proceedings from the Journal Conferences are among the most read and accessed materials we publish. In 2015 and 2016 the 341 articles available from Conferences were full-text accessed (HTML or PDF) 745,774 times for an average of 2,187 full text views per article. This does not include the number Journal Conference abstracts accessed (454,541).

This June the Journal we will present the 56th Journal Conference on *Respiratory Medications for COPD and Adult Asthma: Pharmacologic Actions to Clinical Applications*. We feel it is important for clinicians to appreciate the appropriate use of medications for patients with COPD and asthma. Non-physicians, such as respiratory therapists must understand not only how these drugs are administered, but also the underlying pharmacology and important drug interactions. These issues are important in both the hospital and home setting, and for transitions from one care setting to another. Considering that oxygen is a drug, the prescription and monitoring of its use is as important as other respiratory drugs. This conference will address the pharmacology, clinical application, and the processes involved in developing and implementing optimal respiratory medications for adult patients with COPD and/or asthma. Papers covering the topics presented at the conference will be published in RESPIRATORY CARE.

AARC Membership Dashboard

		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
TOTAL MEMBERS	2017	47348											
	2016	47854	48191	48383	48125	47808	46220	46080	46785	47544	47452	47394	47293
	2015	48815	49262	49571	49554	49071	47142	46628	47631	48693	48784	48103	48291
	2014	50894	50732	50879	50400	50137	48391	47833	48753	48946	49313	48537	48423
	2013	51864	51860	52264	52166	52485	50699	50467	51061	51358	51730	51500	51037
	2012	52043	51977	52530	52438	52424	50983	50420	51751	52267	52458	51991	51557
ACTIVE MEMBERS	2017	38768											
	2016	38820	38733	38839	38533	38339	39405	39119	39483	39310	38954	38743	38610
	2015	40196	40066	40058	39836	39544	38838	39336	39561	39714	39520	38895	38792
	2014	41695	41446	41447	40895	40887	40582	40716	40836	40502	40574	39862	39946
	2013	41694	41484	41746	41476	41991	42145	42153	42326	42251	42333	42000	41518
	2012	42049	42037	42288	42151	42396	42129	42649	42634	42504	42485	42035	41568
NEW MEMBERS	2017	781											
	2016	641	819	573	564	593	566	860	1391	1621	780	657	392
	2015	661	782	737	658	500	745	752	1701	1745	731	429	567
	2014	654	704	622	633	515	691	571	1490	1286	1047	388	746
	2013	825	610	631	657	771	659	662	1327	1254	940	460	423
	2012	723	768	926	614	709	796	864	2041	1534	1003	487	478

CONFIDENTIAL



	Retention	
	All Members	New Members
	(As of Year End Listed)	(As of Report Date)
2016	78.4%	
2015	79.1%	46.9%
2014	76.6%	28.8%
2013	81.1%	24.4%
2012	77.9%	18.2%

Reports Run 2/1/2017

Executive Office Referrals

(from October 2016 BOD meeting)

- ***FM16-3-1.2*** *That the Executive Office proceed with the pilot of the state society support.* ***Carried***

  Result: Shawna Strickland created a list of services available to offer the states. See below "State Society Staff at Executive Office".

- ***16-3-54.1 (Home Care Section)*** *That the Board of Directors charge the Executive Office with the task of investigating the feasibility and financial impact of combining the home care section, long term care section, and continuing care section.* ***Carried***

  Result: See below "Home Care Combo".

- ***16-3-81.1(President's Council)*** *That some members of the Presidents Council be involved in the AARC 70th Anniversary planning.* ***Referred to Executive Office***

  Result: Past Presidents Watson, Giordano, Myers, and Sullivan will partake in the planning.

- ***67-16-4*** *Resolve that the AARC work in concert with the HOD Officers and the Delegate Assistance Committee to increase the assistance offered to affiliates and the needs of the HOD.* ***Referred to Executive Office***

  Result: See attachment "DELEGATE ASST ANALYSIS".

- ***FM16-3-1.3*** *That the AARC Executive Office develop the means and methods to enforce the revenue sharing agreement by the end of 2016.* ***Carried***

  Result: Tom Kallstrom will provide verbal update.

- ***FM16-3-29.1 (Taskforce on Competencies)*** *That the Board of Directors accept the Taskforce on Competencies document and move to the Executive Office for publication.* ***Carried***

  Result: Posted on AARC website and included in NewsNow.

State Society Staff at Executive Office

Goal: Provide states with basic administrative assistance to improve their member communication, engagement and retention.

Cost: $12,000 a year, a minimum of 5 states is required, with a minimum 2-year contract. (Idea: States can pay $3000 per quarter or if they pay for the whole year at once, $10,000.) Payment is due the month prior.

Duties:

Rosters – Run reports and email them to state officers. Send emails to subgroups or create mailing lists as requested. For example, emails to recently-lapsed members, brand new members, students, or for an upcoming meeting, etc.

Maintaining database – Work with officers to keep iMis data current and if they have a separate database, their database current.

Elections – Assist states with running elections.

AARConnect – Post announcements and troubleshoot. Assist with ideas for generating online activity.

Website – Reviewing their website content and sending edits, corrections to their webmaster.

CRCE Applications – Completing and maintaining applications for educational programs.

AARC Data – Ensure we have copies of their meeting minutes, current info on officers, their state meeting info posted on the website, etc.

Membership: Create a group of emails to engage members in the state society. State Presidents can review and select which ones they would like sent. (These will be common, so used by all states in the group.) Assist membership chair with ideas and administrative assistance.

Meetings: Facilitate getting the CRCE logs posted in a timely fashion.

Mentorship: Maintain and provide train materials for incoming officers.

Note: If they wish to send out physical mailings, we will need figure out if we can charge them postage on our account or if we need access to their USPS account or if we need to generate the mailing lists and have them do their own mailings.

Home Care Combo

November 9, 2016
Evaluation of membership for Home Care, Long Term Care, and Continuing Care/Rehab

Analysis of multiple memberships

- Number of members who are members of all three specialty sections: 25
    - Annual dues from this demographic: $1,125
- Number of members who are members of 2 of 3 specialty sections: 79
    - Continuing Care/Rehab + Home Care = 27
    - Continuing Care/Rehab + Long Term Care = 29
    - Home Care + Long Term Care = 23
        - Annual dues from this demographic: $2,370

Analysis of single membership

- Number of members who are a member of just 1 of 3 specialty sections: 1,056
    - Continuing Care = 310
    - Home Care = 548
    - Long Term Care = 190
        - Annual dues from this demographic: $15,840

Total number of unique members who belong to one or more of the 3 sections: 1,160

Total annual dues based on section membership as of 11/7/16: $19,335

Direct cost impact
Home Care + Long Term Care + Continuing Care Rehab into one section @ $15/year

- Assuming retention of 1,160 members x $15 = $17,400
    - Annual cost savings = $1,935

Indirect cost impact:

- Short-term increased indirect expenses associated with:
    - Merge sections on AARConnect
    - Combine membership in iMIS and process overpayments into future dues
    - Review all materials for specialty section information and make appropriate corrections
        - Printed materials
        - Website materials
        - Scheduled emails
        - Online membership application functionality
    - Develop rotation for specialty section chair elections/potential board seat
- Long-term
    - Reduced time of office staff for managing 8 sections instead of 10
        - Membership
        - Publications (bulletins, newsletters)
    - Reduced costs for Specialty Practitioner of the Year materials (8 sections to award instead of 9; 1 SPOTY costs approximately $500)

Most important advantage to combining membership (survey responses):
Create a stronger voice in the post-acute care

Biggest concern to combining membership (survey responses):
Loss of individualized session at AARC Congress

Comments:

- Although I do believe there is a huge benefit in combining the sections, we must make sure that we improve communication amongst the RT's currently working in different post acute settings so that pt transitions are improved. RT's need to work together to create and modify the pts care plan so gaps gaps in follow thru are minimized.
- As long as the homecare respiratory therapists that work in DME are represented with the same respect and knowledge that Kim provides, I am ok with it.
- Currently the AARC does not understand professional respiratory services outside an institutional setting, the combining of these sections may not improve that situation
- Every topic that is addressed needs to follow through (from hospitalization, to discharge, to home) to ensure all aspects are covered.
- Everyone thinks bundling is the way to go, how are we to say nay.
- For too long, we have pursued our individual care concerns and goals without much in the way of conversation or collaboration between these sections. As the need for and utilization of better planned and coordinated post-acute care continues to emerge and impact delivery of health care, quality of that health care and achieving of positive outcomes, for us to combine and learn about what each other does is of critical importance. We cannot properly plan comprehensive care plans without knowing more about the specifics of what each section has heretofore been concerned with AND has been doing.
- Great idea! It seems like it would be more efficient and more effective in getting the information out.
- Hopefully combining sections would benefit members and patients in the long run.
- Hospitals have multidisciplinary meetings to improve processes and the patient experience. This is a step for post acute care for combining sections. Having added insights with all aspects of the patient journey is only beneficial.
- I am stating that I would be in favor of combining sections. However, I still believe it would be beneficial to continue with individualized sessions at the AARC Congress.
- I believe that it would be beneficial to combine the three sections listed above. With the way Healthcare is moving I am seeing these three sections merging in my daily flow of work.
- I believe that there is a large possibility that combining sections, not only in the AARC but also in the physical realm of business would not only benefit the patient but the provider as well. With recent changes and decreases in allowables healthcare standard have a potential to drop. One way the financial decrease could be supplemented would be through combing resources and power offering quicker more manageable therapy for the patient.
- I do have some concerns as shown above; however, with the reduction of RT staffing levels in home care and this potential for increased need in LTC this makes sense.

- I have mixed feelings about combining them. I think working together is the way to go but I feel each may lose some identity. It would have to have co-chairs from each section representing the group so everyone is heard.
- I really look forward to, and benefit from, the specifics in the Pulmonary Rehab track at the annual Congress. If we could keep that track in tact with the "addition" of some sessions combining post-acute health management across the continuum, I would be all for it. But, please, don't let this merge take away from the unique needs of PR. Thank you!
- I think that home care is an unique service when the RT can have aone on one
- I think this is a good idea. I previously worked at a DME and am now clinical coordinator at a hospital and in charge of Pul Rehab program--I have wished for a long time for more communication between home care and pul rehab as well as clinic and hospital staff. We all need to be on the same page, reinforcing the same things to our patients.
- I worry that questions/postings for my area (pulm. rehab.) that I've found so beneficial will be more difficult to notice?
- I would be in favor of he sections working to together but as separate units, not as one big unit where we would lose our group identities.
- I would like a forum in which members of all sections could discuss these issues & strategize short & long range goals. There could be subgroups within a larger section - having a distinct identity & specialty training while combining joint interests to promote patient care & access to services of RTs in the home, equipment & supplemental O2.
- I would like a guarantee that I will continue to see as much info from my group as usual. Otherwise I will not pay extra for this service.
- I would not be in support of this if it is being driven by a few individuals who hope to secure a seat on the AARC BOD
- If the option is to not have an AARC board seat due to low Home Care membership vs. having a combined group with a board seat, it would make sense to combine. It's happening all over healthcare. Hate to see it, but it is what it is.
- In my experience, RCP's working in long term care, home care, and rehab usually have experience in one of the three areas and focus in preventative disease management of patients so decrease re-hospitalization and continuity of care in all of these areas.
- In some cases the combining of these sections is good for a multitude of reasons- continuum of care and building a stronger communication system within the post acute care clinical team. But the disadvantage is we will still be divided on approaches to care based on our practice. Defining LTC in the home vs. at a skilled facility will remain having many differences in scope of RT practice.
- It is too bad that the Home Care section couldn't get enough members to keep the section together. It is important that we have a voice with the AARC and if combining sections is what it takes, we need to do it.
- It's difficult to answer these without hearing/seeing how it would look. We need to do what is best for our patients.
- Please be sure to give all areas enough space/ time / voice in communications
- Pulmonary Rehab. Should not be combined with other post acute care. It is a separate reimbursement system and regulations with CMS

- The focus of care should be across the continuum and also include the transition from acute care and on prevention/wellness. Not just on post acute by itself.
- There's a huge divide between RT's Hospital - RT's Home or out of Hospital. The Hospital side being the majority - thinking itself more like a nursing group? than an entity crossing social lines in area of practice. Fact is "patients want to go home, be home, stay home, die at home, live at home, be sick at home, smile or cry at home. It's simply cheaper at home to do many of the things hospitals try to do at home. Hospitals are burden with huge sets of rules and expense to get to a simple end. In my view when you've gotten to the hospital something bad has happen and failed at home, or acutely in life. Today's new rules of the road of for Homecare - especially from the reimbursement side with ACA are sorry to say - the end of homecare good, bad or ugly. There's just no money for the private sector to work, much less improve the system, while the system continues to cut and people continue to be sick. Not good math. What happens in the AARC sections - it's nice to be able to communicate - but you have to take a survey to see if you want to or not, that it might step on someone's toes? Oh well - another brick in the wall.
- These are two totally separate sections. All the state regulations in LTC is different than homecare. I'm disappointed if you combine these two sections.
- Two different groups. Pulm Rehab info and Home/Long Term Care info are not the same
- While there should be one section chair it should rotate among disciplines. In addition despite a chair being from one discipline or the other there should be a "liaison" appointed/elected from each discipline to assure a unified voice.

State Government Affairs
Activity Report – March 2017

Cheryl A. West, MHA, Director of Government Affairs

Introduction

The 2016 November elections saw very significant gains for those in the Republican Party. There were four additional Republican trifectas—i.e. states where one party controls both legislative chambers and the governor's office: Iowa, Kentucky, Missouri, and New Hampshire. All together Republicans now control 68 chambers, Democrats control 31, one, Nebraska; because it has just 1 legislative chamber is "officially bipartisan".

State Governors and legislatures are in part looking to the Republican Congress and the new Trump Administration to help determine key state health insurance issues, in particular possible Medicaid revisions as well as the final fate (repeal or repeal and replace) of the ACA aka Obama Care.

State societies should be sensitive to the fact that because a majority of state legislatures and in some cases the legislature and the Governor/state administration are controlled by one political party that legislation supportive or not supportive of the respiratory profession and the pulmonary patient , will more than likely be enacted. Therefore state societies must remain vigilant especially in this era of de-regulation to make sure that any movement to repeal or dilute respiratory therapy licensure, respiratory scope of practice or patients access to pulmonary services will be opposed.

RT Licensure Board Reconfigurations/Revisions/Consolidations

Working with our state society's leadership we are continuously monitoring for any potential indications that a state legislature or policy arm of the state administration is seeking to "revise, reform, consolidate or repeal" the state structure of any health profession licensure in general and of course respiratory therapy specifically. As this Report is being written the following states are either poised to or have launched such efforts.

OH in late 2016 extensive legislation was introduced and fast tracked by the OH legislature that would have combined, deleted or re-structured many state licensing boards, including the independent Respiratory Care Board. In terms of RT, the legislation would have removed the RC Boards' current regulatory responsibility to oversee RT related DME providers and assign that specific area of regulation to the Board of Pharmacy. The other part of the RC's Boards' regulatory responsibility, that is overseeing respiratory care and respiratory therapists would be have been transferred to the Ohio Board of Medicine. The OSRC and the AARC of course opposed the dismantling of the current OH Respiratory Care Licensure Board structure. However both organizations were also fully aware that the OH legislature was determined to enact these licensure board changes. The fallback position was to insist that if the RTs were to come under the Ohio Board of Medicine that a respiratory care advisory committee or council had to be added to the final bill language a provision that was not in the original legislation. The AARC provided letters of support to the OSRC leadership to be used in their lobbying efforts. The bills were defeated at the end of 2016. **However** confidence is high that the provisions to consolidate many Boards, including RC, will be reintroduced in 2017.

AZ the positive news was in late December the State's Joint Health Committee recommended that the respiratory care license be extended another 8 years. In early January a bill was introduced to do that. However a cautionary note was told to us by the Executive Director of the AZ RC Licensure Board that, just like OH in 2016, the AZ state legislature seems determined to start consolidating state licensure boards. The ASRC and AARC will continue to closely monitor legislation that would launch the consolidation effort.

NE there is a bill that while very general would give the legislature authority to review whether professions and occupations currently requiring either licensure, state registration or some other state oversight should continue to have that level of scrutiny. While not focusing on any professions or occupations specifically most licensed health professions are concerned that this is the proverbial camel's nose under the tent, and most including the NE RC Society are voicing opposition to the legislation fearing that if enacted that in the future legislature will use its authority to start dismantling health professional licensure boards .

RRT Only Legislation

NJ 2016 legislation to revise and update the NJ RT licensure scope of practice (including clearly defining RT protocols and adding disease management) was amended in mid-December to include the provision that future licenses would only be issued to those holding the RRT credential. We are urging the leadership in the state to insert a more robust clarification that RTs holding the CRT credential prior to the RRT only implementation will continue to be able to renew their license if all other renewal qualifications are met.

VA respiratory therapists are under the umbrella of the Virginia Board of Medicine. The members of the RT Licensure Advisory Committee have approached the full board to apprise them of the desire (with rationale) to move towards a RRT only requirement for future licensure.

OR legislation is being drafted in the state that would require by January 1, 2018 the RRT credential for licensure. AARC was asked to review the proposed legislative draft and provide comments. We are urging that very clear RRT exemption language be included to provide assurances that any licensed CRT will continue to be able to renew the license as long as other renewal requirements are met.

Note: California moved to the RRT only for licensure several years ago. The law contains a very simple provision that provides assurance that CRTs will not be denied a license if that credential was obtained prior to the implementation date of the RRT only requirement.

