

AMERICAN ASSOCIATION FOR RESPIRATORY CARE

Board of Directors Meeting
December 12, 2008 – Anaheim, California

Minutes

Attendance

Toni Rodriguez, EdD, RRT, President
Tim Myers, BS, RRT-NPS, President-Elect
Michael Runge, BS, RRT, Past President
Ruth Krueger, MS, RRT, VP/Internal Affairs
Karen Stewart, MS, RRT, FAARC, VP/External Affairs
Susan Rinaldo Gallo, MEd, RRT, Acting Secretary-Treasurer Pro Tem
Debbie Fox, MBA, RRT-NPS, Past Speaker
Terence Carey, MD, BOMA Chair
Patricia Doorley, MS, RRT, FAARC
Rick Ford, BS, RRT, FAARC
George Gaebler, MEd, RRT, FAARC
Michael Hewitt, RRT-NPS, FAARC, FCCM
Denise Johnson, BS, RRT
Joan Kohorst, MA, RRT-NPS
Jim Maguire, PhD
Robert McCoy, RRT, FAARC
James Taylor, RRT
Linda Van Scoder, EdD, RRT
Brian Walsh, RRT-NPS, RPFT

Absent

Colleen Schabacker, BA, RRT, FAARC, Secretary/Treasurer (Excused)

Consultant

Dianne Lewis, MS, RRT, FAARC, President/Presidents Council
John Hiser, MEd, RRT, FAARC, Parliamentarian

Staff

Sam Giordano, MBA, RRT, FAARC, Executive Director
Tom Kallstrom, BS, RRT, AE-C, FAARC, Chief Operating Officer
Ray Masferrer, RRT, FAARC, Associate Executive Director
Steve Nelson, RRT, FAARC, Associate Executive Director
Sherry Milligan, MEd, Associate Executive Director
William Dubbs, MHA, MEd, RRT, Director of Education and Management
Cheryl West, MHA, Director Government Affairs
Miriam O'Day, Director Legislative Affairs
Tony Lovio, Controller
Brenda DeMayo, Administrative Coordinator

CALL TO ORDER

President Toni Rodriguez called the meeting of the AARC Board of Directors to order at 8:05 a.m. PST, Friday, December 12, 2008.

SPECIAL REPRESENTATIVE REPORTS

AMA CPT COMMITTEE REPORT

Susan Rinaldo Gallo reported that since her written report was submitted, an additional code pertaining to patient reassessment in Pulmonary Rehab has been created.

AMERICAN HEART ASSOCIATION (AHA) REPORT

Mike Runge moved to accept **Recommendation 08-3-63.1** “That the AARC continue to support AHA by maintaining a representative from the AARC.”

Tim Myers moved “To refer **Recommendation 08-3-63.1** to the President-elect.”

Motion to Refer Carried

SPECIAL REPRESENTATIVE REPORTS ACCEPTANCE

Karen Stewart moved “To accept the Special Representative reports as presented.”

Motion Carried

UNFINISHED BUSINESS

New York Society Update

President Toni Rodriguez advised members that the New York Society was willing to work with the chapter on their mutual disagreement. The chapter chose mediation, while the NYSSRC chose binding arbitration. AARC’s lawyers advised that binding arbitration was the preferable method. It is felt that the AARC leadership did all they could to resolve this and it is back in the hands of the New York Society.

RATIFICATION OF HYPERBARIC ROUNDTABLE CHAIR

Tim Myers moved to accept **FM 08-3-45.1** “To ratify the Presidential appointment of Dr. Cliff Boehm as Chair of the Hyperbaric Roundtable.”

Motion Carried

George Gaebler moved to accept **FM 08-3-45.2** “To approve the goals of the Hyperbaric Roundtable as follows:

1. Establish an effective platform for networking and communication between the members of the Roundtable.
2. Enroll additional members and begin to actualize the vision of an effective and efficient roundtable for all healthcare practitioners with an interest in hyperbaric medicine.
3. Bring the concerns and issues of your membership as related to research in respiratory care to the attention of the AARC Board of Directors as indicated.
4. Provide the AARC Program Committee with formal proposals for lectures/seminars that meet the needs of your membership and enlighten all healthcare practitioners on the topic of hyperbaric medicine.”