….any person applying for licensure who provides evidence that he or she passed the national certified respiratory therapist examination prior to January 1, 2015, shall not be required to pass the national registered respiratory examination, if there is no evidence of prior license or job-related discipline, as determined by the board in its discretion….

RT Specific Legislation

ND (enacted) at the request of the ND State Board for Respiratory Care several small revisions to the RT licensure law have been enacted. The most impact on the profession is to allow the Licensure Board to raise the licensure fee to a maximum of $200 (from the current $100)

Legislation Impacting RTs

OH enacted legislation covering many health professions including RTs that would allow a licensee to earn CE credits at the rate of one credit hour for each sixty minutes spent providing health care services as a volunteer.

MN several years ago the MN Society partnered with the MN Nurses Association in efforts to mitigate a bill that created community paramedics that allowed these clinicians to provide services that fell within the RT scope of practice.. The RTs and nurses were able to insert language requiring additional training by a nurse or RT for the community paramedics. There is now another bill in MN that expands on what the services of the community paramedic and now additional the newly added medical assistant may provide in the home, which includes ventilator monitoring and trach care (among other services). The MN Society is again working with the MN Nurses Association in an effort to revise or in the best case, defeat this bill.

MS a bill that would require all licensure boards to include/collect information on a licensee tax liability which could be used as a potential disciplinary consideration

Issues Impacting RTs

CA there has been a recurring situation in California that has reached a point where action is required. There are a number of long term care facilities that are utilizing licensed vocational nurses (LVNs) to provide respiratory services to ventilator patients.

The RT services that are been rendered by the LVNs significantly exceed the legal scope of practice for CA LVNs. Nevertheless, and despite complaints to the Department of Consumer Affairs that LVNs are providing respiratory services that they are not licensed to provide, nothing has been done to stop this practice and LVNs continue to provide RT services to long term care ventilator patients.

It now appears that with the backing and support of several long term care facilities the CA Board for Licensed Vocational Nurses and Psychiatric Technicians (LVN/PT) is mounting a regulatory effort to try to make the case to the attorneys in the Department of Consumer Affairs (DCA) that LVNs meet the criteria set out in the exceptions provisions of the CA respiratory care licensure law. A hearing of the LVN/PT Board was held in mid-December to begin the regulatory process whereby this board would "rule" and the DCA would concur that LVNs qualify under the exemption provision of the CA RC licensure law, thus freeing them to continue to provide respiratory care services. This effort has been met with fierce opposition by the California Society. At the CSRC's request the AARC provided a strongly worded letter rejecting the position of the LVNs.

Legislation or Regulations of Interest

HI a bill that would provide an additional payment to long term care facilities taking care of complex medical patients, ventilators are mentioned

NJ legislation to establish a School Asthma Protocol Task Force in order to develop guidelines for the most appropriate means of implementing the Pediatric Asthma Reduction Effort (PARE)- a school asthma protocol. **NY** also has a bill establishing an Asthma Prevention and Education Program and includes RTs in the language

MO a newly adopted rule establishes the MO HealthNet payment policy for asthma education and in-home environmental assessments

NY legislation that has been repeatedly introduced but never passed that would prohibit participation in torture and improper treatment of prisoners by health care professionals and includes RTs in list of professions.

OH finalized a rule to make it easier for children on ventilators to qualify under Medicaid to receive health services in intermediate care facilities. The rule also permits a pathway for the pediatric vent patients to be able to extend his/her stay beyond the current permissible length of stay.

Tobacco Legislation

There is legislation in several states that would prohibit smoking in various places: **CA** in public housing; **DC** (passed at the end of 2016) tobacco and smokeless tobacco (vaping) at sporting events and in public housing; **HI** on the University of Hawaii campus (includes vapor devices) also a **HI** bill banning smoking in foster care homes; **KY** on school property; **NY** would include vaping products to the list of tobacco that could not be smoked in public areas; **VA** on playgrounds, and public parks; **SC** in and around the state capitol buildings

KY & MS have bills to prohibit smoking in a car with a child under age 6; **SC** no smoking in cars with children under age of 5, **HI** references minor and **NH** says not with a passenger under 16

State legislatures are again introducing bills that will raise to 21the age when a person may purchase tobacco products. Thus far: **AZ**, **DC, IN, MS**, **OK, VT,** & **WA** have introduced (but not passed) these provisions. An **Alaskan** bill does not give an age, but simply says "minor", **ND** sets the age at 19 and includes vapor products

NE also has a bill to raise the age of purchase to 21, but in addition the same bill goes one step further and would prohibit the *use and consumption* tobacco products until age 21

And of course there is the usual number of states that have legislation that will raise the tobacco tax or include vapor products and e-cigarettes under the tobacco tax umbrella: **HI**, **MN, MT**, **NY**,**OR, & WA**

Telemedicine

CT a bill requiring a face to face clinician encounter prior to receiving telehealth services

IN expands the Healthy Indiana program to include telemedicine

NY expands the care sites that may now be considered an originating site in order to provide telehealth services

ND has a bill to expand telemedicine services but the only providers would be advanced practice nurses

OK reimbursement for telehealth services would be the same as in person services

TX there is legislation to require the state Medicaid program to cover telemedicine services for children who are diagnosed with severe asthma. Another **TX** telehealth bill would include those on ventilators in the home to be managed by telehealth if certain conditions are met

VT to require Medicaid and insurance providers to cover telehealth services delivered outside a health care facility

WA several bills that support the expansion of telehealth services

EMS Compact Legislation

Over the past 3 years the concept of legislatively authorizing what is termed Multi-state Compact legislation has gained momentum. Basically these new laws when passed (and the majority are not enacted) revises licensing laws to make it easier for EMS personnel (sometimes only paramedics, sometimes only EMTs and most of the time both classifications: EMS personnel) to cross state lines without obtaining another license.

States that have Compact (Multi-State License) Legislation
MO (reintroduced from 2016 when it did not pass), **HI** a 3 year pilot demo, **MI, MS, & NY**

Conclusion

A verbal update will be provided at the Spring meeting

FINAL NOTE

It has been an honor and a privilege to serve as your AARC Director of Government Affairs for the past 29 years. Thank you for allowing me to have the job of a lifetime.

Federal Government Affairs Activity Report
March 2017

Cheryl West, MHA, Director Government Affairs
Anne Marie Hummel, Director Regulatory Affairs
Erika Miller and Zara Day, Legislative Lobbyists from CRD Associates, LLC

The Congress

Appropriations

A new Congress was sworn in in early January, but they must still finish the FY2017 appropriations bills that should have been addressed by the last Congress. In early December, Congress passed a continuing resolution (CR) to fund the government through April 28; this date was selected to give the Senate time to hold hearings and confirm President Trump's cabinet and Supreme Court pick. In the interim, we have learned from staff of the Labor, Health and Human Services, Education, and Related Committees subcommittee that Congress will pass a CR to fund the government for the balance of the fiscal year when the deadline is reached. In order to remain under the budget caps, we anticipate there will be a 0.5 percent cut to all programs, including health programs. The cut may increase depending on how Congress decides to pay for a defense appropriations supplemental and the President's proposed border wall.

Affordable Care Repeal and Replacement

Congress is moving ahead with a plan to repeal core elements of the Affordable Care Act (ACA), but some lawmakers are beginning to have second thoughts about how far they should go. Relying on a fast-track procedure called budget reconciliation, four congressional committees have been tasked with coming up with detailed repeal legislation, with a vote likely to come sometime in March. But that timeline could slip because many lawmakers have already begun to hear from constituents concerned about what repeal might do to their own healthcare. Other lawmakers are worried repeal could cause chaos in the insurance market, or that constituents could lose coverage altogether.

For some, the change in heart came with the release of a new report from the nonpartisan Congressional Budget Office concluding that ACA repeal would result in an estimated 18 million people losing health insurance in 2018, rising to 32 million by 2026. The report also stated that repeal would likely result in a 20 – 25 percent hike in health insurance premiums over the next year. As a result, some top lawmakers are shifting their sights from repealing and replacing ACA to the more modest goal of repairing it so as to avoid negative repercussions.

Perhaps the deepest split among Republicans is over what to do about the ACA's Medicaid expansion, which extended coverage to about 11 million new low-income people. Legislators from the 31 states that accepted the expansion are more likely to want to preserve that expansion and the federal funds that came with it.

Also at issue is what to do about the taxes assessed by the ACA, like the so-called Cadillac tax on employer-based health plans and the medical device tax. While some GOP lawmakers insist those tax provisions must go, others say the revenue is needed to help pay for any replacement plan.

As issues change daily, a verbal update via phone link will be provided at the Board meeting.

Legislation

AARC Capitol Hill Advocacy Day 2017

AARC Advocacy Day will kick off with a meeting update the afternoon of Monday, April 3, followed by respiratory therapists going to the Hill on Tuesday, April 4. We will continue to advocate that RTs be included in any telehealth legislation introduced in the new Congress. As you know, any bills not acted on in 2016 will have to be re-introduced. We also plan to ask Congressional leaders to ensure that language is added to the Labor-HHS Appropriations Report (FY 2018) requesting that CMS conduct a data analysis of COPD claims in various health care settings that will show how respiratory therapists improve health outcomes, reduce hospital readmissions, and lower costs. Further details will be discussed at the Board meeting.

Virtual Lobby Week 2017

Virtual Lobby Week will be from March 20 through April 4. Updates to our messaging are underway.

The Medicare Telehealth Parity Act

Our lobbyists have had several meetings with Cong. Harper and Cong. Thompson's staff about the reintroduction of the Medicare Telehealth Parity Act. They are aware of AARC's Advocacy Day on April 3 and sensitive to our desire to have it reintroduced prior to that time. With any bill, cost is always an important consideration. We have heard from legislative staff of a possibility that the Parity Act may be broken into smaller bills upon reintroduction in order to gain a more favorable score from the Congressional Budget Office. At the time of this report, we are not certain the direction the bill will take; however, a verbal update will be given at the Board meeting once we have more information.

The CONNECT for Health Act - (Clinical Opportunities for Novel and Necessary Effective Care Technologies)

The CONNECT for Health Act establishes a telemedicine demonstration waiver and covers telehealth and remote patient monitoring in alternative payment models and Medicare Advantage plans. As currently drafted, a key provision would lift current telehealth restrictions as to who can furnish telehealth services as long as they are enrolled in Medicare. Respiratory therapists would be excluded because they are not enrolled providers and there is no language in the Medicare statute to recognize them as such.

In the last session of Congress the bill had both House and Senate support, which is a key factor in moving legislation forward. The bill also has the support of over 90 organizations and is expected to be reintroduced, but cost was an issue last year and we are uncertain what shape the bill may take. It is also the bill supported by the Telehealth/Remote Patient Monitoring Coalition of which AARC is a member. Our lobbyists have been actively meeting with key Congressional leaders advocating for

respiratory therapists to be included as telehealth providers when the bill is reintroduced.

The CHRONIC Care Act - (Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care)

This bill is the result of months of work by the Senate Finance Chronic Care Workgroup in looking at ways to improve care for patients who suffer from chronic conditions, including expansion of telehealth services. The bill, which was introduced in December 2016, provides Accountable Care Organizations the ability to expand telehealth services, specifically covers telehealth for individuals with stroke, and enables Medicare Advantage plans to add telehealth services not currently covered as a supplemental benefit. The bill does not expand the type of practitioners who may furnish telehealth. When the Workgroup asked for comments on proposed policies prior to introducing a bill, AARC strongly suggested they include language from the Medicare Telehealth Parity Act that recognized respiratory therapists as telehealth providers.

Other Legislative Initiatives Supported by AARC

In the last Congress there were several bills AARC supported when they met with Congressional leaders during our Advocacy Day that are important to the pulmonary community. These legislative initiatives include grants to elementary/secondary schools to establish school asthma management plans, requiring airlines to stock no fewer than two packs of epinephrine auto-injectors in on-board medical emergency kits, and permitting physician assistants and nurse practitioners to provide direct supervision in cardiac/pulmonary programs. We will continue to support these efforts since they are expected to be reintroduced this year. A one page summary of the legislation will be included in the packets left with staff to review at their convenience.

Regulations/Other Advocacy Activities/Items of Interest

A new segment of this report will include a brief overview of topics in which AARC's Government Affairs has been busy promoting the value of RTs and the profession and advocating on behalf of our patients through comments to various government agencies and Congressional committees. Further as members of the Tobacco Partners Coalition and the Telehealth/Remote Patient Monitoring Coalition, the AARC often joins other stakeholders in jointly signing comments that impact our patients and the respiratory profession.

Advocacy Efforts on Behalf of the Profession and Patients

The October Executive Office Board Report provided an overview of 19 examples in which AARC has advocated on behalf of the profession. A sample of topics included 1) adding additional respiratory quality measures as part of the new physician payment system; 2) opposing Disney's vested interest in a media firm known to support the tobacco industry; 3) opposition to appropriations riders that would undermine FDA's authority to regulate tobacco products; 4) support to fund CDC's National Asthma Control Plan; 5) expansion of telehealth under Medicare, etc. Recent comments to various entities on behalf of the profession include the following topics:

· Ensuring respiratory therapists are part of the remote patient monitoring team to be included in a pilot project to monitor COPD and asthma via digital peak flow meters.

· Outlining the value of respiratory therapists in meeting the goals of the COPD National Act Plan.

· Ensuring that respiratory therapists are part of the Interdisciplinary Team to oversee the health and well-being of frail and elderly patients enrolled in Programs of All-Inclusive Care for the Elderly (PACE).

· Ensuring respiratory therapists met the qualifications as providers to furnish specialized rehabilitation services in long-term care facilities.

· Improving the transfer of health information for respiratory patients through improved quality measures for patients receiving post-acute care.

· Endorsement of new Pediatric Telehealth Procedures developed by the American Telemedicine Association with assistance from AARC members.

· Support for the creation of ICD-10-CM diagnosis codes relating to use of e-cigarettes and other electronic nicotine delivery systems (ENDS) requested by the American Thoracic Society.

· Recommending respiratory therapists to be included in the CHRONIC Care Act as telehealth providers.

Pulmonary Rehabilitation Issues

In the last Board report, we discussed CMS' proposal to significantly increase the payment rates in 2017 for hospital outpatient pulmonary rehabilitation programs. Unfortunately, when the final rule was published in November, the pulmonary community was shocked to see the final rates were substantially reduced – some back to the same rates as in 2012 (i.e., G0237-G0239). Based on public comments from a provider roundtable representing 14 hospital systems in 35 states, CMS revised the status indicator it uses to determine whether services are bundled or paid separately when the claim is submitted and that resulted in the reduction. AARC, together with other pulmonary organizations, met with CMS to discuss our concerns and the impact of such a reduction on patients and patient access. While nothing can be done for 2017, CMS was receptive to receiving input from the community on ways to improve their methodology as they develop rates for 2018. Plans are underway to submit comments to CMS some time in February. Additional details will be provided at the Board meeting.

On a separate issue, meeting representatives also discussed with CMS whether there was any leeway to exempt cardiac and pulmonary programs from statutory requirements that hospital outpatient departments located off-campus that have acquired physician practices be paid at the physician fee schedule rate for services now furnished as part of the hospital outpatient PPS. This issue was highlighted in the last Board report. Unfortunately, CMS has no option under the law to make changes. The impact could reduce the start-up of new programs and limit access to needed services. The only recourse is to seek a change in the legislation.

Home Mechanical Ventilation - Update

As you know from previous reports and discussions, AARC is one of several pulmonary

organizations and patient advocacy groups seeking changes to current local policies that impact coverage of noninvasive home mechanical ventilation. In the last Board report, we discussed efforts underway to gain Congressional support to facilitate a meeting with the Senate Legislative Counsel to start the process of drafting legislation. This was prior to the national election and change in Administration and, needless to say, the November outcome dramatically impacted the agenda.

Subsequent to the lame duck session, NAMDRC's lobbyist has been successful in reaching out to Chris Collins (R-NY), a key member of the Trump transition team and active member of the Energy and Commerce committee. His legislative director is working directly with House legislative counsel and is also eager to write a strong letter to the incoming Secretary of HHS once confirmation has been obtained. One holdup is ironing out language regarding FDA classification of devices and that is expected to be resolved soon.

Chronic Care Management (CCM) Services - Update 2017

In January 2015 CMS began paying separately for chronic care management (CCM) services for individuals with 2 or more chronic conditions expected to last at least a year or until death or put the individual at significant risk of an acute exacerbation. These services have been discussed in previous Board meetings as they offer an opportunity for respiratory therapists to work in physician offices where the RT can improve the care of COPD and asthma patients.

Addressing concerns that the current CPT Code 99490 did not account for more complex and more time-intensive chronic care coordination, CMS raised the payment rate for calendar year 2017 and added three additional codes in which payment can range from $43 to over $141, depending on how complex the patient's needs are.

Reform of Long-Term Care Facilities – Specialized Rehabilitation Services

As reported previously, CMS finalized regulations that updated and reformed policies and procedures for long-term facilities that included adding respiratory therapy as a specialized rehabilitation service. The changes, however, brought into question whether respiratory therapy time provided by RTs would be counted in the same manner as Physical Therapy, Occupational Therapy or Speech Therapy in determining the Resource Utilization Group (RUG) rates, which include staff time measures, resident assessments and cost calculations of resources. CMS responded that respiratory therapy time is not counted like the other therapies and instructions in the Resident Assessment Instrument should be followed.

CMS also added respiratory therapists as licensed health professionals to be consistent with language in the skilled nursing section of the Medicare statute. We have tried to get confirmation from CMS as to whether this means licensed RTs are required to provide respiratory services or whether specially trained nurses would be included. We are waiting for the interpretive guidelines which are under development to give us additional direction on this issue and will update AARC members and the Long-Term Care listserv when more specific information is available.

Competitive Bidding Round 2019

On January 31, CMS announced plans to consolidate all rounds and Competitive Bidding Areas (CBA) into a single round of competition for 2019. As a result of this change, Round 2019 will have

141 CBAs and a total of 11 products. Insulin pumps and supplies will be added to the national product category list. A new twist has been added that impacts CPAP devices. [NOTE: Subsequent to this announcement, CMS issued a statement that implementation will be delayed in order to give the new Administration time to review the plans. All information has subsequently been removed from CMS' website.]

Here is what we most likely can expect in the near future. CMS is adding 10 new CBAs specific to the CPAP devices and related accessories product category. No other product category will be subject to competitive bidding in these 10 new CBAs for Round 2019. In five of the 10 new CBAs, payment will be made on a bundled, non-capped monthly rental basis, with one monthly rental payment for the CPAP device, related accessories, and services for each month of use. In the remaining five new CBAs, payment will be made using the same payment rules for CPAP devices and related accessories in all other existing CBAs. In other words, payment in the remaining five new CBAs will be made for the CPAP device on a capped monthly rental basis, with separate payment on a purchase or rental basis for humidifiers used in conjunction with the CPAP device. Separate payment will also be made for the purchase of essential accessories (such as tubing and masks) and for repair of a beneficiary-owned CPAP device.

Some time ago, CMS announced that it was going to start bundling payments for CPAP devices but at the time no implementation had been set. CMS also planned to test the new payment in a number of CBAs. That plan is now coming to fruition. At the time of the proposal, AARC submitted extensive comments and concerns about the impact such a change would have on beneficiaries.

COPD Asthma and Monitoring Project (CAMP)

The Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group of Sacramento, CA recently submitted a proposal to the Physician-Focused Payment Model Technical Advisory Committee in the Department of Health and Human Services to implement an innovative payment model that remotely monitors Medicare beneficiaries with COPD and asthma via digital peak flow meters.

The model is designed to improve patient safety and quality of care and reduce health care expenditures through reduced emergency room visits and subsequent hospitalizations. A remote monitoring center headed by a "command center manager" would oversee the data transmissions supported by specifically-trained providers who will track member input and engage participants via voice phone, secure text messaging, email and video conferencing. A web-based, classroom-style individualized COPD/asthma education course and smoking cessation course is also planned.

In comments to the Committee, AARC stressed the need to have a respiratory therapist manage the commend center as well as lead the disease management course. Further, before a formal recommendation is made to the Secretary, AARC asked the Committee to get assurances from the sponsors that CAMP participants would have access to the expertise of skilled respiratory therapists since there was no mention of them in the proposal.

Operating Procedures for Pediatric Telehealth

The AARC has endorsed new procedures established by the American Telemedicine Association to

address the needs of our nation's pediatric population when receiving critical services via telehealth. The procedures cover such topics as patient privacy and safety, informed consent, special circumstances and the environment, emergency contingencies, mobile devices, clinical encounters and provider considerations.

In its endorsement, AARC emphasized its position statement that recognizes respiratory therapists as providers of telehealth under Medicare, Medicaid, commercial and other health insurance programs. AARC member Brooke Yeager and Dr. David McSwain from the Medical University of South Carolina Center for Telehealth were instrumental in providing substantial input into the development of the guidelines.

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. Updates will be provided at the fall meeting.

House of Delegates Report

Keith Siegel – Spring 2017

Recommendations

None

Report

- Worked with the Executive Office, House Officers, House Committee Co-Chairs and Delegates on house business.
- Appointed co-chairs to each HOD committee and worked with individual Delegates to get them on committees that interest them.
- Appointed House Officers as committee liaisons.
- Identified Speaker's goals, HOD objectives, committee charges, and committee calendar and disseminated documents to the House via AARConnect.
- Held monthly conference calls with House Officers and Executive Office liaison to share information and in support of House objectives, goals, strategies and charges.
- In January, held 1st quarterly joint conference call between House Committee Co-Chairs, House Officers, and Executive Office liaison to share information and in support of House objectives, goals, strategies and charges. Every committee was represented by at least one co-chair.
- Participated in monthly phone call with President Walsh to share information and identify areas where the HOD, BOD and EO can collaborate to further President Walsh's goals, improve the efficiency of HOD meetings, and strengthen the state affiliates and membership.
- Worked with Immediate Past Speaker Jakki Grimball on transition of Speaker roles and responsibilities.
- Participated in a conference call with the Delegate Assistance Committee to discuss updating DA policies.

I would like to thank President Walsh, my fellow House Officers and Parliamentarian, committee co-chairs, as well as Shawna Strickland and Asha Desai for all of your invaluable help and support.

Board of Medical Advisors Report

Submitted by Terence Carey, MD – Spring 2017

Recommendations

None

Report

As the Chair of the Board of Medical Advisors (BOMA) to the AARC, I am pleased to present the following report.

I. BOMA Membership

A. Dr. Loretta Grecu has replaced Dr. Thomas Fuhrman as one of the American Society of Anesthesiologists' representatives due to Dr. Fuhrman's appointment to the board of the National Board for Respiratory Care.
B. The American Thoracic Society will need to appoint a replacement representative to BOMA due to the resignation of Dr. Allen Dozor.
C. Of interest, BOMA, since its inception, has now had 5 members who started their careers as RTs (Drs. Christopher, Boehm, Fuhrman, Aranson, and Kelley).

II. Expectations of BOMA Members

A letter from the Chair was sent to BOMA members with the following expectations:

1. To become members of the AARC;
2. That attendance at the annual face-to-face meeting held at the fall AARC Congress and participation in spring conference call are mandatory; and
3. That BOMA members, representing their sponsoring societies, give verbal or written reports of those societies' activities that relate to the AARC.

III. BOMA Activities

A. BOMA supports the efforts of the AARC to help create an Advanced Practice RT (APRT), and announced that it would like to add one or more BOMA members to the AARC's *ad hoc* Committee in this effort, if the AARC's leadership sees fit. Considerable discussion took place at the October 2016 BOMA meeting, focused on the most effective ways to ensure the acceptance of the APRT qualification at the state level.

B. BOMA will be making nominations for the following awards:

1. Monaghan/Trudell Award

2. ARCF Mitchell A. Baran Achievement Award for Clinical Excellence in Aerosol & Airway Clearance Therapies
3. Forrest M. Bird, MD, PhD, ScD Lifetime Scientific Achievement Award
4. ARCF Dr. Charles H. Hudson Award for Cardiopulmonary Public Health
5. ARCF Mike West, MBA, RRT Patient Education Award

IV. BOMA Initiatives

A. Recruit medical directors of RT departments to join the AARC.

B. Encourage BOMA members to participate in the annual AARC Congress either as speakers or moderators.

C. Approach medical societies represented on BOMA to collaborate with the AARC in revising and creating guidelines that relate to respiratory care. Such a connection has already been made with CHEST/ACCP, facilitated by Mr. Steve Welch, its new EVP, and by Dr. Gerard Silvestri, its current president. In the past 2 years, the Board of Regents of the ACCP voted to approve advancement to fellowship of clinical non-physician members (eg, nurses, RTs, etc.). In addition, Dr. Silvestri has extended a welcoming hand to the AARC to have representation on its Program Committee.

D. Dr. Aranson, the current BOMA Chair, will be attending the AARC Patient Advocacy Day in Washington, DC in April.

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Medical Advisors Meeting

October 16, 2016– San Antonio, TX

Minutes

Attendance

Terence Carey, MD (ACAAI), Chair
Robert Aranson, MD, FACP, FCCP, FCCM, Chair-elect (ACCP)
Steven Boas, MD (AAP)
Russell Acevedo, MD, FCCP (ACCP)
David Bowton, MD, FCCP (ACCP)
Ira Cheifetz, MD, FCCM, FAARC (SCCM)
Lori Conklin, MD (ASA)
Loretta Grecu, MD (ASA)
David Kelley, DO (ASA)
Janet Lioy, MD (AAP)
Neil MacIntyre, MD (ATS)
Col. Michael Morris, MD, FACP, FCCP, USA RET
Peter Papadakos, MD, FCCM, FAARC (SCCM)
Frank Salvatore, MBA, RRT, FAARC, BOD Liaison to BOMA

Excused

Paul Selecky, MD, FACP, FCCP, FAARC, FAASM (NAMDRC)
Kent Christopher, MD, RRT, FCCP (NAMDRC)
Harold Manning, MD, FCCP (ACCP)
Robert Brown, MD (ATS)
Allen Dozor, MD (ATS)
Kevin Murphy, MD (ACAAI)
Ravi Tripathi, MD (ASA)

Guests

John Wilgis, MBA, RRT

Staff

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

CALL TO ORDER

The Chair, Dr. Carey, called the meeting of the AARC Board of Medical Advisors to order at 10:00 am CST.

INTRODUCTIONS

The Chair, Dr. Carey, asked members to introduce themselves asked members to disclose any potential conflicts of interest:

Aranson – ACCP Board of Regents
Papdakos – NYS Board of Profession
Bowton – Pacira Pharmaceuticals, Covidien
Morris – Boehringer-Ingelheim
Conklin – VA Board of Medicine
MacIntyre – Consultant: Ventec, Breathe, Inspirx, Alana

APPROVAL OF MINUTES

Dr. Aranson moved to accept the minutes of the April 25, 2016 conference call of the AARC Board of Medical Advisors.

Motion carried

CHAIRMAN'S REPORT

Dr. Carey stated that Dr. Aranson was sworn in at the Business Meeting this morning as the new chair of BOMA. The key initiative of the AARC is the advancement of the profession at this time and changing the required degree from an Associate to a Bachelor degree. A discussion arose about guidelines and protocols for respiratory therapists in hospitals and in other settings.

Dr. Carey thanked the Board of Directors for their leadership and commented that the association is in very good hands.

Frank Salvatore and John Wilgis gave an update of the Ad Hoc Committee on Advanced Practice Respiratory Therapy (APRT) (See Attachment "A" from John Wilgis). Dr. Aranson stated he will add BOMA members to assist with this Ad Hoc Committee.

CoARC (Commission on Accreditation for Respiratory Care) Report

President of CoARC, Brad Leidich, gave highlights of the CoARC written report submitted. CoARC Executive Director, Tom Smalling, and Associate Executive Director, Shane Keene, were present.

NATIONAL BOARD FOR RESPIRATORY CARE

President of NBRC, Robert Joyner, gave highlights of its submitted written report. NBRC Executive Director, Gary Smith, and Chief Operating Officer, Lori Tinkler, were also present.

A discussion arose about the independence of respiratory therapy practice. Dr. Conklin and other BOMA members advised that the phrase, "supervised by a physician at all times," should be used in order to achieve acceptance of the APRT credential. Physician Assistants fear they may lose their jobs to respiratory therapists.

EXECUTIVE DIRECTOR REPORT

Executive Director, Tom Kallstrom, gave highlights of his submitted report. Many partnerships were enhanced in 2016: Pulmonary Fibrosis Center, ALA, AAN, AACVPR, COPDF, and Alpha-1 Association.

The Chinese Thoracic Society is coming to Dallas next week to visit hospitals and witness how respiratory care is performed in the United States.

AARC PRESIDENT'S REPORT
Frank Salvatore gave highlights of his submitted written report.

RECESS
Dr. Carey recessed the meeting of the Board of Medical Advisors at 12:10 pm CST.

RECONVENE
Dr. Carey reconvened the meeting of the Board of Medical Advisors at 12:50 pm CST.

LEGISLATIVE AFFAIRS REPORT
Cheryl West provided updates on state legislative issues, including those states that are undertaking efforts to move to the "RRT only" as a state licensure requirement. Ann Marie Hummel provided more detail on various Medicare regulations impacting the profession as well as updating the status of the Telehealth Parity Act. The dates for the 2016 AARC Hill Advocacy event have been set for April 3-4, 2016.

OTHER REPORTS
Tom Kallstrom gave highlights of the submitted ARCF report. The 4th annual ARCF fundraiser was held Friday night. Preliminary reports suggest that ~$50,000 were raised. Billy Dawson, Nashville entertainer at the fundraiser, is very involved with the COPD Foundation. Neil MacIntyre spoke about the ARCF awards. The new Mitch Barron Award stipulates that BOMA must endorse the nominees. Tom mentioned the upcoming Journal Conference in June 2017.

AWARD NOMINATIONS
Dr. Carey reminded BOMA members that nominations from BOMA for the Bird, Hudson, and West awards are due by June 1, 2017. The new Monaghan/Trudell Award requests that BOMA be more involved in choosing the nominees.

AARC President, Brian Walsh, introduced himself to the Board of Medical Advisors and shared his 2017-18 presidential goals.

SPECIALTY SECTION REPORTS
The Specialty Section Reports were reviewed.

UNFINISHED BUSINESS
There was no unfinished business.

NEW BUSINESS
There was no new business.

ADJOURNMENT
Dr. Carey adjourned the meeting of the AARC Board of Medical Advisors at 2:15 pm CST.

Attachment “A”

Exploring the Current Status of Mid-Level Provider Density and Sufficiency of Educational Background in the Care of Patients with Cardiopulmonary Disease

Exploring the Current Status of Mid-Level Provider Density and Sufficiency of Educational Background in the Care of Patients with Cardiopulmonary Disease

The American Association for Respiratory Care (AARC), a not-for-profit professional association based in Dallas, TX represents more than 52,000 respiratory therapists and allied health practitioners trained to assist physicians in the care of patients with lung disorders and other conditions worldwide. The AARC is working to explore the current status of Mid-Level Provider density and sufficiency of the educational background of currently practicing mid-level providers in the healthcare of patients afflicted with cardiopulmonary disease.

As the AARC is the non-physician professional organization specifically supporting the care of patients with cardiopulmonary disease, we are obligated to assure our patients have access to the medical care needed to optimize their health.

It is well-accepted that appropriate health care leads to better quality of life for the patient. Appropriate and timely healthcare reduces overall cost through reductions in acute care (e.g., decrease hospital re-admission, decreased ICU length of stay) for exacerbations of disease and improved management of chronic maladies.

It is also well accepted that while the role of mid-level providers is increasing in the United States healthcare system, there are no mid-level provider educational programs specifically directed at care of patients with cardiopulmonary disease. Additionally, to date, there has been no formal assessment of mid-level provider roles and responsibilities in the healthcare of patients with cardiopulmonary disease. There is no data available to allow the AARC and other groups to facilitate planning for the future needs of the patients we serve.

To this end, the AARC solicited voluntary support from the three professional organizations governing the profession of Respiratory Care (i.e., AARC, the National Board for Respiratory Care, and the Commission on Accreditation for Respiratory Care) to establish a collaborative working group charged with evaluating published data and provide the AARC with recommendations on how best to assess the future needs of patients suffering from cardiopulmonary disease.

Specific outcomes of the working group include:

- Create and conduct a national needs assessment of essential stakeholders to gain an understanding of the status of healthcare availability to patients afflicted with cardiopulmonary disease being treated by mid-level providers.

- This needs assessment is anticipated to provide objective data essential for the three professional organizations to develop an opinion on the practitioners we represent and the patients we serve and provide insight into future needs of the US healthcare system.

It is anticipated that a needs assessment will be completed in 2017. At that time, the AARC will provide information to the Board of Medical Advisors derived from the data provided by stakeholders.

President`s Council

Submitted by Dianne Lewis – Spring 2017

Recommendations

None

Report

This year the Presidents Council has chosen Robert L Chatburn MHHS RRT-NPS FAARC as the Jimmy A. Young Medal Winner. He has served the AARC for many years and innumerous capacities. Please congratulate Rob on this award.

At this time nothing new to report. We are waiting for the nominations from the HOD for Life and Honorary membership.

Other

The BOD will be nominating for Life and Honorary members at this meeting. The list of previous winners and criteria will be available for your review.

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	Alfred Sofer, MD
	Jerome M. Sullivan	
1992	Patrick J. Dunne	David J. Pierson, MD
	Phil Kittredge	
1993	Bob Demers	Richard L. Sheldon, MD
	Bernard P. Gilles	
1994	Philip R. Cooper	Forest Bird, MD, PhD, ScD
	Dianne L. Lewis	
1995	Deborah L. Cullen	Neil R. McIntyre, MD
	Patricia A. Wise	
1996	Jim Fenstermaker	Steven K Bryant, MBA
	Trudy J. Watson	
1997	Charlie G. Brooks, Jr.	Charles Durbin, MD
	Pat Brougher	
1998	Kerry E. George	Barry A. Shapiro, MD
	W. Furman Norris	
1999	Dean R. Hess	James K. Stoller, MD
	Cynthia J. Molle	
2000	Jerry Bridgers	Michael T. Amato
	Dianne Kimball	William Bernhard, MD
2001	Robert Fluck	
	Garry W. Kauffman	Sherry Milligan
2002	Susan B. Blonshine	
	William Galvin	
	Carl Weizalis	

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
2016	Colleen Schabacker George Gaebler	Bruce Rubin

Revised November 2015

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 Teri Miller – Spring 2017

Recommendations

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

Report

Due to the timing of the audit and Board of Directors meeting, a verbal report will be given.

Bylaws Committee

Submitted by: Bob DeLorme - Spring 2017

Recommendations

That the AARC Board of Directors find that the Illinois Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws.

That the AARC Board of Directors find that the Nebraska Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws.

That the AARC Board of Directors find that the Idaho Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws.

That the AARC Board of Directors find that the Kentucky Society for Respiratory Care Bylaws are not in conflict with the AARC Bylaws.

(See attached file "Bylaws" for copies of the above mentioned bylaws.)

Report

The AARC Bylaws Committee has approved and submitted the following State Affiliate Bylaws: Illinois, Nebraska, Idaho and Kentucky Bylaws and their Amendments for review and approval by the AARC Board of Directors.