Motion Carried

RATIFICATION OF INFORMATICS ROUNDTABLE

Ruth Krueger moved to accept **FM 08-3-82.2** “To ratify establishment of an Informatics Roundtable.”

Motion Carried

Susan Rinaldo Gallo moved to accept **FM 08-3-82.3** “To assign the President-elect the job of selecting a Chair and establishing goals for the Informatics Roundtable.”

Motion Carried

AD HOC COMMITTEE ON LEARNING INSTITUTES

President Toni Rodriguez reported that she will continue the Ad Hoc Committee on Learning Institutes with the following structure:

Toni Rodriguez as Chair of the Learning Institutes:

Management Content Coordinator – Rick Ford
Education Content Coordinator – Linda Van Scoder
Research Content Coordinator – Rob Chatburn

RECESS

President Toni Rodriguez recessed the meeting of the AARC Board of Directors at 8:55 a.m. PST, Friday, December 12, 2008.

RECONVENE

President Toni Rodriguez reconvened the meeting of the AARC Board of Directors at 9:10 a.m. PST, Friday, December 12, 2008

COMMITTEE ON ACCREDITATION FOR RESPIRATORY CARE (COARC) REPORT

CoARC Chair Shelley Mishoe reported that CoARC is separating from CAAHEP and will become a free-standing accrediting organization through an appeals process. She stated they will also change their name to the **Commission on Accreditation for Respiratory Care**. Executive Director Tom Smalling assured members that CoARC does not receive funding from any of the allied organizations and thwarted any questions of conflict of interest, or questions of objectivity. They don't anticipate any increase in costs.

Jim Taylor moved to accept **FM 08-3-79.1** "That the AARC Board of Directors support CoARC's move toward independent accreditation and supports their engagement with CHEA and ASPA."

Motion Carried Unanimously

HOUSE OF DELEGATES RESOLUTIONS

Denise Johnson moved to accept **HR 94-08-24** "Resolved that the AARC provide the option of direct deposit of state affiliate's quarterly revenue sharing checks into affiliate's checking accounts."

Karen Stewart moved "To refer **HR 94-08-24** to the Executive Office for investigation of feasibility and cost, and report back in March."

Motion to Refer Carried

RECESS

President Toni Rodriguez recessed the meeting of the AARC Board of Directors at 9:55 a.m. PST, Friday, December 12, 2008.

RECONVENE

President Toni Rodriguez reconvened the meeting of the AARC Board of Directors at 10:10 a.m. PST, Friday, December 12, 2008.

HOUSE OF DELEGATES RESOLUTIONS CONTINUED

Debbie Fox reported that the following resolution from 2003 remains open and asked the Board for their input.

Ruth Krueger moved to accept **HR 57 2003-28** "Resolved that the AARC adopt the following revenue sharing model:

We propose a plan that will encourage state affiliates to actively promote membership by financial reward. The program is two-tiered and bonuses would be annual and calculated at year-end based on yearly average affiliate AARC active and associate membership numbers.

- a. Establish a sliding base rate using the AARC active and associate membership numbers.
- b. State affiliate bonus based on annual affiliate AARC active and associate membership increase.”

Motion Defeated

President Toni Rodriguez passed the gavel to President-elect Tim Myers at 10:30 a.m. PST, Friday, December 12, 2008.

POLICY REVIEW

Karen Stewart moved “To accept Policy No. FM 007.”

Motion Carried with addition of new review date

Karen Stewart moved “To accept Policy No. FM 008.”

Motion Carried with addition of new review date

Karen Stewart moved “To accept Policy No. FM 009.”

Motion Carried with addition of new review date

Karen Stewart moved “To accept Policy No. FM 010.”

Motion Carried with addition of new review date

Karen Stewart moved “To accept Policy No. FM 011.”

Motion Carried with addition of new review date

Karen Stewart moved “To accept Policy No. FM012.”

Motion Carried with addition of new review date

Karen Stewart moved “To accept Policy No. FM 013.”

Motion Carried with addition of new review date

Karen Stewart moved “To accept Policy No. FM 014.”