The Committee will start work on answering a question from the HOD. The HOD has asked for an interpretation of:

Article VII,
Section 6(a) states:

"Each delegation shall have one (1) vote for each Active Member within their Chartered Affiliate as submitted by the Executive Office and certified by the House of Delegates Credentials Committee."

Here is the HOD question: "The question has been raised whether every vote, whether significant or routine, must be done by a poll vote, whereby we individually poll each affiliate and award one vote for each member of that affiliate?"

The Bylaws committee will be reviewing the question and hopefully giving an interpretation and if needed a suggested Bylaws change for consideration at the summer meeting.

There will also be one Bylaw the committee will review to see if it should be deleted.

ARTICLE X – CHARTERED AFFILIATES
SECTION 4. DUTIES

"A copy of the minutes of every meeting of the governing body and other business meetings of the Chartered Affiliates shall be sent to the Executive Office of the Association within thirty (30) calendar days following the meeting."
This particular wording was removed from the article dealing with International Affiliates. The committee will consider if this particular article should also be deleted because the Charter Affiliates are separate legal entities, as such they are not required to share these corporate documents to the AARC.

Thanks to the committee members: Brian Cayko, Heather Neal Rice, Raymond Pisani and Frank Salvatore

Elections Committee

Submitted by: Mary Roth - Spring 2017

Recommendation

None

Report

1. Call for nominations have been sent out, for the positions of President Elect, two Directors at Large, three Specialty Sections-Continuing Care, Transport & Long-term Care.

2. Because of low number of nominees a letter to Continuing Care & Long-Term Care, section chairs was sent to ask their sections to submit nominees.

3. Deadline for nominations is 2/28/17.

Executive Committee

Submitted by: Brian Walsh - Spring 2017

Verbal report

Finance Committee Report

Submitted by: Brian Walsh - Spring 2017

Verbal report

Judicial Committee

Submitted by Anthony Dewitt – Spring 2017

Recommendations

None

Report

- The committee has fulfilled all assignments given to it.
- At present there are no issues before the committee that require disposition.
- No disciplinary matters have been reported, and none are pending.

Program Committee

Submitted by Thomas Lamphere – Spring 2017

Recommendations

That the AARC Board of Directors approve the following members of the 2017 AARC Sputum Bowl Committee.

Renee Wunderley – Committee Chair
Sherry Whiteman - Score Keeper
Rick Zahodnic - Practitioner Moderator
Angie Switzer - Student Moderator
Julie Boganwright - Timekeeper

Justification: The 2016 AARC Sputum Bowl was a great success thanks in large part to the efforts of the Sputum Bowl Committee. The preliminary rounds ran smoothly with terrific competitions held in both the student and practitioner divisions. The "finals night" competition went off without any problems and the audience enjoyed the event! Renee Wunderley chaired the committee for the first time in 2016 and did a great job before, during and after the event ensuring the numerous tasks were all completed.

The recommendation for the new committee members includes several changes from 2016. Tom Lamphere will be leaving the committee in order to focus on his responsibilities as chair of the Program Committee. Mr. Lamphere has served as the moderator of the student competitions and that role will now be assumed by Angie Switzer. Mrs. Switzer will also take on the main responsibility for ensuring the question bank is updated and ready to go for the competition.

Julie Boganwright was a volunteer at the 2016 competition and did an outstanding job! She fits in perfectly on the committee and is recommended for the vacancy on the committee. Rick Zahodnic and Sherry Whiteman have several years of experience on the committee and will ensure that things run smoothly.

Report

1. Prepare the AARC Congress Program, Summer Forum, and other approved seminars and conferences.
Status: The committee met in Dallas on Jan. 12-14, 2017 to review approximately 575 individual lecture proposals submitted in ten different specialty areas and ten different 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: The meeting locations for both Summer Forum and Congress have been approved by the BOD for 2018 (San Antonio, TX and Las Vegas, NV, respectively).

The next open year for AARC Summer Forum is 2019 and AARC Congress is 2020. 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 by the summer meeting.

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 2017 Summer Forum and 2017 Congress. The Program Committee dedicated a significant amount of time to reviewing all of the proposals. While the decision as to which topics were ultimately accepted was typically difficult, the committee concentrated on providing content that focused on hot topics, industry priorities and membership feedback from the 2016 meetings. Additionally, the committee ensured that President Walsh's goals of quality, safety, and value were common themes and are well represented in the final program.

5. Miscellaneous
The length of Congress presentations will remain at 35 minutes in 2017 in 8 concurrent sessions as was the case in 2016. Additionally, timers visible to both the speaker and moderator will be present in all lecture rooms and moderators will also have laminated signs to remind the speaker how much time remains (i.e. 15 minutes, 5 minutes, "Time is Up"). This should help to keep speakers on time.

Strategic Planning Committee

Submitted by Frank Salvatore – Spring 2017

Recommendations

None

Report

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

The strategic workgroups will give updates during the meeting.

See attached file “Strategic Planning Cmte”.

Specialty Section Reports

Adult Acute Care Section

Submitted by Keith Lamb – Spring 2017

Recommendations

None

Report

The section continues to use Connect to discuss case reports, imaging and current trends in patient care and science and presenting journal club articles.

Case Reports are being done by other members, and a list of future presenters is being kept by section leadership so that there is one planned for every month. This format is going very well.

Continue to produce a biannual bulletin and quarterly newsletters.

Members of the section continue outreach internationally, high level research, and publishing in multiple peer reviewed journals.

We have a Virtual Section Meeting planned for February 22nd. An agenda is to be sent out prior to the meeting. We will ask for recommendations from the section members that attend in order to plan future meetings that we hope will include lectures and presentations on topics that are suggested by the section members.

Continuing Care-Rehabilitation Section

Submitted by Krystal Craddock – Spring 2017

Recommendations

None

Report

Activities to date:

- Engaging members by posting journal discussion from RCJ publication "A Respiratory Therapist Disease Management Program for Subjects Hospitalized With COPD".
- Submitted spring 3 bulletin articles. Topics include incorporating a choir into pulmonary rehab, starting up a COPD readmission reduction program at a small community hospital, and 2017 GOLD guideline updates.
- Frequently posted/encouraged members to submit for lecture topic ideas and speakers at the AARC summer forum and congress.
- Continually responding to posts and/or connecting members with others as needed.

Other

Goals moving forward:

- Would like to engage and encourage member's participation more. Seems they respond to posts that are questions and very willing to help others but would like to see if / how we can get more involvement via case studies or journal discussions.
- Need to recruit members to write for the fall bulletin early and with new and interesting topics for our section.
- Must encourage nominees for new chair. An election is due to occur for a replacement as I have been asked to step in as interim chair by President Brian Walsh.

Diagnostics Section

Submitted by Katrina Hynes – Spring 2017

Recommendations

None

Report

2017 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 6, 2017.
    a. *Charge met. All proposals were reviewed by the Chair and feedback provided to Thomas Lamphere for consideration by the program committee for the 2017 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 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 Board Report.
    a. *Biannual virtual Respiratory Diagnostic Specialty Section Meetings have been identified; confirmation with the Executive Office is pending approval.*
    b. *January 2017 the ERS-ATS published the new Technical Standards on Diffusing Capacity of the Lungs. This information was communicated to the Section Members via the AARConnect List Serve.*
3. 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 PowerPoint and encouragement to inexperienced speakers who aspire to stand at the podium.*
4. Enhance communication with and from section membership through the section AARConnect, 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 via e-mail, AARConnect, conference call, etc.*
5. 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 Board Report and updated for each Board report.
    a. *The Diagnostic Section library and swap shop materials will be reviewed annually.*
    b. *A taskforce has been created, consisting of 6 section member volunteers, to review and reorganize the Diagnostic Section Library, as well as update the resource contact list. The project will begin the 1st quarter. Progress to be reported in the 2nd quarter board report.*
6. 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 and Mrs. Susan Blonshine co-authored the article titled *CPET: Quality Assurance* pending publication in the AARC Times.
2. Ruppel's Manual of Pulmonary Function Testing, 11th Ed. by Carl Mottram published February 2017.
    a. Mrs. Katrina Hynes contributed chapters 8 and 10
    b. Mrs. Susan Blonshine contributed chapter 12
3. Mrs. Katrina Hynes and Mr. Carl Mottram co-authors Chapter 5, Pulmonary Function Testing, in Neonatal and Pediatric Respiratory Care, 5th Ed. by Brian Walsh pending publication.
4. Mrs. Katrina Hynes was elected 2017 AARC Respiratory Diagnostic Section Chair for a second term.
5. Jason Blonshine elected 2017 Michigan State Society, Diagnostic Section Chair-Elect.
6. Mr. Ralph Stumbo Jr. was named 2016 Diagnostic Section Practitioner of the Year.
7. Mr. Carl Mottram RRT FAARC, Director of the Pulmonary Function Laboratories and Associate Professor of Medicine at the Mayo Clinic was elected as 2016 President-Elect for the Clinical and Laboratory Standards Institute. In this role he also serves on the Executive Committee of the Board.
8. Mrs. Katrina Hynes was elected AARC Alternate Representative to the Joint Commission Professional and Technical Advisory Committee (PTAC).
9. 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.
10. 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 2017

Recommendations

None

Report

- First and foremost, advocate for your section members utilizing the BOD reporting and recommendation process.

Status: A new business item was suggested to engage associate degree programs in facilitating a stronger career pathway for their graduates to earn a baccalaureate degree.

- Create section specific measures of success and present to the board at least once a year.

Status:

1. Achieve a section membership of 1100 members by September 30, 2017
2. Develop two-way dialogue between representatives of associate degree programs and the Education Section/AARC leadership regarding establishing a strong career pathway for associate degree graduates to pursue a baccalaureate degree.
3. Identify education research ideas together with section members either through discussions on AARC Connect or at national meetings to facilitate the goals of the AARC. These ideas can serve as the foundation for collaborative research or provide ideas for educators who are seeking relevant projects.

- 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 December.

Status: Collaborated with the education representative to the program committee and AARC liaison to outline the Summer Forum pre-course, Summer Forum, and International Congress programs.

- 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 Board Report.

Status: The final quarter of 2016 engagement activity was the Education Book Club. This year's first quarter activity will be a Scholarship of Teaching and Learning discussion of an article from the 2016 Respiratory Care Education Annual.

- Jointly with the Executive Office, undertake efforts to demonstrate value of section membership, thus encouraging membership growth.

Status: Messages to promote the Student webcast (February 2017), enhancement to the Student Education Channel were reinforced on Connect. An article in the February issue of

AARC Times was also written to promote the education career pathway for RTs in clinical settings to pursue future teaching positions.

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

Status: The request for this award along with the scoring rubric used to evaluate candidates will be promoted in late spring.

- Identify, cultivate, and mentor new section leadership. Section leadership is only allowed to serves one term.

Status: The chair-elect is being copied on section business to provide an orientation. Feedback provided by the elections committee to section members who were not added to the ballot has been very effective in providing potential future leaders with goals to better position themselves for nomination in the next term.

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

Status: There is regular weekly communication on the Education section in Connect. Responses to section members' requests have been provided within 48 hours.

- Encourage networking and the use of AARC resources such as the AARConnect library, swap shop and listserve that promotes the art and skill of respiratory care.

Status: Tabatha Dragonberry has been posting around once/month with information from the Mentoring Excellence resource. Tim O'pt Holt will be promoting ideas to recruit future respiratory care educators.

- 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 Spring Board Report and updated for each Board report.

Status: In-person contact with membership at the Summer Forum will be used to recruit a team of volunteers to review the materials in the Swap Shop. The Connect library is up-to-date.

- Share best practice with fellow section chairs to improve value or membership participation.

Status: A letter summarizing the value of the Education Section was shared with Amanda Feil for circulation to other section chairs. The process of creating this letter by engaging other education members was shared at the section chair orientation webcast.

- 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 as of January 31, 2017, was 1066. A recruitment push at the end of October and November utilized a team of 15 state representatives who targeted educators in their state to join the Education Section. With the assistance of the AARC office, members who had their memberships expiring in the months of November and December were specifically identified and this information was passed along to the state representative. A

letter summarizing the benefits of the Education Section that was collaboratively drafted was sent to the state recruiters to provide a list of services to pitch. End of month statistics will be used to report and track a more consistent membership value. In-person phone calls helped identify that online membership renewals did not automatically prepopulate specialty section membership. This information was shared with the AARC office and this problem has been resolved.

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

Status: The programming for Summer Forum and the International Congress has been developed with clinical educators in mind. The Education Book Club and the Scholarship of Teaching and Learning have also address topics with wide educational appeal. Further a collaborative email with the management section chair was sent to encourage managers to foster an education career pathway with their clinical staff members who are interested in teaching.

Home Care Section

Submitted by Zach Gantt – Spring 2017

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**
    - 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.**
    - Started to create conversation on AARConnect, will increase presence on Connect over the next quarter. Spoke with Shauna Strickland and Tom Kallstrom 2/20/16 about various issues, including how to do webinars or section meetings for the membership
3. **Undertake efforts to demonstrate value of section membership, thus encouraging membership growth.**
    - Working with the two largest GPOs for homecare VGM and Medgroup as well as AAhomecare to try to drive interaction and engagement
    - Working with various manufacturers to drive engagement and push for homecare membership
4. **Solicit names for specialty practitioner of the year and submit the award recipient in time for presentation at the Annual Awards Ceremony.**

    Will begin to advocate for nominations
5. **Identify, cultivate, and mentor new section leadership**.
    - New to the position but will begin to look at ways to do this over the next quarter
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.**

- Current information is up to date, but information is limited.

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.**

    - AARC Connect has been monitored and topics are relevant.

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.**

    - Membership continues to be a problem.
    - The Home Care, Long term care and Continuing Care sections were surveyed to gauge support for combining the sections. Positive results for combining all 3 sections, but concerned with the amount of responders.
        - Awaiting financial impact report

Long Term Care

Submitted by Gene Gantt – Spring 2017

No report submitted.

Management Section

Submitted by: Cheryl Hoerr – Spring 2017

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: 106 individual proposals were submitted under the management section. Section Chair collaborated with the Program Committee Liaison to review submitted proposals. Presentation slots for both the Summer Forum and the International Respiratory Congress and Exhibition were populated with topics of interest to RT leadership with a special focus on those that coincide with AARC strategic goals. There was an additional focus on collaborative sessions targeting both managers and educators.

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

   Status: The decision was made to eliminate the section bulletin. Roger Berg tendered his retirement (related to health issues). Despite several pleas for new material on line and at section meetings, we have received no inquiries and no submissions for the spring bulletin as of this writing. Ongoing interest in 2016 was lackluster and the decision was made to cease publication n 2017. We are working on scheduling an online management section meeting in March and a live section meeting will be held 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. Managers are encouraged to join the Leadership Book Club community on Connect and contribute to the discussions. Managers were also encouraged to submit proposals for presentation at the AARC Congress and Summer Forum, as well as for the Open Forums.

4. Identify, cultivate, and mentor new section leadership

   Status: Julie Jackson was chosen as the Management Section Specialty Practitioner of the Year. Julie is currently serving the ISRC as a delegate to the AARC House of Delegates, and is also an

ISRC past president. She will be a speaker for the Management Track during the Summer Forum. On an ongoing basis section members are encouraged to (1) contribute content to the management section list serve, (2) attend the Summer Forum in order to meet other RC leaders, (3) join the Leadership Book Club to grow their skills, and (4) to submit a proposal for the Summer Forum and/or International Congress and Exhibition.

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 infection prevention, terminology (e.g., "vent checks" vs "patient ventilator assessments"), BS degree requirements by CLIA moderate complexity labs, CPT coding, other healthcare professionals administering respiratory therapy, medical gas and equipment storage regulations, and miscellaneous equipment and treatment modalities.

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: Five 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. No work has been able to be accomplished on this project due to competing priorities.

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 1,480 active members and 1,521 total management specialty section members. Amanda Feil, AARC Membership Development Manager, has been planning a survey of management section members to gather ideas about the value of membership, actions managers have used with success to recruit new members, and overall membership experience.

Neonatal-Pediatrics Section

Submitted by Steve Sittig – Spring 2017

Recommendations

None

Report

- The section list serve continues to be active with relevant content.
- The section submitted numerous content related topics for 2017 AARC Congress.
- Planning content related quarterly president directives with AARC Office.

Sleep Section

Submitted by Katherine Turner - Spring 2017

No report submitted.

Surface to Air Transport Section

Submitted by Tabatha Dragonberry - Spring 2017

Recommendations

None

Report

- There have been many discussions on what experience should be suggested for therapists transitioning to transport. We would like for a recommendation be created to highlight the preferred experience for RTs.
- In contact with Jon Inkrott and Olivia Jenkins who are interested in running for Section Chair
- Jon Inkrott placed our first case study up to engage membership on discussion board to add value
- Olivia Jenkins will post case study next month
- Looking for other RTs interested in creating an engaging case scenario for DB

Special Committee Reports

Benchmarking Committee

Submitted by: Chuck Menders – Spring 2017

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. Continued to utilize email and AARC Connect to discuss current state of benchmarking program, issues, and upcoming actions and needs.

3. Work has begun on developing AARC Benchmarking 2.0 utilizing the best of the current program and streamlining the keys components of that system with a new platform, new reports and new metrics, including outcome metrics.

4. Committee is providing testing and feedback as it is requested. Rick Ford, Cheryl Hoerr, Tom Berlin and Chuck Menders continue to serve as the Project Advisors.

5. The basic shell of the new product has been developed, but further work was slowed by personnel/leave of absence issues. However, another programmer has stepped in and is now continuing work on the project.

6. We hope to have our new Benchmarking 2.0 system ready to resume testing by the end of the 1st quarter, and deployed soon after.

7. Devore Technologies was given 60 day notice that we are terminating our relationship with them as host for our legacy system in January, and requested transfer of all assets from Devore to the AARC.

8. Membership in AARC Benchmarking has decreased from 61 on September 10, 2016 to 56 subscribers as of February 9, 2017. Once the new system is launched, we will reach out to previous subscribers about Benchmarking 2.0 and an opportunity to re-subscribe.

Billing Codes Committee

Submitted by: Susan Rinaldo Gallo – Spring 2017

Recommendations

None

Report

In addition to the Coding list serve, many billing and coding issues are posted on the Management list serve as well. An example of a recent coding topic that was discussed on the Management list serve is below. The discussion was related to changes in CMS NCCI policy, (January 1, 2017) to the inhalation treatment codes. Restrictions on the use of this code have occurred every year for the past 3 years!

Below is my post from January explaining the NCCI changes.

Many times on this list serve we have discussed the changes for billing CPT Code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction...)

As you probably remember, restrictions were placed on code 94640. It could only be reported once during a*n **episode** of **outpatient** care* regardless of the number of separate inhalation treatments administered.

We had several postings about what constituted an "episode". This was interpreted differently by various health care institutions causing lots of confusion. Many groups, (including the AARC) must have sent questions. Well now CMS has defined an episode it relates to this specific code. The following is from the most recent NCCI (National Correct Coding Initiative) edit from CMS:

"An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility. If a patient receives inhalation treatment during an episode of care and returns to the facility for a second episode of care that also includes inhalation treatment on the same date of service, the inhalation treatment during the second episode of care may be reported with modifier 76 appended to CPT code 94640." This change takes place January 1, 2017.

Diversity Committee

Submitted by: Crystal Dunlevy/Jakki Grimball – Spring 2017

Recommendations

None

Report

1. Jakki Grimball and Crystal Dunlevy have each authored an article on diversity for the March issue of *AARCTimes*; Crystal will do an AARC webinar on Implicit Bias in March.
2. AARC Level of Diversity
    - The Executive Board approved a survey which was sent to the AARC leadership (State Society board members, delegates and officers; AARC board members, committee chairs and specialty section chairs) in January. Response rate was 67% 141/210). Results: respondents were primarily White (91%), heterosexual (94%); and female (56% vs 42% male).
    - Shawna Strickland will request approval from the Executive Board to survey the membership via a link in the diversity issue of *AARCTimes* (March) and "News Now."
3. Jakki is collecting input from committee members about improvements and edits that need to be made to the current web page through 2/22. (http://www.aarc.org/resources/professional-documents/cultural-diversity-resources/).
4. Diversity video series
    - The committee voted unanimously to assemble a video series of topics related to diversity/cultural competence/healthcare disparities.
    - Crystal is collecting suggestions for both topics and speakers through 3/3.
5. There are currently no CRCE offerings that are related to diversity.
    - Washington, D.C. requires that 2 CRCEs be dedicated to LGBTQ sensitivity. State boards will likely follow suit.
    - To that end, the committee voted unanimously to develop one 2 CRCE offering or two 1 CRCE offerings on LGBTQ healthcare issues.
    - Crystal and Jakki solicited suggestions for authors and topics through the end of March.

Federal Government Affairs Committee

Submitted by Frank Salvatore – Spring 2017

Recommendations

None

Report

1. Find ways to gain support for the Telehealth bill. **(Ongoing)**
    - We're working with Cong. Greg Harper's office to get the bill reintroduced in this congress. If we have a bill number by the time of the meeting, we will update the board.
2. Investigate ways for Respiratory Therapist to be recognized as professionals by the government. (Department of Labor, Department of Defense, etc.) **(Ongoing)**
    - President Walsh has been working with Anne Marie Hummel to work on putting together a letter to try to get the DOL to review and render an opinion based on the current state of the profession.
3. Assist the State Societies with legislative and regulatory challenges and opportunities as these arise. Over the next two years provide assistance to states that begin moving toward RRT and/or BS entry for those seeking new license. **(Ongoing)**
    - Committee leadership is working on a document to provide to states who are looking into moving to RRT Entry Licensure. Will provide copy once completed for the board to review.
4. Work with PACT coordinators and the HOD to establish in each state a communication network that reaches to the individual hospital level for the purpose of quickly and effectively activating grassroots support for all AARC political initiatives on behalf of quality patient care. **(Ongoing)**
    - Communication in preparation for the VLW and the PACT Hill day has commenced.
5. Oversee the virtual lobby week and/or any calls to action that come up over the year. **(Ongoing)**
    - The virtual lobby week is set to begin March 20, 2017. We are ramping up our communication to both the PACT and the HOD-President's List Serves.
6. Assign committee members specific states to act as liaisons toward and ensure the members communicate with their liaison state during active committee work periods. **(Completed)**
    - The committee members have been assigned states and will be the primary liaison to those states for both federal and state issues.
7. Assist in coordination of consumer supporters. **(Ongoing)**

Measures of success:

- 20% increase in the number of co-signers of the Telehealth bill.
- Produce 10% more emails sent to Capitol Hill this virtual lobbying week.

Fellowship Committee

Submitted by: Patrick Dunne – Spring 2017

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 early October dates of the AARC Congress, the 2017 deadline for receipt of online nominations for Fellow will be Saturday, July 1st. The Selection Committee will then commence review of all nominations received by the established deadline. The selection process will be completed by mid-July with notification letters being sent shortly thereafter.

International Committee Report

Submitted by John Hiser – Spring 2017

Recommendations

None

Report

1. Coordinate market and administer the International Fellowship Program.

   We are in the process of gearing up for this year. The web site and the online application have been updated. A call for applicants has been posted on AARC Connect, various list serves and in AARCTimes.

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

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

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

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

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

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

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

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

Measures of Success

1. Host at least 5 International Fellows this year.
   As you know the International Fellowship program in administered by the AARC, funded by the ARCF and supported by the ICRC. Each year for the past several years, with the exception of 1 year, we are informed by the ARCF as to how many fellows they will fund for a particular year. As I understand it, this number is based upon the number of sponsors. The ARCF has a policy of funding 1 fellow per 2 ($5000) sponsors. In other words, a 2 to 1 ratio.
   I'm told that the cost per fellow is approximately $5000.

It is not within the committees' ability to influence the number of fellows invited to participate in the program. This is something that is controlled by the ARCF.

2. Production of collaborative educational programs guidelines, recommendations or position statements.
   The committee stands ready to assist in any way possible.
3. Track and publicize AARC leadership travel to countries outside the USA in support of our Mission and Vision.
   Several articles have been published in the past regarding leadership travel outside the US. I would encourage all members of the Board and the House, and also individual members to let me know of any travel for seminars, workshops, medical mission trips or other activities related to international activities. Each year I try to include as many of these as possible in the *AARCTimes* international issue in December of each year.
4. Increase the number of international members by 10% per year.
   I'm very happy that this issue has been highlighted as a measure of success. More visibility about international membership I think would be very helpful in achieving the goal. I also would recommend that the board revisit the idea of basing international membership dues on each individual countries gross national product (GNP) or gross national income per capita (GNI).

I want to thank Crystal Maldonado for all of her hard work. I also want to thank the members of the committee.

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

Committee members:
Michael Amato, MBA
Arzu Ari, PhD, RRT, FAARC
Ed Coombs, RRT, ACCS
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
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 Amanda Richter – Spring 2017

Recommendation

That the AARC eliminate the free student membership program with appropriate notification of students and schools currently utilizing the program.

Result:

- We will return to the currently discounted, but not free, student membership program.

Rationale:

- The Free Web Student Program allows schools to provide students with a free web membership if all instructors and preceptors are AARC members.
- This program was initiated as a trial approximately 10-15 years ago. It was intended to assist in getting students to use the membership so that they see the value and join after graduation as active members.
- By providing any type of free membership we are devaluing our membership. This program is ultimately a failed experiment; it has not worked and does not work.
- It creates confusion among students and does not impact retention or promote professionalism.
- It has been unsuccessful in meeting the objective to increase student membership conversion. Higher retention rate has seen with pay student members. While it may bring in more students, we don't retain those that received free membership as well as those who paid for their membership.
- While we may see a drop in the total number of student members, we would expect to see an increase in the number of paying student members. Since retention rate is higher in pay members, the end result of conversion to active members should not be significantly different and should continue to increase in the coming years.

Report

The membership committee began this year by conducting a SOAR (Strengths, Opportunities, Aspirations, Results) analysis to help us align our priorities for membership. We held our initial kickoff meeting on January 19, 2017 and established following subgroups/projects and recommendations to the executive office:

- Students: This group is assessing best practices, student engagement, and gathering information from key stakeholders.
- Social Media: Add "AARC" to Facebook account to improve search (*Complete*); Recommend adding Instagram as a form of social media
- Improve "member-only" content on AARC.org as much of the content on website is open to anyone, reducing the benefit for members. (*Changes underway*)
- CRCE pricing on AARC.org is non-member pricing, even when logged in. Recommend having both or moving to member pricing + notice for non-members. Shawna has followed up on this: *The vendor cannot program more than 1 price on the summary page and the marketing team and I agree that publishing the member price would be perceived as less*

than truthful to non-members who purchase the courses (over 30% of our purchases in AARC U are non-member). Having run into these barriers, we have instituted or begun the following actions: Marketing will be using this website when promoting courses that are free for members; Marketing is developing graphics that we can use on each course description in AARC U that either say "free for members" or "member discount." Reagan and Shawna are developing language at the top of each channel in AARC U to click "more information" for member pricing. Once we get the language the way we want it and marketing develops a graphic for us, we'll have our vendor add it to the top of each channel page.

- Recommend having a "Where does my money go" diagram/graphic representation for dues distribution
- Development of historical content (publicly available) to show what AARC does/has done. (*New Empower webpage recently published*)
- Better coordination with chartered affiliates: recommend improving the publication of state affiliate events through AARC; recommend somehow allowing members to gain access to state society emails – can there be a box to check that the member allows their email to be shared with the state? Most states have their own list serves built for email marketing, how do we help get members connected with their state?
- Medical Directors: Dr. Cohn will help head a subgroup to evaluate medical director membership and strategies to improve our physician membership

We plan to complete a survey series to help us narrow our focus and further develop and prioritize our 2017 action plans moving forward.

The committee made the recommendation to President Walsh to add Hanna Donato from Colorado as our new graduate member.

Other

I would like to thank all of our committee members for their high level of engagement and participation. I would like to thank the Amanda F., Shawna, and the executive office team for all of their assistance and hard work. A special thank you to Amanda F. for working closely with us this year, we great appreciate her time and effort!

Position Statement and Issue Paper Committee

Submitted by Pat Doorley – Spring 2017

Recommendations

That the AARC Board of Directors agree to suspend the "60-day comment period from AARC membership" required by AARC BOD Policy CT .008 (see the statement below) for Position Statements and Issue Papers that are recommended for retirement during 2017.

The Position Statement and Issue Paper Committee referred to as the "Committee" for the remainder of the document, will be tasked by the AARC Board of Directors (BOD) to develop or review position statements or issue papers. This development, renewal or retirement involves a group of content experts, selected by the Committee. A completed new, renewal or retirement draft of the statement or paper will be posted on the AARC web site for a 60-day comment period from AARC membership. Following the comment period, the statement will be revised if necessary and sent to the BOD with recommendations of approval, renewal or retire.

Rationale: Though seeking the input of membership is very important and deemed necessary and appropriate by the Committee for the document review process, there are several Position Statements and Issue Papers that have not been reviewed in recent years. Several of these documents may be recommended for retirement in 2017 based on the Committee's initial review. Requiring the 60-day review period for each of these documents will not likely result in information that will alter the final recommendations of the Committee to the BOD, but it will add a significant amount of time to an already complex process.

Report

Objectives:

1. Present a plan to the BOD to have all position statements and issue papers updated to meet the BOD Policy CT.008 (Position Statements and Issue Papers) requirements.
    - Please find attached (Appendix A/embedded Excel file) a list of the 28 current AARC Position Statements and 10 current AARC Issue Papers (Whitepapers) with their last date of review/revision if known identified.
    - The documents have been reviewed by members of the Committee and placed on a 5 year review/revision calendar based on their most recent review/revision as required in item # 5 of BOD Policy CT .008. This calendar may be revised during the course of the year in order to more evenly distribute the number of documents that require review annually. An update will be provided with each Committee report.
    - The Committee will complete the review/revision of the following four Position Statements during 2017 following the process described in BOD Policy CT .008:
        - Administration of Sedative and Analgesic Medications
        - Hazardous Materials Exposure
        - Respiratory Therapists in the Emergency Department

        - Transport of the Mechanically Ventilated, Critically Injured or Ill, Neonate, Child or Adult
    - The Committee will complete an initial review of the remaining 24 Position Statements to determine their continued relevance/importance and provide an update to the BOD in the Summer BOD meeting report.
    - The Committee will complete an initial review of all of the Issue Papers to determine their continued relevance/importance and provide an update to the BOD in the Summer BOD meeting report.
        - Four of the documents are not dated and an attempt will be made to determine when they were developed.
        - Three were developed 9 to 14 years ago and have not been revised over that time span.
        - Three have been developed or reviewed/revised in the past 5 years.

2. Inventory the current Position Statements and Issue Papers and convert to the new format by end of 2017.
    - The new format for Issue Papers has been established by the Executive Office. (See the Issue Paper entitled "Safe Initiation and Management of Mechanical Ventilation", 2016 for the format.)
    - A new final format for Position Statements has not been established at this time. The Committee will work with the Executive Office to establish this format by the end of March 2017.
    - All Position Statements and Issue Papers that are determined to have continued relevance will be converted to the new format by the end of 2017. However the actual 5 year review/revision of each will remain on the schedule that has been developed and appears on the calendar.

3. Execute the plan to bring all Position Statements and Issue Papers into compliance with BOD Policy CT .008 by the end of 2018.
    - The language of all Position Statements and Issue Papers related to the terms Respiratory Care, Respiratory Therapy, and Respiratory Therapists will be reviewed/revised as the initial reviews of the documents are being conducted and the documents are reformatted.
    - References cited in all Position Statements and Issue Papers will be formatted according to the Respiratory Care Journal Standards.
    - BOD Policy CT .008 requires that the Position Statements and Issue Papers be grouped in categories such as ethics and human rights, disease, consumer advocacy, practice, quality or safety. The Committee will try to develop a recommendation for categories appropriate for each of the current Position Statements and Issue Papers for the consideration of the BOD by the end of 2017.

Other

- The Position Statement and Issue Paper Committee has not been requested to develop any new statements or papers at this point in time.
- The language on the AARC website needs to be corrected to reflect the change in name of "White" Papers to "Issue" Papers throughout the website. P. Doorley will work with the Executive Office to have this change made.

- I would like to thank each of the members of the Committee – Joyce Baker, Joel Brown, Joe Goss, Denise Johnson, and Kimberly Wiles – and our Executive Office Support – Kris Kuykendall and Doug Laher – for their contributions to the achieving the objectives of our Committee.

American Association for Respiratory Care
Policy Statement

SECTION: Board of Directors

SUBJECT: **Position Statements and Issue Papers**

EFFECTIVE DATE: June 30, 2016

DATE REVIEWED: August 1, 2016

DATE REVISED: August 1, 2016

Definition of Position Statement: A position statement is an explanation, justification or a recommendation that reflects the AARC's stance. As the name implies its intention is to provide comprehensive reasoning regarding the rationale behind the position set forth and will cite references as necessary.

Definition of Issue Paper: Issues paper is an authoritative report or guide informing readers concisely about an issue and to present the AARC's philosophy or recommendations on how to resolve. It will cite references as necessary.

The Position Statement and Issue Paper Committee referred to as the "Committee" for the remainder of the document, will be tasked by the AARC Board of Directors (BOD) to develop or review position statements or issue papers. This development, renewal or retirement involves a group of content experts selected by the Committee. A completed new, renewal or retirement draft of the statement or paper will be posted on the AARC web site for a 60-day comment period from AARC membership. Following the comment period, the statement will be revised if necessary and sent to the BOD with recommendations of approval, renewal or retire.

Policy Amplification:

1. The BOD may initiate a new or renewal of position statement or issue paper at any time.
2. AARC House of Delegates or AARC Board of Medical Advisors may recommend to the BOD to create a new or revise a position statement or issue paper.
3. The Committee shall consist of 6 active and practicing members from a diverse practice background (i.e. management, adult acute care, sleep, neonatal/pediatrics, homecare, education, etc.) appointed by the President.
4. On an ongoing basis the Committee will recommend to the BOD the need to review, revise or retire as appropriate.
5. Each position statement or issue paper will be reviewed/revised at least every 5 years and shall be presented with a recommendation to the BOD for approval.
6. Each statement or paper will be dated upon BOD action and posted publicly on the AARC web site and grouped in categories such ethics & human rights, disease, consumer advocacy, practice, quality or safety.

7. The following definitions will be used when writing position statements or issue papers:
    a. **Respiratory Care:** umbrella term that identifies a distinct subject area and healthcare profession; a subject area in healthcare that includes all aspects of the care of patients; used to identify the services provided by respiratory therapists and other healthcare practitioners such as physicians, nurses, physical therapists, managers, educators, etc.
    b. **Respiratory Therapy:** term that describes specific therapies related to the area of healthcare known as respiratory care; typically used to refer to the procedures, treatments and technology-based interventions to improve cardiopulmonary health.
    c. **Respiratory Therapists:** term that identifies the professional practitioners who are credentialed as Registered and/or Certified Respiratory Therapists and who practice in the area of healthcare known as respiratory care.
8. Position Statements and Issue Papers adopted by the AARC will be available to the public in electronic form.
9. References will be formatted according to the Respiratory Care Journal standards.
10. The Position Statement or Issue Paper will be organized according to the AARC approved format.