Motion Carried with addition of new review date

MAINTENANCE OF PREVIOUS OPEN RECOMMENDATIONS

Linda Van Scoder moved “To reconsider **Recommendation 08-1-9.1** That the AARC BOD accept the committee’s recommendation for approval of the Massachusetts State Society Bylaws.”

Motion to Reconsider Defeated

Mike Runge moved to bring back to the floor **Recommendation 08-1-28.1** “That more time is needed to write an appropriate statement regarding AARC guidelines for ethical behavior during mass casualty events.”

Motion Defeated

Susan Rinaldo Gallo moved to bring back to the floor **Recommendation 08-1-28.2** “That the Ethics Committee continues to develop the Ethics Survey for respiratory care educators.”

Motion Defeated

Karen Stewart moved to bring back to the floor **Recommendation 08-1-56-4** “That the AARC BOD authorize President Rodriguez or myself (Gene Gantt) as Chair of the Long Term Care Section to draft a letter to Health and Human Services Secretary, Michael O. Leavitt, requesting the development of a National Coverage Policy for Prolonged Mechanical Ventilation (similar to that of end stage renal disease) in order to remove the state-to-state disparities of coverage for those chronically ventilated in the US.”

This recommendation was previously referred to the Executive Office and was completed. This recommendation is now closed.

FM 08-1-1.3 was defeated at this meeting. This recommendation is closed.

FM 08-1-83.1 was addressed at this meeting. This recommendation is closed.

Recommendation 08-2-32.1 – Rick Ford will report at this meeting. This remains open at this time.

Recommendation 08-2-26.2 – This recommendation was addressed at this meeting. This recommendation is closed.

Recommendation 08-2-53.1, 08-2-56.1 and 08-2-55.1 – The Board agreed to keep these recommendations open.

Recommendation 08-2-57-2 – This recommendation was addressed and is now closed.

Recommendation 08-3-58.1 – The Board agreed to keep this recommendation open.

Recommendation 08-2-65.1 – This recommendation is closed.

Recommendation 08-2-65.2 – This recommendation is closed.

FM 08-2-1.1 – This motion has been implemented and is now closed.

HR 16-08-01 - This resolution was defeated at this meeting and is now closed.

HR-44-08-02 - This resolution was defeated at this meeting and is now closed.

HR 22-08-04 - This resolution was referred to HOD and they're still working on it. The Board agreed to leave this open.

HR 29-08-05 - Toni Rodriguez will address this resolution at the Tripartite meeting at this Congress. The Board agreed to leave this open at this time.

FM 08-2-82.1 – This motion has been implemented and is now closed.

FM 08-2-04.7 – This motion has been implemented and is now closed.

President-elect Tim Myers advised members that in the future these outstanding motions, recommendations, and resolutions will be addressed by the Executive Committee approximately one month prior to each meeting, and if necessary, be brought before the Board for action on any remaining open.

NATIONAL BOARD FOR RESPIRATORY CARE (NBRC)

NBRC President Sherry Barnhart introduced Executive Director Gary Smith, as well as Lori Tinkler and Rob Shaw of the NBRC. Ms. Barnhart reported that in July, the proposed admission policy for the sleep disorders specialty exam was approved upon 2nd reading. The applications for Federally registered trademarks for the credential acronyms have been filed; CRT-SDS (for certified) or RRT-SDS (for registered). The Adult Critical Care Job Analysis Committee developed their task survey which will be mailed to a random sampling. The NBRC Board approved new changes to the Continuing Competency program effective January 1, 2009. New proposals would allow RTs more options for those renewing or those whose credentials have expired.

NEW BUSINESS

AARC HISTORIAN

Dianne Lewis reported that AARC Historian Bob Weilacher has resigned and highlighted the importance of having an Association Historian. The President's Council is currently developing a job description for that position.

Susan Rinaldo Gallo moved to accept **FM 08-3-83.1** “That the AARC send a letter of thanks to Bob Weilacher for his many years of service as AARC Historian.”

Motion Carried

PROTOCOL IMPLEMENTATION COMMITTEE REPORT

Rick Ford’s Protocol Implementation Committee submitted their document entitled “Guidelines for Respiratory Care Department Protocol Program Structure” for Board input. There was discussion concerning whether it falls under the position statement category or that of a white paper. It was also suggested that this document be reviewed by the Board of Medical Advisors at their meeting on Sunday and the President-elect can refer it back to the Committee for development of a white paper.