DEFINITIONS: Position Statement, Issue Paper, Respiratory Care, Respiratory Therapy, Respiratory Therapist

APPENDIX A: Position Statement and Issue Paper Review Calendar 02/12/2017

Position Statement	Reviewed	Revised	2017	2018	2019	2020	2021
AARC Statement of Ethics and Professional Conduct		Apr 15				X	
Administration of Sedative and Analgesic Medications		Jul 07	X				
Best Practices in Respiratory Care Productivity and Staffing		Jul 15				X	
Competency Requirements for the Provision of Respiratory Therapy Services	Jul 14				X		
Continuing Education	2015					X	
Cultural Diversity		Apr 13		X			
Definition of Respiratory Care		Jul 15				X	
Delivery of Respiratory Therapy Services in Skilled Nursing Facilities Providing Ventilator and/or High Acuity Respiratory Care	Apr 16						X
Electronic Cigarette		Nov 15				X	
Guidance Document on Scope of Practice		Nov 13		X			
Hazardous Material Exposure		Nov 11	X				
Health Promotion and Disease Prevention		Apr 14			X		
Home Respiratory Care Services		Jul 13		X			
Insertion and Maintenance of Arterial Lines by Respiratory Therapists		Jul 15				X	
Insertion and Maintenance of Vascular Catheters by Respiratory Therapists		Jul 15				X	
Interstate Transport License Exemption		Jul 14			X		
Licensure of Respiratory Care	Apr 15					X	

Position Statement	Reviewed	Revised	2017	2018	2019	2020	2021
Personnel							
Pre-Hospital Ventilator Management Competency		Jul 14			X		
Pulmonary Rehabilitation		Apr 14			X		
Respiratory Care Scope of Practice		Jul 13		X			
Respiratory Therapists in the Emergency Department		Apr 12	X				
Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialist	Jul 13			X			
Respiratory Therapist Education		Nov 15				X	
Respiratory Therapy Protocols	Apr 13			X			
Telehealth and Respiratory Therapy		Apr 13		X			
Tobacco and Health		Apr 14			X		
Transport of the Mechanically Ventilated Critically Injured or Ill, Neonate, Child or Adult Patient		Nov 09	X				
Verbal Telephone Orders		Jul 14			X		
Total			**4**	**7**	**7**	**9**	**1**

Issue Papers	Reviewed	Revised	2017	2018	2019	2020	2021
Best Practices in Respiratory Care Productivity and Staffing	2012		X				
Development of Baccalaureate and Graduate Education Degrees	No Date		X				
Guidance Document on Scope of Practice	2003		X				
AARC White Paper on the RRT Credential	2003	2013		X			
Respiratory Care: Advancement of the Profession Tripartite Statements of Support	No Date		X				
Safe Initiation and Management of Mechanical Ventilation	2016						X
Smallpox Guidance Document	2003		X				
Study on the Effect of State Regulation of Respiratory Therapy Practitioners on Salaries and Vacancy Rates	No Date		X				
Utilization in Respiratory Care	No Date		X				
Ventilator Acquisition Guidance Document	2006		X				
Total			**8**	**1**			**1**

State Government Affairs Committee

Submitted by: Raymond Pisani- Spring 2017

Recommendation

None

Report

The State Government Affairs Committee continues to work closely and coordinate efforts with the Federal Government Affairs Committee in preparation for the upcoming AARC PACT Hill Lobby Day in Washington DC.

Virtual Museum Committee

Submitted by: Trudy Watson- Spring 2017

Recommendation

None

Report

The Virtual Museum (VM) Committee members continue to work on the development of new galleries and to expand the content of our existing galleries. We plan to launch a minimum of three new galleries in 2017.

Our biggest hurdle is in obtaining images for the museum's galleries. We've only had a handful of images contributed since my last report. If you have any contacts or know of anyone who might have relevant materials for inclusion in the museum, would you please contact them to see if they'd be willing to share their images with us?

We've received several requests for permission to use images from the Virtual Museum in educational videos. Several images from the VM will be included in an upcoming exhibition on the history of mechanical ventilation in the Czech Republic. The images will be included in a display at the National Medical Library Medical Museum in Prague. The head of the museum promised to send photos of the exhibition once it is finalized later this spring.

In January, the materials for nominating the Legends of Respiratory Care were updated and distributed to the nominating agencies under President Walsh's signature. The AARC Board, along with the ARCF, CoARC, and NBRC are each invited to nominate up to five individuals by June 30, 2017 for consideration as Legends of Respiratory Care. We encourage you to nominate individuals who made a significant historic impact on respiratory care and the profession.

Steve DeGenaro, a member of the VM committee, recently donated his extensive collection of medical photographs to the Dittrick Museum of Medical History at Case Western University in Cleveland, Ohio. (Steve and his wife, Mary previously contributed over 100 vintage photos from the collection for us to use in the VM.) Steve's photo collection will be featured in an exhibition which will open in April and will coincide with the AARC's 70th anniversary activities. Tom Kallstrom, Doug Laher, Steve DeGenaro, and I participated in conference calls and emails with Jim Edmonson, the director of Dittrick Museum to coordinate activities for the opening of the exhibition on April 21 and a half-day educational program on April 22. We will have a demonstration of the virtual museum available for attendees and will feature images from the VM in a presentation during the educational conference.

Special Representatives Reports

AMA CPT Health Care Professional Adv Comm

Submitted by: Susan Rinaldo Gallo – Spring 2017

Recommendations

None

Report

1. At the February meeting there was a code proposed for Digital Blood Gas Monitoring. This code was proposed by a Sen Tec, Inc. consultant.

Code description: "Transcutaneous, noninvasive, digital blood gas monitoring of carbon dioxide and oxygen tension. For patients older than term birth plus 1 month, additional oxygen saturation and pulse rate monitoring incorporated in the same sensor."

Currently there are codes for O2 saturation (94760-62) and end-tidal CO2 monitoring using infrared technology (94770). Neither of these accurately describes transcutaneous monitoring of O2 and CO2.

The CPT panel rejected this request for a variety of reasons. The AARC, ACCP, and ATS have volunteered to work with group to help them revise the proposal. They plan to resubmit this code in October.

2. Of interest, code 99490- Chronic Care Management Services can be reported by the provider when RCPs perform these services. This is an Evaluation & Management code, commonly referred to as a physician code. In AMA CPT Language, RCPS come under the category of "clinical staff". Below is the code description from the 2017 CPT book:

"Chronic care management services are provided when medical and or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan. Patients who receive chronic care management services have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, of functional decline. Code 9949 is reported when, during the calendar month, at least 20 minutes of clinical staff time is spent in care management activities."

The physician's office would report this code, similar to Smoking Cessation codes.

Am Assn of Cardiovascular & Pulmonary Rehabilitation

Submitted by Gerilynn Connors - Spring 2017

Recommendations

None

Report

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

    a. Strong collaboration with AARC for a Pulmonary Rehabilitation Staff Certification/Credential, using the template of the AAC Chronic Disease Certification

    b. AACVPR 2017 BOD has strong pulmonary representation from Trina Limberg and Dr. Charlotte Teneback – pulmonary MD

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

    a. Nov 2017 Conf. call occurred with MAC M medical director, Dr. Feliciano about audit status and continuing issues to share with our membership
    **a new LCD for Respiratory Therapy, Cardiac Rehabilitation has been released attached are the document as a POINT OF INFORMATION below
    **LCD Exercise Testing that AACVPR MAC M committee submitted edits to has not been released yet

Local Coverage Determination (LCD): Respiratory Therapy (Respiratory Care) (L34430)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
Palmetto GBA	A and B and HHH MAC	11201 - MAC A	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11301 - MAC A	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11401 - MAC A	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11501 - MAC A	J - M	North Carolina

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LCD Information

Document Information

LCD ID
L34430

LCD Title
Respiratory Therapy (Respiratory Care)

Original Effective Date
For services performed on or after 10/01/2015

Revision Effective Date
For services performed on or after 12/05/2016

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
08/18/2016

Notice Period End Date
10/02/2016

CMS National Coverage Policy Title XVIII of the Social Security Act, §1862(a)(1)(A) allows coverage and payment

Local Coverage Determination (LCD): Cardiac Rehabilitation (L34412)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
Palmetto GBA	A and B and HHH MAC	11201 - MAC A	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11202 - MAC B	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11301 - MAC A	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11302 - MAC B	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11401 - MAC A	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11402 - MAC B	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11501 - MAC A	J - M	North Carolina
Palmetto GBA	A and B and HHH MAC	11502 - MAC B	J - M	North Carolina

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LCD Information

Document Information

LCD ID
L34412

Original ICD-9 LCD ID
L32872

LCD Title
Cardiac Rehabilitation

Original Effective Date
For services performed on or after 10/01/2015

Revision Effective Date
For services performed on or after 01/19/2017

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
N/A

Notice Period End Date
N/A

American Heart Association

Submitted by Keith Lamb – Spring 2017

Recommendations

None

Report

The in-person Spring ECC Meeting is April 19-21. I will report off on that meeting as I am planning to attend.

AHA/ILCOR recently opened up guideline topics for public input. Surveys were open for two weeks that allowed for input on what evidence should be further studied.

Chartered Affiliate Consultant

Submitted by Garry Kauffman – Spring 2017

Recommendation

Expand the scope of services and financial support of the chartered affiliate consultant to support the chartered affiliates' business operations to ensure their continued viability.

Additional notes: Expansion of this support service could include but not be restricted to: subsidization of consultant expenses for on-site strategic and operational planning sessions, creation of web-based support services managed by the chartered affiliate consultant, and implementation of webinars orchestrated by the chartered affiliate consultant collaborating with individuals having demonstrated best-practices within their chartered affiliate. I will make my time available to AARC leadership to explore these and other means to improve chartered affiliate viability and performance.

Report

I had no new engagements with the chartered affiliate leadership for on-site assistance. 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, share best practices, and answer questions with regard to a variety of issues germane to their performance. These include New York, Pennsylvania, Virginia, West Virginia, Kansas, Indiana, Georgia, Iowa, New Jersey, Rhode Island, Washington State, Idaho, and Utah.

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 successful for our Chartered Affiliates and the AARC in the increasingly demanding and evolving health care system.

Coalition for Baccalaureate and Graduate Respiratory Therapy Education (CoBGRTE)

Submitted by Margaret Traband – Spring 2017

Recommendations

None

Report

CoBGRTE is dedicated to improving respiratory therapy education. CoBGRTE was founded in the year 2000 as a steering committee, was formally recognized by the AARC in 2002 and was incorporated as a professional association in January, 2012. Currently CoBGRTE has 67 institutional members which include almost all of the colleges and universities awarding the baccalaureate and/or master's degree in respiratory care in the United States. CoBGRTE continues to see new institutional, corporate, individual and student members. The publication, *The Coalition Chronicle* goes out to over 600 recipients each month, including all of their members, key stakeholders and board members of the executive boards of the AARC, CoARC and NBRC.
A primary goal of CoBGRTE is to increase the number of Baccalaureate and graduate (e.g. masters' degree) respiratory care programs in the USA. Additional objectives include:

- Scholarship awards to students pursuing a BS or master's degree in respiratory therapy
- Providing a forum and means of communication among baccalaureate and graduate educators, students, clinical affiliates and other interested parties.
- To assist associate degree programs in developing consortium and transfer agreements with colleges offering baccalaureate and graduate degrees.
- To assist associate degree programs as they transition to offering a BSRT degree.
- Advocate for the development and establishment of new baccalaureate and graduate respiratory therapy educational programs.

CoBGRTE keeps an up-to-date roster of programs awarding bachelor's or master's degrees in respiratory care. Currently, 67 colleges/universities programs offer the bachelors and/or master's degree. Of these, there are now 12 universities which offer the master's degree in respiratory care (or a master's degree with a concentration in respiratory care); several additional master's degree programs are in the approval process.

CoBGRTE sponsors continuing education forums and roundtable discussions, most recently at the 2016 AARC International Congress meeting. Two Roundtable Discussion Dinners have been held this past year one at the AARC Summer Forum on June 25 (n=48) and another at the AARC Congress on October 16 (n=70). The purpose of the dinners is to collectively identify and solve problems related to respiratory therapy education.

The CoBGRTE Executive Committee met with the AARC Executive Committee last June 2016 to review projects where we could collaborate. A result of the meeting was a decision that AARC and

CoBGRTE would work collaboratively to help 88 ASRT programs based in senior colleges transition to offering BSRT degrees.

On January 5, 2016 the AARC published its position paper on Respiratory Therapist Education. The AARC took a crucial step in advancing the profession of Respiratory Care with this position paper, it placed AARC on record that the education needed to enter professional practice as a respiratory therapist must be at the baccalaureate level.

Also very important is the very supportive CoARC Response on January 25, 2016 to the AARC Position Paper on Respiratory Therapist Education programs. To support the increasing extent and complexity of the skills required of graduates of Respiratory Care programs and the associated movement of the profession toward baccalaureate and graduate degrees, the CoARC Board of Commissioners, in collaboration with the AARC, proposed changes to Standard 1.01 in the *Accreditation Standards for Entry into Respiratory Care Professional Practice,* to be effective January 1, 2018*:*

In response to the CoARC announcement, the CoBGRTE did not submit an application to Council on Accreditation of Allied Health Education Programs (CAAHEP) to establish a new Committee on Accreditation (CoA) for baccalaureate and graduate respiratory care educational programs on February 15, 2016, as previously planned. The CoBGRTE believes that its current concerns about CoARC accreditation policies can be resolved by working closely with the CoARC and the AARC to reconcile differences in a collaborative fashion through improved communication among all parties. The focus of such communication should be on helping associate degree RT programs devise mechanisms by which graduates earn baccalaureate degrees in respiratory care. This goal is best accomplished through a harmonious, collegial collaboration among CoBGRTE, AARC and CoARC. CoBGRTE is confident that other accreditation issues of concern will be eventually resolved as we move the profession forward together. A decision to continue CAAHEP associate membership will be made by July, 1, 2017.

The CoBGRTE Board of Directors has approved the staffing of 15 committees in 2017 and the chairs and goals for each committee were published in the January 2017 issue of *The Coalition Chronicle.* The complete officiary listing Committee members can be found at www.cobgrte.org on the Member Resources page.

The CoBGRTE Board of Directors will meet on Monday June 26 at the AARC Summer Forum. Meetings between the CoBGRTE Executive Committee and the Executive Committees of CoARC and AARC have been scheduled on 6/26 and 6/27 respectively.

Committee on Accreditation of Air Medical Transport Systems

Submitted by Steve Sittig – Spring 2017

No report submitted.

Extracorporeal Life Support Organization

Submitted by Bradley Kuch – Spring 2017

Recommendations

None

Report

Given the growing ECLS volume in both pediatric and adult cases, coupled with cost containment initiatives, there is much opportunity for further participation of Respiratory Therapist as ECMO Coordinators and ECMO Specialist. The conferences below include the topic of staffing models and training. Both are required to help grow the respiratory professional's role in ECLS management. The following may help grow relationships between ELSO and AARC as it relates to further utilizing Respiratory Therapist in the ECMO care model.

- Participate in the development of staffing models show casing the Respiratory Therapist skills set.
- Continue to collaborate with Jim Fortenberry as it relates to the AARC and ELSO partnerships. This may include data sharing, guideline development, and best practice position papers.
- Maintain a presence at regional and national academic meetings.

Several educational offering are available this year related to extracorporeal life support and advanced respiratory therapies, which include:

- The 33rd Annual Children's National Symposium: ECMO and the Advanced Therapies for Respiratory Failure has taken place on February 26-March 2, 2017. Focus this year include:
    - Special Workshop: Staffing models, team development, and model ECMO
    - Protocol development
    - Cannulation for Long-term ECLS
    - Quality Measures and Simulation
    - Recue therapy using the VDR Ventilator
    - Anticoagulation & Bleeding
- The 27th Annual Specialist Education in Extracorporeal Membrane Oxygenation (SEECMO) Conference is scheduled for June 2, to June 4th, 2017
- STS/ELSO ECMO Management Symposium is set to take place March 10 to 12, 2017 – aimed at surgeons and intensive care physicians
- 28th Annual ELSO Conference is scheduled for September 24th to September 27, 2017 in Baltimore Maryland

The ELSO Award Excellence in Life Support deadline is fast approaching:

- The ELSO Award for Excellence in Life support is due April 1, 2017 at 12:00 am EST. There are 2 pathways that include:
  - Award for Excellence (Gold or Platinum Level) - $3,500
  - Center on the Path to Excellence (Silver Level) - $2,000

- ECMO Center Volume and outcome data continue to growth, as ECLS continues to be a significant treatment for refractory cardiac and respiratory failure.

- There were 189 ECMO centers in North America in 2016, up from 172 on 2014.

- Neonatal Respiratory ECMO Cases remain consistent at about 650/year since 2011, with an average survival rate of 62% in 2016.

- Pediatric Respiratory Cases continue to increase. Most complete data demonstrates a 22.9% increase (2014 vs. 2015), with a survival rate of 59%.

- Adult Respiratory ECMO cases have demonstrated an 10.8% increase from 2015 to 2016, with a survival rate of 55%. These data are not complete as data is slow to come in towards the end of the calendar year.

International Council for Respiratory Care

Submitted by Jerome Sullivan – Spring 2017

Recommendations

None

Report

I. Update on FRCSC: As indicated in previous reports to the AARC BOD the standardized Fundamental Respiratory Care Support Course (FRCSC) is a modular training course intended for implementation outside of the United States for health care providers not experienced in respiratory care as practiced in North America. We are pleased to report that the **Design Phase** of the curriculum has been completed. Due to the wide-ranging need and the disparity in the level of experience of intended audiences the curriculum has been designed in a modular format. The modular design provides users with the flexibility to request those topics which are identified by needs assessment. The project is now in its **Implementation Phase** and we have committed author agreements with national and international experts for a number of Modules including:

Respiratory System Anatomy & Physiology
Overview of Common Cardiopulmonary Disorders
Aerosol Therapy
Airway Management
Noninvasive Respiratory Support (HFNC, CPAP & NIV)
Lung Protective Ventilation Approaches in Various Disease States
Liberation From Mechanical Ventilation
Inter/Intra-hospital transport of Critically Ill Patients
Neonatal & Pediatric Resuscitation
Sleep Disorders

II. Sulltanate of Oman Celebrates 1st Respiratory Care Week: The council has been informed by Khalsa Al Siyabi, Senior RT Royal Hospital and Head of Respiratory Services, Oman Ministry of Health that congratulations are in order as the Sultanate of Oman has celebrated its Inaugural RC Week.

After development and evolution of over 20 years the profession of Respiratory Therapy has matured and come of age in the Sultanate of Oman. The profession marked its state of development in the Sultanate by celebrating the First Respiratory Care Week 23-25, October, 2016. The Royal Hospital marked the inaugural recognition with events designed to raise awareness of the Respiratory Care profession and the need for improved lung health. Photo exhibits showed RT's in action and RT Stations demonstrated equipment for airway management, NIV and home care equipment including oxygen concentrators and transport

ventilators. Omani physicians, were introduced to the RT profession and worked with Respiratory Therapists while studying in the US and Canada in the early 1990's. In 1994 the RT profession was introduced in the Royal Hospital and began with defining the duties and responsibilities of RT's and establishing a health professional education and training program. The Royal Hospital was the first site for RT's in Oman as it is the largest and main facility offering medical, surgical, renal, oncology, neurology, pediatric, and neonatal services.

Oman Respiratory Care Services started from zero with a lot of challenges having only one Respiratory Therapist and one nurse. Currently the RT Department at Royal Hospital has a staff of 22 RT's serving the facility and providing 24 hour coverage for the patients. Today the RT's are welcomed and accepted by their physician and nurse colleagues. It is significant that as of 2012, in an effort to improve patient care services, Respiratory Therapists provided coverage in all regions of the Sultanate.

III. 10th Intercoastal Respiratory Therapy Assembly (ICRTA): Chia-Chen Chu, MS, SRRT, FAARC, Dept. of Respiratory Therapy, China Medical University & Hospital, Taichung City, Taiwan and Xu Liang, MS, MD, Dept. of Respiratory Medicine, Wuhan Third Hospital, Wuhan, Hubei, PRC Co-Chaired the Organizing Committee for the Assembly. The 10th Intercoastal Respiratory Therapy Assembly (ICRTA) and Wuhan Association of Critical Care Physicians Academic Conference was held September 9 - 11, 2017 in Wuhan, Hubei Province. The Assembly co-sponsored by the Wuhan Association of Critical Care Physicians and the Taiwan Society for Respiratory Therapy, was organized by Wuhan Third Hospital. More than 380 respiratory therapists, physicians and nurses specializing in intensive care and respiratory medicine from U.S., South Korea, Taiwan and Mainland China participated in the forum, and over 30 poster presentations were accepted for exhibition. Twenty seminar faculty experts delivered excellent presentations covering the latest developments and contemporary topics in respiratory therapy. In addition to the plenary lectures, there were small group breakout sessions and 4 workshops focusing on critical care topics from the prospective of intensive care unit practitioners including; respiratory therapists, physicians and nursing. After the forum, many participants expressed that respiratory therapy in China started late and that there was a great shortage of respiratory therapists and inadequate understanding of respiratory therapy by clinical departments. The forum enhanced communication among all disciplines, involved in providing respiratory care. Professor Jerome M. Sullivan, President of ICRC, discussed the Fundamental Respiratory Care Support Course (FRCSC) a new respiratory therapy training program being developed in the U.S., which attracted great attention from Chinese participants. John D. Hiser, Chairman of the International Affairs Committee of AARC, also brought out lively discussion from the participants with his presentation on the International Fellowship program. Stemming from the seminar a series of training sessions on respiratory therapy technology standardization have been held in many medical centers in Hubei Province. After the successful conclusion of the conference, following tradition the ICRTA flag was transferred to next year's 11th host hospital. Li Yajun, President of the First Affiliated Hospital of Xi'an Medical College, personally accepted the flag. Dr. Li's hospital in Xi'an, China will be the host site for the 11th Intercoastal Respiratory Therapy Assembly in 2017.

IV. China-Japan Friendship Hospital Team Visits US for Respiratory Care Education Exchange Program: Four members of the China-Japan Friendship Hospital (CJFH) staff completed a two-city exchange program for Respiratory Care training, education and clinical observation in the United States. The visitors represented the departments of Respiratory Therapy, Critical Care Medicine and Nursing. The exchange visit was offered October 14 – 21, 2016 in San Antonio and Dallas Texas. This invitation was extended on behalf of Thomas Kallstrom, Executive Director of the American Association for Respiratory Care (AARC) and Jerome Sullivan, President of the International Council for Respiratory Care (ICRC). The visit was intended to strengthen and expand the relationship with CJFH and with the Chinese Thoracic Society (CTS) to explore ways to promote the development of Respiratory Therapy in China. Representatives of CJFH included:

Qingyuan Zhan, MD, Director of Respiratory & Critical Care Medicine
Jingen Xai, MS, RT, Lead Therapist
Yangling Shen, BS, RN, Head Nurse of Respiratory & Critical Nursing
Jing Sun. BS, RN

In San Antonio, Texas the CJFH Team began the exchange visit by attending the AARC 62nd International Congress and Exhibition, October 15-18, 2016. In addition the team was invited to attend the ICRC Annual Business Meeting held in conjunction with the AARC Congress on Monday October 17th. The ICRC Meeting was attended by over 130 Governors, organizational representatives, International Fellows and delegations representing 26 countries. In the afternoon session of October 17th they also visited the University of Texas Health Science Center at San Antonio for observation of Respiratory Care education program models at the Bachelor and Graduate levels. They will also were afforded the opportunity for clinical observation in a neonatal pediatric facility.

In Dallas, Texas the CJFH Team visited the AARC Executive Offices. Leadership meetings with CJFH, AARC & ICRC representatives involved the potential of future Chinese RT education & training programs offered in concert with AARC and CTS. Discussions included the possibility of certification/accreditation of future RT programs by CTS & AARC as well as frequency of those programs, and qualifications of faculty & facilities. A general overview of the AARC Clinical Practice Guidelines was provided. Discussions occurred regarding several RT Education Program models, RT curriculum organization, overview of essential courses, and the Train the Trainer Program for RT faculty development.

The second day in Dallas the CJFH Team and their US colleagues toured and observed clinical systems at Baylor Heart Hospital & Medical City Hospital. During the luncheon session at Baylor Heart Hospital there was a presentation on RT Education Program models, curriculum organization, and an overview of essential courses. This observational & instructional activity included, site visits of Respiratory Care Departments and emphasized RT hospital department structure, management & staffing principles. The Team also was introduced to US Quality Assessment (QA) of RT hospital service & treatment, and the uniform reporting of hospital patient records.

The AARC and the ICRC look forward to a long and successful relationship with CTS to achieve quality globalization of respiratory care for our patients.

V. ICRC Celebrates 25th Anniversary in San Antonio: The ICRC celebrated its 25th Anniversary in conjunction with the Annual Business Meeting October 17, 2016 in San Antonio, Texas in conjunction with the largest respiratory care meeting in the world; The American Association for Respiratory Care (AARC) 62nd International Congress and Exhibition. The ICRC Meeting was attended by over 130 Governors, organizational representatives, International Fellows and delegations representing 26 countries. The Council met in a day-long session to consider actions items, present annual reports, entertain special reports and to recognize international respiratory care clinical & educational award winners. Early in the Agenda was the recognition of Alberto Juan Lopez Bascope, MD as the recipient of the Hector Leon Garza, M.D., International Achievement Award. The Toshihiko Koga, M.D. International Medal was awarded to Lisa Trujilo, DHSc, RRT, FAARC. As part of the program three International Fellowship winners presented reports to the Council on the status of respiratory care in their home countries. The Fellows and their respective countries were: Marina Labor, MD, PhD - Croatia, Julita V. Toledo, RMT, RTRP, MPA - Philippines, Jingen Xai,MS,RT - China.

Special reports were presented on "Global Allergy Asthma Patient Platform: Best Practices to End Death & Suffering Due to Allergy and Asthma" and "Proposed New International Standards for Small-Bore RT & Oxygen Device and Accessory Connectors: Risk Identification and Potential Misconnections". The Presidents and Executive Directors of the Latin American Respiratory Therapy Certification Board representing 12 countries, the American Association for Respiratory Care representing over 50,000 members, and the National Board for Respiratory Care all presented updates on their organizations. Annual reports and developments in respiratory care education, credentialing and clinical practice were presented by Governors to the ICRC representing the following countries: Mexico, Turkey, Japan, Colombia, USA, Canada, Saudi Arabia, Italy, China, South Korea, Philippines, Egypt, UAE, Taiwan, India, Argentina and Costa Rica. The meeting was adjourned to be reconvened in conjunction with the AARC International Congress & Exhibition scheduled for October 4-7, 2017 in Indianapolis, Indiana, USA.

Joint Commission - Ambulatory PTAC

Submitted by David Bunting - Spring 2017

No report submitted.

Joint Commission - Home Care PTAC

Submitted by Kim Wiles – Spring 2017

Recommendations

None

Report

The quarterly conference call meeting was held by the Joint Commission on 12/12/16. The main topic of discussion was the Medication Management (MM) Phase I review for the OME (homecare accreditation program). The Department of Standards and Survey Methods (DSSM) conducted a field review focusing on maintenance of the MM chapter (and other chapters). This project was conducted to address medication safety and quality issues that have emerged from the field in recent years. This review was conducted September 1, 2016 through October 13, 2016. Results of those findings were discussed.

There was also a lengthy discussion with the group around the following proposed revisions and how they would be met by OME organization.

- The organization provides emergency power for essential medication dispensing.
- Adding Body Surface Area (BSA), when necessary, to clinical documentation
- Addition of an element addressing Signed and Held medication orders.
- Labeling date and time on medications with aless than 24 hour expiration.
- Addition of adding strength and date and time of administration.

Joint Commission - Lab PTAC

Submitted by Darnetta Clinkscale– Spring 2017

No report submitted.

National Asthma Education & Prevention Program

Submitted by Natalie Napolitano – Spring 2017

Recommendations

None

Report

Notifications for posting of protocols for evidence based review as well as the portal for voluntary submission of scientific information was open.

- The effectiveness of indoor allergen reduction – 10/17/2016
- The role of bronchial thermoplasty in the management of asthma – 10/17/2016
- Systematic Review of intermittent inhaled corticosteroids and of long-acting muscarinic antagonists for asthma – 10/7/2016
- The role of immunotherapy and the management of asthma: systematic review – 10/7/2016
- Fractional exhaled nitric oxide clinical utility in asthma management – 10/7/2016

I have been asked to be part of the review committee for the "Systematic Review of intermittent inhaled corticosteroids and of long-acting muscarinic antagonists for asthma" and have accepted and will be working with that group in the future.

No meetings of the NAEPP have occurred. We still have not heard anything on who will be named to the new coordinating committee.

Neonatal Resuscitation Program

Submitted by John Gallagher – Spring 2017

Recommendations

None

Report

There are no updates to report from the NRP Steering Committee.

The Neonatal Resuscitation Program Steering Committee (NRPSC) met prior to the American Academy of Pediatrics national meeting in San Francisco, on October 19-21, 2016. The AARC liaison contributed to discussion, planning, and program development in addition to providing an update on AARC initiatives. The AARC liaison also assisted in coordinating and conducting a difficult airway workshop for attendees during the NRP Current Issues Seminar, a one-day conference for providers which highlights new concepts and reinforces clinical skills.

The next NRP Steering Committee meeting will be held at the headquarters of the American Academy of Pediatrics in Elk Grove, IL on March 6 and 7, 2017.

Roundtable Reports

(I)	*ROUNDTABLES*	Chair	Staff Liaison	BOD
37	Patient Safety	S. Sittig/K. McQueen	T. Myers	S. Tooley
38	Simulation	J. Perretta	S. Strickland	L. Trujillo
39	Disaster Response	C. Friderici	S. Strickland	J. Lindsey
40	Neurorespiratory	G. Faulkner	D. Laher	C. Hoerr
41	Tobacco Free Lifestyle	G. Sergakis	S. Strickland	N. Napolitano
42	Pulmonary Disease Mgt	M. DaSilva	T. Kallstrom	S. Tooley
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	B. Walsh
48	Geriatric	M. Hart	S. Nelson	T. Op't Holt
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 2017

Recommendations

None

Report

See attachment “Ad Hoc Committee on Advanced RT Practices_Credentialing_Education March 2017”.

Ad Hoc Committee on Research Fund for Advancing Respiratory Care Profession

Submitted by Lynda Goodfellow – Spring 2017

Recommendations

That the AARC BOD accept the renamed and revised research program guidelines so that the AARC sponsors research that examines relationships between clinical interventions by respiratory therapists and the outcomes of care.

See attached file – "2017_reserach_fund_vision_grant_final"

Justification: The revised guidelines and web information can serve to solicit those proposals that are more closely aligned with current practice and strategic initiatives of the profession.

Report

Since the last 2016 AARC Board meeting in San Antonio, Texas, the Ad Hoc Committee on Research Fund for Advancing Respiratory Care has completed the following items:

- Reviewed and made recommendations on one full proposal and one abstract submission
- Reviewed the current process for "call for proposals" and made recommendations to revise the application by adding a structured request for proposals with timelines and details regarding proposal submissions
- With guidance from the President and Executive Office, the request for proposals is changed to solicit proposals in three categories: Young Investigator Award, Telehealth, and Respiratory Therapy Advanced Practice
- Reviewed the AARC Website information for research funding and suggested changes be made that reflect the new application process and guidelines

Ad Hoc Committee on State Initiatives

Submitted by John Wilgis – Spring 2017

Recommendations

None

Report

- The committee co-chairs met via conference call on January 24, 2017 to strategize an approach for committee work for 2017.
- Committee Call planned for March 2017.
- New members were added to the committee per approval from AARC President Brian Walsh.

Committee members include:

- Kenneth Alexander, M.S., RRT, Vice President, Louisiana Hospital Association
- Gene Gantt, B.S., RRT, President / CE0, Eventa
- Joseph Goss, M.S.J., RRT-NPS, AE-C, Assistant Professor, Bergen Community College
- Jacklyn Grimball, M.A., RRT, AE-C, PAHM, Disease Management Supervisor, BlueChoice Health Plan – South Carolina
- Zach Gantt, RRT, CEO Encore Healthcare
- Steven Sittig, RRT-NPS, FAARC, Pediatric Transport Clinical Specialist, Sanford Health
- Co-Chair - John Wilgis, M.B.A., RRT, Director of Emergency Management Services, Florida Hospital Association
- Co-Chair - Jan Fields, Ed.D., Ph.D., RRT, AE-C, PMP, Assistant Professor, School of Public Affairs and Administration, western Michigan University and Program Evaluator, JKF Evaluation
- AARC Liaison - Thomas Kallstrom, M.B.A., RRT, FAARC, Executive Director / Chief Executive Officer, American Association for Respiratory Care
- AARC Liaison - Cheryl West, M.H.A., Director of Government Affairs, American Association for Respiratory Care
- Ex-Officio - Sam Giordano, M.B.A., RRT, FAARC. Former Executive Director, American Association for Respiratory Care (Retired)

Committee Objectives

1. 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.
2. 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."

Ad Hoc Committee on Student Website Enhancement

Submitted by Tom Lamphere – Spring 2017

No report submitted.

ARCF
CoARC
NBRC

American Respiratory Care Foundation

Submitted by Michael T. Amato – Spring 2017

Recommendations

None

Report

The American Respiratory Care Foundation (ARCF) has been very active since the last Board of Trustees meeting in June 2016. 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 4th annual ARCF Fundraiser Reception "Night in the Grotto" during the AARC Congress 2016. There were over 350 attendees and a net of $60,167 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 2017 ARCF Fundraiser Reception to be held on October 3rd in Indianapolis, Indiana 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.

This June 22-23, ARCF will present the 56th Journal Conference focusing on "Respiratory Medications for COPD and Adult Asthma: Pharmacologic Actions to Clinical Applications". The proceedings from this Conference will be published in a 2017 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 2017 ARCF awards has begun. The deadline for applications to be submitted is June 1, 2017.

Solicitations for sponsorship for the International Fellowship Program were sent out in early January. As-to-date, we have had one company commit to sponsorship, Draeger. Push for sponsorships will continue.

<u>Summary</u>

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 2017 on April 25 in North Carolina. I want to thank all of you that gave to the Foundation in 2016 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.

CoARC Report

Submitted by Tom Smalling – Spring 2017

See attachment “CoARC Update March 2017”

Date: February 15, 2017

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

As I begin my second term as NBRC President, I appreciate the opportunity to provide you an update on activities of the NBRC. Since my last report, the Board of Trustees met in November 2016 to discuss business related items pertinent to the credentialing system. The following information summarizes the current status of significant changes to several examinations and major activities in which the Board and staff are currently involved.