Motion Carried

FELLOWSHIP FUNDING

John Hiser reported that the Virginia Society collected \$4200, the Georgia Society contributed \$1000, and another \$5000 was submitted by the Massachusetts Society. Combined, this will fund two fellows.

CONTINUING RESPIRATORY CARE EDUCATION (CRCE)

Brian Walsh moved to accept **FM 08-3-83.2** “That the AARC Executive Office develop a proposal with workflow requirements and financial implications that encompass an online submission and transcript CRCE system. This system shall allow the breakdown of five or more content categories to facilitate reporting to state licensure boards and NBRC. Three of those categories should mirror the NBRC requirements of general respiratory care, neonatal/pediatrics, and pulmonary function/diagnostics technology.”

Pat Doorley moved “To refer **FM 08-3-83.2** to the Executive Office for cost analysis and report back in July.”

Motion to Refer Carried

PAT LEE RECOGNITION

James Taylor moved to accept **FM 08-3-83.3** “That the President send a letter in recognition of Pat Lee’s retirement.”

Motion Carried

TREASURER’S MOTION

Susan Rinaldo Gallo moved to accept “That the expenses incurred at this meeting be reimbursed according to AARC policy.”

Karen Stewart moved “To adjourn the meeting of the AARC Board of Directors.”

Motion Carried

ADJOURNMENT

President Toni Rodriguez adjourned the meeting of the AARC Board of Directors at 12:15 p.m. PST, Friday December 12, 2008.

ATTACHMENT “A”

Recommended Minimum Standards Ventilator Care in Rehab Facilities

Recommended Minimum Standards Ventilator Care in Rehabilitation Facilities

Standard

1. A licensed respiratory care practitioner should be on site 24/7 for ventilator care, administration of medical gases, administration of aerosol medications, and to perform diagnostic testing and monitoring of life support systems.

Rationale

Ventilator and related care is very technology driven. It is not appropriate to provide this level of care without personnel who are specifically trained in the current technology. Appropriate personnel are essential for ongoing assessment of weanability. Most SNFs primarily utilize Licensed Practical Nurses; Ventilator Care is not in their scope of practice.

Standard

2. A Pulmonologist or physician experienced in ventilator care should direct the plan of care.

Rationale

This patient population requires specific therapeutic regimens and the physician should be experienced in this level of care.

Standard

3. The facility should establish admissions criteria to ensure the medical stability of patients prior to transfer from the acute care setting.

Rationale

Medical and respiratory stability criteria for this level of care were published in 1998 by the American Academy of Chest Physicians. These criteria will assure that acuity is appropriate for SNF care.

Standard

4. Arterial Blood Gas (ABG) should be readily available to document acid base status, and/or End Tidal Carbon Dioxide (edCO₂) and continuous pulse oximetry measurements should be performed in lieu of AGB studies.

Rationale

These clinical measurements are essential for ensuring patient safety. These measurements aid in guarding against oxygen loss and patient disconnects.

Standard

5. There should be an audible, redundant external alarm system located outside of the patient's room to alert caregivers of a patient disconnection or ventilator failure.

Rationale

In the SNF environment standard ventilator alarms may not be heard outside the patient room. For patient safety an audible external redundant alarm system is essential.

Standard

6. Ventilator and emergency equipment should be connected to electrical outlets with backup generator power in the event of power failure.

Rationale

This ensures continued uninterrupted operation of the life support equipment in the event of a primary electrical failure.

Standard

7. Ventilators should be equipped with internal battery backup systems.

Rationale

In the event of total loss of power this assures that the ventilator will continue to function until the patient can be moved to safety.

Standard

8. Facilities should be equipped to employ the use of current ventilator technology consistent with meeting patients' needs for mobility and comfort.

Rationale

Ventilators should be capable of pressure support ventilation as well as PEEP and CPAP. They should also be of a size that allows patient mobility.

Standard

9. A backup ventilator should be available at all times if mechanical ventilation is provided to a patient.

Rationale

In the unlikely event of a total ventilator system failure, a replacement unit should be available.