Recertification Commission

Recommendations for modifications to the NBRC's Continuing Competency Committee were considered by the Continuing Competency Committee in November and they directed the Executive Office staff to create a detailed implementation plan which will be reviewed by the Committee and likely moved to the Board for approval at the April 2017 meeting.

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 potential 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 also participated on the Competency Ad Hoc Committee along with the CoARC and AARC to develop competencies for entry into practice.

Job Analysis Studies

Job analyses for the Neonatal/Pediatric Specialist and Adult Critical Care Specialist have been completed and the Board will review the final reports at their April 2017 meeting. New test specifications for these examination programs will be introduced in 2018. In April, an advisory committee including outside representatives from the AARC, BOMA and CoARC, will convene to begin the next respiratory therapy job analysis which will result in new test specifications for the Therapist Multiple-Choice and Clinical Simulation Examinations in 2020.

2016 Examination and Annual Renewal Participation

In 2016, over 208000 examinations across all programs were administered. Credentialed practitioners who renewed their active status for 2016 exceeded 57,000. 2017 annual renewal notices were mailed in early October and a follow-up email reminder will be sent in late February. To date, over 37,000 individuals have renewed their active status for 2017. Many have exercised the $5 discount by renewing online.

Examination Statistics – January 1 –December 31, 2016

Examination	***Pass Rate***
Therapist Multiple-Choice Examination –13,512 examinations	
• First-time Candidates	Exceed High Cut-Score – 72.2% Exceed Low Cut-Score – 81.7%
• Repeat Candidates	Exceed High Cut-Score – 27.6% Exceed Low Cut-Score – 47.5%
Clinical Simulation Examination –12,207 examinations	
• First-time Candidates	56.8%
• Repeat Candidates	44.7%
Adult Critical Care Examination – 800 examinations	
• First-time Candidates	75.0%
• Repeat Candidates	47.2%
Neonatal/Pediatric Examination – 1,141 examinations	
• First-time Candidates	78.2%
• Repeat Candidates	48.5%
Sleep Disorders Specialty Examination – 107examinations	
• First-time Candidates	83.3%
• Repeat Candidates	56.3%

PFT Examination – 463 examinations

- First-time Candidates — Exceed High Cut-Score – 33.0%; Exceed Low Cut-Score – 70.5%
- Repeat Candidates — Exceed High Cut-Score – 13.6%; Exceed Low Cut-Score - 60.4%

We've Moved

The NBRC Executive Office relocated to Overland Park, KS in early December. Phase 1 of our new database has been released and we will begin implementing our brand refresh initiatives soon. Please watch for more information in the months ahead.

Your Questions Invited

I am honored to be serving as President of the NBRC and am enjoying 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 the CoARC, as well as each of the physician sponsoring organizations of the NBRC. 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

- Floor Motion from October 2016 meeting
- Roundtable Policy RT.001 (see attachment “RT.001”)

FM 16-3-26.1 – That the Position Statement/Issue Paper Committee develop a resource for best practices to include licensure requirements for practice of the respiratory therapist as an ECMO specialist.

This floor motion was made by Natalie Napolitano during the Fall Board meeting, was tabled, but never readdressed.

New Business

Policy Review

- CA.002 – Chartered Affiliates – Chartered Affiliate Requirements and Responsibilities
- CA.003 – Chartered Affiliates – Chartered Affiliates Revenue Sharing Adjustments
- SS.003 – Specialty Section

Entry level BSRT (Walsh)

AARC 70th Anniversary (Lewis)

Developing strong career paths within associate degree programs to increase the number of baccalaureate degree RTs (Becker)

Adult Acute Care Section (Lamb)

American Association for Respiratory Care
Policy Statement

SECTION: Chartered Affiliates

SUBJECT: **Chartered Affiliate Requirements and Responsibilities**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: April 2012 (checklist and revisions by HOD Speaker with assistance from BOD Secretary due at Summer Forum 2012)

DATE REVISED: April 2012

REFERENCES:

Policy Statement:
Chartered affiliates shall be responsible for providing necessary formal documentation required for Chartered Affiliate Membership in the AARC.

Policy Amplification:

1. Chartered Affiliates shall be required to provide the following written documentation to the AARC.

    A. Proof of state and federal not for profit status.

    B. Proof of Chartered Affiliate Treasurers and other checking account signatories being bonded.

2. The Affiliate Charter shall remain the property of the Association, and replacement or additional copies must be purchased at cost plus handling.

3. It shall be the responsibility of the Chartered Affiliates Committee to solicit and maintain documentation.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

Policy No.: CA.003

SECTION: Chartered Affiliates

SUBJECT: **Chartered Affiliates Revenue Sharing Adjustments**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED:

DATE REVISED: July 2005

REFERENCES: AARC-Chartered Affiliate Revenue Sharing Agreement.

Policy Statement:
The AARC Executive Director shall be authorized to withhold Chartered Affiliate revenue sharing on the basis of past due state debts and documented violations of the AARC-Chartered Affiliate Revenue Sharing Agreement.

Policy Amplification:

1. The AARC Executive Director shall be authorized to withhold amounts owed the AARC by the Chartered Affiliate which are past due by 90 days.

    A. The Executive Director shall deduct the amount past due from the next revenue sharing payment made to that affiliate.

    B. In the event that the past due amount exceeds the revenue sharing payment, the amount still owed shall be deducted from the subsequent revenue sharing payments until outstanding debts are fully paid.

2. The AARC Executive Director shall be authorized to withhold Chartered Affiliate revenue sharing on the basis of documented violation of the AARC-Chartered Affiliate Revenue Sharing Agreement.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care
Policy Statement

SECTION: Specialty Sections

SUBJECT: **Leadership**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED: March 2008

DATE REVISED: July 2007

REFERENCES:

Policy Statement:
The Specialty section members, in a manner consistent with the Association Bylaws, shall elect Specialty Section Leadership

Policy Amplification:

1. Terms of office for Specialty Section Chairpersons-elect and Chairpersons shall commence at the end of the Association's Annual Meeting.

2. The Chairperson of a Specialty Section shall not serve more than one consecutive term in the same office.

3. In the event of the vacancy in the office of Specialty Section Chair, the Chair-elect, if one is serving at the time, shall serve the unexpired term of the Chair and his or her own three (3) year term.

    A. If no Chair-elect is serving at the time of the vacancy, the President shall appoint a member of the Specialty Section to serve as Chairperson, subject to ratification by the Board of Directors.

    B. A Chair-elect so appointed shall serve until the next scheduled election, or until a successor is elected by the Specialty Section Membership.

4. The Specialty Section Chair may be removed from office by a 2/3-majority vote of the Board of Directors upon refusal, neglect or inability to perform their duties, or any conduct deemed prejudicial to the Association.

    A. Written notice of action by the Board of Directors shall come from the President.

B. This written notice will be sent to the Chair and Chair-elect as formal notification that the office has been declared vacant.

5. The duties and responsibilities of Specialty Section Chairpersons shall include:
   A. Oversight of all Specialty Section activities
   B. Assurance that Section activities are in compliance with Association Bylaws and policy
   C. Assurance that Section activities are in compliance with Association Bylaws and policy
   D. Submitting reports of Section activities to the AARC Board of Directors to be included in each meeting agenda book.
   E. Submitting periodic or interim reports that may be required by the President or Board of Directors.
   F. Serving as the primary spokesperson for the Section, through which Section members express opinions, ideas and concerns to the AARC Board of Directors
   G. Submitting minutes of all Section business/membership meetings to the Executive Office liaison within thirty (30) days following the meeting.
      1. Copies of the minutes will also be sent to the VP/Internal Affairs.
   H. Following guidelines established and approved by the Board of Directors for the specialty Sections.
   I. Being responsible for the Section fulfilling the charges from the President and as outlined in Association policy.
   J. Organizing the Section business/membership meeting of the Specialty Section to be held at the Annual International Congress and Summer Forum.

6. The Chairperson of the Specialty Sections that have at least 1000 active members on December 31 of the year of nominations/elections shall serve a concurrent three (3) year term as a Section Director on the Board of Directors.

7. The duties and responsibilities of the Specialty Section Chair-elect shall include:

   A. Assisting the Chairperson with facilitation the activities of the Section and assuring successful completion of its goals and charges

   B. Assisting the Chairperson with organizing the Section business/membership meeting of the Specialty Section to be held at the Annual International Congress and Summer Forum.

DEFINITIONS:

ATTACHMENTS:

Engaging Associate Degree Programs in Facilitating Career Pathways

Problem Statement: The AARC has a goal of having at least 80% of RTs either holding or working towards a bachelor's degree by 2020. Prospective therapists may not be aware of this goal when they enter associate degree programs. The quickest pathway to increase the number of RTs with bachelor's degrees is to work with the 85% of RT entry-level educational programs that offer associate degrees. Achieving a bachelor's degree will be more challenging if the AAS degree is earned vs. the AS degree. Presently there is a significant annual increase in the number of associate degree programs that are converting to the AAS degree making the pathway to a bachelor's degree more challenging.

Goal: Develop a strategy in concert with associate degree program leaders to develop career pathways from associate degrees to baccalaureate degrees. To facilitate the career pathway, educate prospective students regarding the:

- Associate degree as the first step in the career pathway towards earning a baccalaureate degree
- Articulation agreements or names of baccalaureate completion programs to facilitate the career pathway
- Number of degree credits likely to transfer to a baccalaureate degree (transparency)
- AARC's initiatives to increase the numbers of practicing RTs to have baccalaureate degrees
    - www.bls.gov
    - Other career websites
- Clarification about the difference between a BAS vs. BS degree

Preliminary data: The websites from a random sample of 100 associate degree programs were evaluated. There were 89 programs that were recruiting an incoming class for 2017 that had unique curricula on their websites. Preliminary findings from the dataset yielded:

- 0 programs referenced AARC goals for therapists to have baccalaureate degrees on their websites
- 39 (43.8%) programs had a comment related to a baccalaureate degree (generic) on their website
    - 2 programs cited that their AAS degree was not the correct choice if the student wanted to pursue a baccalaureate after graduation
    - 15 (16.9%) of programs (n = 89) had language related to RT BS completion
    - 13 (14.6%) of programs (n = 89) had an articulation agreement posted on their program website
    - 11 (12.4%) of programs (n = 89) had links to baccalaureate degree completion programs
    - 5 programs posted articulation agreements and links to other BS programs
- 16 (18%) of programs (n = 89) made reference to college transfer credits
- Location of baccalaureate information (n = 39)
    - Type of webpage
        - 27 (69.2%) had their baccalaureate information on the RT program webpage
        - 12 (30.8%) had their baccalaureate information on a college webpage
    - Location of baccalaureate information on webpage
        - 21 (53.8%) had information in a subfolder
        - 6 (15.4%) had information at the bottom of the page
        - 7(17.9%) had information in the middle of the page
        - 5(12.8%)

Potential Recommendations

Related to AARC:

1. The AARC will conduct/support research to evaluate whether a baccalaureate degree affects the quality or safety of patient care.
2. The AARC will create a position statement on continuing education. (Do we create a new position statement that addresses a more permanent goal for BS completion? The 2020 deadline of 80% of RTs having or working towards a BS degree will expire before a recommendation can be implemented.)
3. The AARC will identify websites (bls.gov, career coaching) commonly used by universities and assure that there is language that highlights the increasing role of the bachelor's degree for prospective students.
4. The AARC will provide definitions of AS, AAS, BS, BAS degrees on a website as a decision-making resource for prospective students.

NOTE: Evidence to support that the baccalaureate degree offers increased quality or safety is required for COARC to defend itself against potential antitrust violations. It is likely that the CoARC will be reluctant to move aggressively toward BS recommendations in the absence of direct evidence. Showing that a BS degree provides greater safety or effectiveness places the BS degree on a continuum. It does <u>not</u> imply that an AS degree is unsafe or ineffective.

Related to CoARC:

1. The CoARC will require programs to provide the following on their annual program summary report: names of organizations with whom they have articulation agreements, type of degree offered, whether the degree is accredited by CoARC as Degree Advancement, number of degree credits that transfer as part of articulation agreement, baccalaureate degree programs that their graduates attend, type of baccalaureate degree offered, and usual number of degree credits that transfer.
2. The CoARC and the AARC will collaborate to develop a website hosted on the AARC website that allows prospective students to search for associate degree programs that have articulation agreements, baccalaureate degree options where students commonly transfer, and the number of degree transfer credits.

NOTE: CoARC will likely support gathering information that relates to transparency as this is part of their consumer protection role.

Related to NN2/NN2RC:

1. Collaborate with NN2 and NN2RC (name will change in March) leadership to ask their membership to highlight the RT career pathway by posting the AARC goal of having 80% of RTs either hold or be working towards a bachelor's degree by 2020 near the top half of the first page of their program website.
2. Collaborate with NN2 and NN2RC leadership to ask their membership to post links to articulation agreements and other baccalaureate degree programs in prominent positions on their program website.

NOTE: The NN2RC website has as their (mission) Statement: "It is the opinion of the NN2RC that the Associate degree should be maintained as the standard for entry into the field of Respiratory Care with the development of a career pathway into Baccalaureate and Master's degree programs for advancement in the profession." The AARC could align our language and collaborative efforts around career pathway development.

New Business – BOD Spring 2017 – Adult Acute Care Section

Please see the below suggestions presented by the Section Leadership for consideration.

1) The section leadership recommends that a plan be outlined to improve the relationship between the Society of Critical Care Medicine (SCCM) and the American Association for Respiratory Care (AARC). Section leadership believes that a more synergistic perspective could benefit the AARC, SCCM and Respiratory Therapists by improving visibility of RT's in the critical care arena.

2) The section leadership would like to ask the program committee for a rather detailed report of the following:

a) How many RT's typically submit proposals for the congress and summer forum?

b) What % of speakers are assigned topics that they did not submit?

c) What % of lectures topics that are presented by someone other than the original submitter?

The AARC through the section chairs have been asked to submit proposals through AARConnect and other avenues. I have received feedback from section members who are frustrated that their proposals are never accepted and at times they will see other individuals present a topic they submitted. This is especially true when there are lectures that are submitted by young enthusiastic RTs and then handed off to one of the "regulars". They've questioned the process to me because they always see the same individuals giving presentations at each Congress.

Respectfully Submitted,

Keith D. Lamb, Chair

Carl W. Hinkson, Chair-Elect

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

Mitchell A. Baran Clinical Excellence in Aerosol and
Airway Clearance Therapies Achievement Award

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January 30, 2017

Brian Walsh, PhD, RRT-NPS, RRT-ACCS, AE-C, RPFT, FAARC
President
9425 N MacArthur Blvd, Suite 100
Irving, TX 75063

Dear Brian,

I am seeking your Board's nominations for the 2017 *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 consider the early pioneers in the profession and individuals responsible for founding the nominating agencies as you submit your nominees.

Please summarize each nominee's activities, honors, and contributions on the attached Legends Nomination form. The completed forms must be submitted by **June 30, 2017** to Trudy Watson at *tjwatson@mchsi.com*.

The recipients of this prestigious designation will be announced at the 2017 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. Forrest M. Bird, Dr. George Burton, Vijay Deshpande, 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, Ray Masferrer, Dr. William F. Miller, Dr. Theodore Oslick, Dr. Thomas L. Petty, Dr. David Pierson, Gregg Ruppel, James Whitacre, and Jimmy A, Young.

Sincerely,

Trudy Watson

Trudy Watson
Virtual Museum Chair

2017 Legends of Respiratory Care Nomination

Nominating Board: _____ AARC _____ARCF _____ CoARC _____NBRC

Nominee_____

Degrees/Credentials_____

1. In the space provided below, describe the nominee's ***historic impact*** on respiratory care.

2. 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:

_____

3. In which decade(s) did the nominee's primary service/contributions to respiratory care occur?

_____Prior to 1960 _____ 1960-1979 _____1980-1999 _____After 2000

4. 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

Has the nominee received any of the following awards or honors?

_____ Emeritus - Board ARCF, NBRC, CoARC

_____ARCF Hector Leon Garza, MD International Achievement Award

_____ ARCF Forrest Bird Lifetime Scientific Achievement Award

_____ARCF Dr. Charles Hudson Award for Cardiopulmonary Health Award

_____ARCF Dr. 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

_____CoARC Bonner Smith Service Award

_____ CoARC Dr. Ralph Kendall Outstanding Site Visitor Award

____ ICRC Toshihiko Koga Medal, MD Medal

_____Lambda Beta Society National Honorary Member

_____Other (specify)_____

5. 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

6. How many years did the nominee hold elected office in any of the nominating agencies?

_____ President (include President-elect, Past-President in presidential term)

_____ Vice President _____Secretary _____Treasurer

_____ Secretary/Treasurer _____ No elected offices held

7. How many years did the nominee serve as Chair* of any committee(s) of the nominating agencies?

_____10+ _____5-9 _____ 1-4 _____0/Unknown

*includes Chair of AARC Specialty Sections and Editorial Board

8. How many years did the nominee serve as a member of any committees of the nominating agencies? (Combine service years to single or multiple committees)

_____20+ _____10-19 _____<10 _____0/Unknown

9. Does the nominee hold any patents for devices or inventions of historical significance to the respiratory care profession?

_____2 or more patents _____ 1 patent _____0/Unknown

10. Are any national scholarships, awards, or lecture series offered in this nominee's name? _____Yes _____ No

Please specify _____

11. Has this nominee authored or co-authored a textbook related to respiratory care or contributed 10 or more chapters to 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:

_____20 or more _____10-19 _____1-9

12. Has the nominee authored/co-authored journal articles published in a peer-reviewed scientific journal?

_____ Yes _____ No/Unknown

If yes, list the approximate number of published journal articles:

_____20 or more _____10-19 _____ 1-9