ATTACHMENT “B”

Position Statements

Recommendation # 1: Verbal Orders

Registered and Certified Respiratory Therapists, subject to local health care institution policy and state licensure acts, may transcribe ~~physicians'~~ the verbal orders of Licensed Independent Practitioners (LIP) for drugs, devices, and treatments directly related to the provision of a patient's respiratory care.

Effective 3/90

Revised ~~3/00~~ 12/08

Recommendation # 2: Pulmonary Rehabilitation

~~A program of pulmonary rehabilitation program is a physician-supervised, evidence-based multi-faceted continuum of approach to providing services designed for persons with pulmonary disease and their families. As a component of A program includes, but is not limited to, physician prescribed exercise, education and training, psychosocial and outcomes assessment. The goals of this respiratory disease management approach, the goals of pulmonary rehabilitation are to improve, restore or maintain, the patients' to their highest possible level of independent function and to improve their quality of life. Pulmonary rehabilitation, generally conducted by is a multi-disciplinary program and team of specialists, should be included in the overall management of patients with respiratory disease to assist in alleviating symptoms and optimizing health. The respiratory therapist, by virtue of specialized education and expertise, interest in the individual's respiratory care, is uniquely qualified to function as the leader a key partner in of a successful pulmonary rehabilitation program.~~

Effective 1973

Revised ~~2002~~ 12/08

Recommendation # 3: Competency Requirements for the Provision of Respiratory Therapy Services

The complexities of respiratory therapy are such that the public is at risk of injury, and health care institutions are at risk of liability, when respiratory therapy is provided by inadequately educated and unqualified health care providers rather than by practitioners appropriately educated in the specialty of Respiratory Therapy.

~~Anyone~~ All health care practitioners providing respiratory therapy services to patients, regardless of the care setting and patient demographics, shall successfully complete formal training and demonstrate initial competency prior to assuming those duties. This formal training and demonstration of competence shall be required of any health care provider regardless of credential, degree, or license.

Formal Training and Competency Documentation

Formal training is defined as a supervised, deliberate, and systematic ~~continuing~~ educational activity in the affective, psychomotor, and cognitive domains. It is intended to develop new proficiencies with an application in mind, and is presented with attention to needs, objectives, activities, and a defined method of evaluation.

The training shall be approved by a local, regional, or national accrediting entity. In the allied health fields, this training includes supervised pre-clinical (didactic and laboratory) and clinical activities, as well as documentation of competence through tests determined to be valid and reliable. The qualifications of the faculty providing this training shall be documented and also meet accreditation standards.

~~Prior to providing respiratory therapy services, competency shall be demonstrated in the following areas:~~

- ~~1. Review all information contained in the patient's medical record regarding history, established diagnoses, current care regimen, and current signs and symptoms~~
- ~~2. Assess the patient's overall cardiopulmonary status by interview, inspection, palpation, and auscultation~~
- ~~3. Perform and assess diagnostic procedures. Diagnostic procedures include, but are not limited to: pulmonary function studies (spirometry before and after bronchodilator administration; PEFs, inspiratory/expiratory pressures, lung capacities/volumes by gas and/or plethysmography methods, lung compliance, airway resistance, bronchoprovocation studies, cardiopulmonary exercise testing, indirect calorimetry), pulse oximetry, blood gas analysis, 12-lead ECG, and hemoximetry~~
- ~~4. Initiate, monitor, and recommend appropriate continuous mechanical ventilation modalities and relevant care (e.g., tracheal tube cuff pressure, assessment of the patient's ability to be weaned from continuous mechanical ventilation)~~
- ~~5. Determine the appropriateness of the prescribed respiratory care plan, recommend modifications where indicated, and participate in the implementation and further development of the respiratory care plan. Work interdisciplinarily to include the respiratory care plan with the overall care plan for the patient~~
- ~~6. Select, assemble, and use equipment appropriate for the necessary respiratory therapy services, assuring its cleanliness and proper function. Identify and correct malfunctions. Respiratory therapy equipment includes but is not limited to: oxygen administration devices; humidifiers; aerosol generators; ventilators; artificial airways; suctioning devices; gas delivery, metering, and clinical analyzing devices; manometers and gauges; resuscitation devices; high frequency chest wall oscillation devices; PEP devices; ECG machines; incentive breathing devices;~~

~~patient breathing circuits; percussors and vibrators; environmental devices; and metered dose inhalers, dry powder inhalers, and spacers~~

- ~~7. Educate the patient and family members/other caregivers as to the planned therapy and goals~~
- ~~8. Observe universal precautions and other appropriate measures to protect the patient from nosocomial infection~~
- ~~9. Provide care to achieve maintenance of a patent airway, to include placement and care of an artificial airway and suctioning. This may include the insertion of oro- and nasopharyngeal airways, maintenance of proper tracheal tube cuff inflation, trach care, performing chest physiotherapy, and the administration of aerosol therapy~~
- ~~10. Administer medicated aerosols, including but not limited to bronchodilators, mucolytics, and anti-inflammatories with spontaneous ventilation including IPPB/IPV therapy~~
- ~~11. Provide therapeutic services to achieve and maintain adequate arterial and tissue oxygenation, which may include positioning to minimize hypoxemia; administering oxygen; initiate and adjust PEEP/CPAP/bi-level pressure devices and PEP therapy~~
- ~~12. Evaluate the patient's response to therapy and recommend and implement modifications to the care plan~~
- ~~13. Provide emergency respiratory therapy services such as CPR, newborn resuscitation, and placement of artificial airways~~
- ~~14. Provide respiratory care services utilizing techniques and practices that create a safe patient environment and follow accepted practices that enhance patient safety~~

Effective 11/98

Revised ~~10/04~~ 12/08

Recommendation # 4: Hazardous Materials Exposure

The Problem

The EPA defines a hazardous material as any substance or material in a quantity or form that poses an unreasonable risk to health, safety, and property when transported. ~~This~~ These materials ~~is~~ are extremely hazardous to the community during an emergency spill, or release, as a result of ~~its~~ their physical or chemical properties.

The Centers for Disease Control and Prevention (CDC) have classified emergency response and hospital personnel as high risk groups for exposure to infectious and toxic substances. Additionally,

with the potential for attacks with Weapons of Mass Destruction, pre-hospital and hospital healthcare workers have an increased risk of exposure to toxic, biological, and/or radioactive agents.

~~The EPA defines a hazardous material as any substance or material in a quantity or form that poses an unreasonable risk to health, safety, and property when transported. This material is extremely hazardous to the community during an emergency spill, or release, as a result of its physical or chemical properties.~~

The AARC's Position

- Respiratory therapists must be knowledgeable in treating, reversing, and avoiding the effects of ~~these hazardous materials.~~
- ~~Respiratory therapists must be alert to the potential effects of hazardous materials and be able to support~~ provide care to their patients until the effects wear off, or the materials are neutralized when needed.
- Respiratory therapists, while providing care, must ~~avoid any of the deleterious effects of the agents to which the patients have been exposed~~ assure that they do not become victims, or carriers, of the same entities that have harmed their patients. This can be accomplished through the use of Personal Protective Equipment, isolation and decontamination procedures, and quarantine when recommended by professionals trained in hazardous materials incidents.
- The AARC supports efforts toward an epidemiological approach to the prevention of hazardous material exposure.
- The AARC supports the institutional development of appropriate hazardous material exposure guidelines that adhere to standards from both the Occupational Safety and Health Administration and the Joint Commission on Accreditation of Healthcare Organizations.
- The AARC encourages and endorses the inclusion and participation of respiratory therapists in the development of a community-wide plan for the management of exposure to hazardous materials.

Bibliography

~~Burgess JL, Keifer MC, Barnhart S, Richardson M, Robertson WO. Hazardous materials exposure information service: Development, analysis, and medical implications. Ann Emerg Med 1997;29(2):248-254.~~

~~Cos RD. Decontamination and management of hazardous materials exposure victims in the emergency department. Ann Emerg Med 1994;23(4):761-770.~~

~~Kales SN, Polyhronopoulos GN, Castro MJ, Goldman RH, Christiani DC. Injuries caused by hazardous materials accidents. Ann Emerg Med 1997;30(5):598-603.~~

~~Kirk MA, Cisek J, Rose SR. Emergency department response to hazardous materials incidents. Emerg Med Clinics of North America 1994;12(2):461-468.~~

~~Occupational Health & Safety Administration. Occupational Safety & Health Act. Hazardous waste operations and emergency response. 1970. 29-CFR 1910-120. Washington, DC.~~

~~EPA web site www.epa.gov~~

~~Note: Much material is courtesy of the Emergency Nurses Association.~~

Effective 5/7/02

Revised 12/08

Recommendation # 5: Respiratory Therapist Education

~~It is the position of the American Association for Respiratory Care (AARC) that to adequately prepare graduate respiratory therapists to entry level respiratory therapists for clinical practice across a broad spectrum of sites and to prepare professional leaders to meet the demands of providing services requiring complex, cognitive abilities and patient management skills; it is the position of the American Association for Respiratory Care (AARC) that:~~

- ~~• The minimum education leading to entry into the practice of respiratory therapy ~~care~~ should be successful completion of an associate degree respiratory ~~care~~ therapy educational program.~~
- ~~• The minimum education level leading to practice as a clinical specialist, manager, and professional leader should be a baccalaureate and/or graduate degree, or advanced training and experience.~~
- ~~• The minimum education level for respiratory therapy program faculty should be a masters degree and/or advanced training.~~
- ~~• Programs should prepare graduates as respiratory therapists~~
- ~~• Programs that educate respiratory therapists, managers, researchers, faculty, and professional leaders should be accredited through a body, and a process, which will confirm that the programs meet minimum educational requirements.~~

- Respiratory therapists completing Graduate respiratory therapists, upon completion of the above-described minimum education, advanced training, and/or experience should be eligible to pursue and to obtain a credential that acknowledges the didactic preparation and related skills required for practice as a respiratory therapist in the respective area of specialization.

~~This position statement is based on prior projects by the AARC, as well as current activities and data, which support the outcomes of those earlier projects. They include:~~

- ~~The AARC sponsored Delphi study conducted by the AARC Education Committee in 1989. This study engaged acknowledged experts in respiratory care to reach agreement in two areas:~~
 1. ~~The knowledge, skills, and professional characteristics needed for future respiratory care practitioners, and~~
 2. ~~The duration of educational preparation necessary to acquire these competencies.~~
- ~~The 1991 profile of the future respiratory care practitioner created by the AARC Board of Directors.~~
- ~~The 1992 consensus conference on respiratory care education, which brought together more than fifty participants including foundation representatives, government officials, academicians, and clinical health care professionals to determine:~~
 1. ~~Curriculum content for the year 2001, and~~
 2. ~~Implications of that curriculum content for credentialing and accreditation.~~
- ~~The 1993 consensus conference, which resulted in the creation of an action plan to assist educational programs in developing respiratory therapists prepared to practice in the year 2001.~~
- ~~The reports published by the Pew Health Professions Commission in 1991 and 1993.~~

~~The findings of the education and practice related consensus conferences should be included in resource materials as new standards are developed for the accreditation of respiratory care educational programs. The AARC will continue to support the practice of respiratory care by providing continuing education opportunities, and collecting and sharing information on the changing healthcare environment as it impacts respiratory care education and practice.~~

Effective 1998

Revised 2004 12/08

Recommendation # 6: The Role of the Respiratory Care Practitioner in the Provision of Respiratory Care Services in the Hospitals and Alternate Sites Scope of Practice

The practice of respiratory care encompasses activities in: diagnostic evaluation, therapy, disease management and education of the patient, family and public. These activities are supported by education, research and administration.

Diagnostic activities include but are not limited to: (1) obtaining and analyzing physiological specimens; (2) interpreting physiological data; (3) performing tests and studies of the cardiopulmonary system; (4) performing neurophysiological studies, and (5) performing sleep disorder studies. Therapy includes but is not limited to application and monitoring of: (1) medical gases and environmental control systems; (2) mechanical ventilatory support; (3) artificial airway care; (4) bronchopulmonary hygiene; (5) pharmacological agents; (6) cardiopulmonary rehabilitation; and (7) hemodynamic cardiovascular support.

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

Practice Settings

Elements of the scope of practice of respiratory care are performed in acute care hospitals and alternative sites where patient care is provided. Alternative sites include, but are not limited to; military and VA treatment facilities, physician offices, patients' homes, convalescent centers, clinics, skilled nursing facilities, and retirement centers.

The complexities of respiratory care are such that the public is at risk of injury and health care institutions are at risk of liability when respiratory care is provided by inadequately educated and unqualified health care providers rather than by practitioners with appropriate training and education.

Practitioner Qualifications

Practitioners who provide respiratory care services shall demonstrate their ability to meet the educational and experience requirements for the safe delivery of respiratory care services through competency validation mechanisms established by either legislative or regulatory acts of their respective states or commonwealth, or through a validated voluntary credentialing mechanism endorsed by the National Commission for Health Certifying Agencies.

Position

It is the position of the American Association for Respiratory Care that the respiratory care practitioner as a vital member of the health care team is essential to the provision of safe, appropriate, and cost-effective patient care in acute-care hospitals and alternative patient care sites.

Effective 7/87

Revised 2005

Recommendation # 7: Tobacco and Health

The American Association for Respiratory Care is a professional organization dedicated to the protection of health through public education and the provision of the highest standards of respiratory care. By virtue of their education and health care experience, respiratory therapists are professionals who have a clear understanding of the nature of cardiopulmonary disease and are in a position to act as advocates for healthy hearts and lungs. The AARC recognizes its responsibility to the public by taking a strong position against cigarette smoking and the use of tobacco in any of its various forms. In view of the evidence, which confirms the health-threatening consequences of all tobacco in both active and passive forms, the AARC ~~strengthens its commitment toward and reaffirms its belief in the need for~~ is committed to the elimination of smoking and the use of any tobacco products and the inhalation of any toxic substance. The AARC is an advocate for both tobacco cessation and tobacco prevention programs.

The AARC acknowledges and supports the rights of non-smokers and pledges continuing sponsorship and support of initiatives, programs, and legislation to reduce and eliminate smoking. The AARC extends its concern beyond the smoking of tobacco to the use of smokeless tobacco by oral and nasal application. These products are linked to diseases of the gastrointestinal tract, mouth, and nose. There is also evidence that these products, when applied to the mucous membranes, diffuse into the circulation and cause ill effects in remote organs of the body.

Effective: 1991

Revised: 2000

Revised: **2005 12/08**

Statement Title	Original Statement Date	Most Recent Review or Revision	Years Since Last Review or Revision (2009-X)	2008	Schedule Review for 2009	Schedule Review for 2010	Sc R fo
AARC Statement of Ethics and Professional Conduct	1994	2006	3		X		
Administration of Sedative and Analgesic Medications by Respiratory Therapists	1997	2007	2			X	
Age Appropriate Care of the Respiratory Patient	1997	2005	4		X		
Competency Requirements for the Provision of Respiratory Therapy Services	1998	2008	1	Revision Recommended 11/08			
Continuing Education	1990	2005	4		X		
Cultural Diversity	1994	2007	2			X	
Definition of Respiratory Care	1987	2006	3		X		
Hazardous Materials Exposure	2002	2008	1	Revision Recommended 11/08			
Health Promotion and Disease Prevention	1985	2005	4		X		
Home Respiratory Care Services	2000	2007	2			X	

Inhaled Medication Administration Schedules	2008	2008	1	X		
Licensure of Respiratory Care Personnel	1990	2006	3		X	
Pre-Hospital Mechanical Ventilator Competency	2007	2007	2			X
Pulmonary Rehabilitation	1973	2008	1	Revision Recommended 11/2008		
Respiratory Care Scope of Practice	1987	2007	2			X
Respiratory Therapist Education	1998	2008	1	Revision Recommended 11/2008		
Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists	1998	2007	2			X
Respiratory Therapy Protocols	2001	2007	2			X
The Role of the Respiratory Therapist in the Provision of Respiratory Care Services in the Hospitals and Alternate Sites Scope of Practice	1987	2008		Retirement Recommended 11/2008		
Telehealth	2001	2007	2			X

Tobacco and Health	1991	2008	1	Revision Recommended 11/2008			
Verbal Orders	1990	2008	1	Revision Recommended 11/2008			
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