NCSRC Board of Directors Meeting

Concord Embassy Suites
Tuesday, September 25, 2012
1:00pm-4:00pm

Present: Kim Clark, Robin Ross, Ricky Bowen, Trisha Miller, Wendy Ayscue, Wayne Trainor, Travis Houston, Christy Stewart, Myra Stearns,Don Fletcher, Gary Dukes, Eric Dodd, Matthew Bolinsky, Lanny Inabnit, Connie Paladenech, Lawson Millner, Paula Mendenhall, Shelbourn Stevens, John Flynt, Terry Smith, Marrisa Dunn, Jody Miller, Ray Braxton

Mentees: Amy Culp, SCC Student, Jeff Schleuning, FTCC Student, Stacee Manley, CPCC Student, CandidoVegacruz, PCC Student, Jill Hoerr, CVCC Student, Valarie Williams, ECC Student, Shannon Faircloth, SCC Student, Iris Hilton, WCC Student

Absent: Joe Hylton, Jill Saye,Connie Paladenech, Tony Long / Les Foss, Dan Grady

Officer's Reports **Presenter**

1. Meeting called to order at 1:00 PM. Kim Clark
   - The Conference Line was not available.
   - The BOD, committee members, guests and the mentees were welcomed.
   - Gary Dukesmotioned to approve the May 18, 2012 minutes with the suggested revisions being made and with no discussion, and all in favor, the minutes were approved.

2. President's Report Kim Clark
   - There was an issue with the Pay-Pay link in regards to the Vouchers. Kim will be checking on this.

3. Secretary's Report- No report. Trisha Miller

4. Treasurer's Report Kim Clark presented for Joe Hylton
   - Updated financial reports (see reports).
   - The Balance Sheet dated 9/24/12 listed Checking/Savings/COD as $13,190.08; Total Assets as $83,107.92 and Total Liabilities & Equity as $83,107.92.
   - The account balanced.
   - AARC Specialty Section Dues line item showed $120.00 from 1/1/12 – 9/24/12.
   - $20,000 came in through Pay-Pal.
   - Total expense from 1/1/12 – 9/24/12, $32,444.85.
   - The budget does not include all transactions from the conference.

5. Delegate's Report Garry Dukes
   - Gary made reference to the items listed below. Please review the attachment to the minutes for the full report from the House of Delegates Meeting in Santa Fe, New Mexico
   - Recommend changing state bylaws to reflect president elect, president or past president has the ability to be a substitute delegate. (NOTE: NC Bylaws already reflect that the President-elect may optionally serve as a member of our delegation.)
   - HOD presented with recognition plaque for support of International Fellows Program

- HB 941 (targeting Medicare Part B).
- Reworking language in current bill to reflect the RT role in disease management. After language of our bill being reworked, it will then be rescored and reintroduced.
- CPGs need to be updated. Theprocess has started. Shawna Strickland has taken a leadership role in this effort.
- Resolution 23-12-01 – The AARC developed a position paper deeming the administration of bronchodilators to hospitalized patients for off-label use as Medicare abuse and waste.

  Results of discussion and deliberation:

  Friendly amendment added: and or Medicaid (after Medicare).

  Friendly amendment added: in adults (after off-label use).

  Friendly amendment: That the AARC develop a position paper deeming the administration of bronchodilators to hospitalized patients be in accordance with evidence-based medicine and professionally based standards of care.

  Friendly amendment: Inhaled medications in place of bronchodilators.

  Final disposition of Resolution

  Tabled for later in the agenda.

  Resolution withdrawn by author.
- AARC is listening carefully to Management list serve concerning productivity and staffing issues. The new Position Statement on Best Practices in Respiratory Care Productivity and Staffing" will be soon posted on the Web Site. A white paper will be developed and will have evidence to support it. Once it has been developed and approved, there are tentative plans to send it to all CEO's across the country.
- International Fellowship program has been moved over to the AARC from the ARCF. (Checks for this purpose should now be made out to the AARC.)
  - Wake Forest University Baptist Medical Center was chosen to be a host for this year's program. The International Fellow from Ecuador will spend 1 week inWinston-Salem this fall.
- Medicare has decreased funds for pulmonary rehab.
- The AARC has a pulmonary rehab tool kit for use. Need to work those in the hospital who do the charges to capture all charges associated with the pulmonary rehab, therefore, hopefully increasing reimbursement. Reimbursement for Pulmonary Rehab will increase by approximately $1.00 for FY 2013.
- AARC PACT "on the hill" will be March 11th and 12th, 2013.
- Reworking HR941. Being drafted as Chronic Obstructive Disease Management by Respiratory Therapist. It will have a package of services provided by the RT. Similar to diabetes disease management. This bill will be rescored and may be introduced into this session or the next session.
- There is a push for an increase in membership specialty sections. The Home Care section is below 900 members.
  - 759 Department heads were identified who were **not** AARC members. There is a new Campaign to boost membership.

o Resolutions

4 Resolutions have been submitted

- 1. "Resolve that any credentialed Registered Respiratory Therapist (RRT) actively enrolled in an AARC recognized and/or accredited advanced level educational program (e.g., Bachelors in Respiratory Therapy) holding Associate Member (Student Member) status be eligible to participate in Continuing Respiratory Care Education programs as a Student Member."

Don Fletcher made a motion to approve Resolution 1 and Robin Ross seconded the motion. There were 3 opposed and the motion was carried.

- 2. "Resolve that any credentialed Registered Respiratory Therapist (RRT) actively enrolled in an AARC recognized and/or accredited advanced level educational program (e.g., Bachelors in Respiratory Therapy) is eligible to change their membership status to Associate Member (Student Member) with all rights and benefits provided to that level of membership."

  Lanni Inabnit made a motion to approve Resolution 2 and Robin Ross seconded the motion. There were 3 opposed and the motion was carried.

- 3. That the AARC investigate the formation of an apprenticeship program in partnership with the American Respiratory Care Foundation (ARCF), for Respiratory Therapists who would like to learn from established researchers.

  Matthew Bolinski made a motion to approve Resolution 3 and Lanny Inabnit seconded the motion and with no opposed, the motion was carried.

- 4. Be it resolved that the AARC investigate starting a public membership for patients and other interested parties.

  Robin Ross made a motion to approve to Resolution 4 and Wendy Ayscue seconded the motion. There was 1 opposed. The motion was carried.

Standing Committee Reports	**Presenter**

6. Elections — Travis Houston

President-Elect	Myra Stearns
Vice-President	Joe Hylton
Treasure	Travis Houston
Secretary	Wendy Ayscue
Delegate	Jill Saye
BOD Western Region	Cathy Bitsche
BOD Eastern Region	Trisha Miller

- Myra Stern left a BOD vacancy when she was voted President-Elect.
- There was a motion by Trisha Miller to appoint a Central BOD for a 3 year period. This was seconded by Myra Stern and with no opposed and no further discussion, the motion was carried.
- Myra Stern made a motioned for John Flynt to fill the Central BOD vacancy and Robin Ross seconded and with no opposed and no further discussion, the motion was carried.
- Don Fletcher motioned to place Karl Kaminski in Eastern BOD to finish out Wendy Ayscue's term due to her appointment to Secretary and to keep Wayne Trainor in Eastern BOD untill 2015. Gary Dukes seconded this motion and with no opposed and no further discussion, the motion was carried.

7. Budget and Audit - No report — Joe Hylton

8. ByLaws and Standing Rules — Garry Dukes

   - During 2012, the Bylaws and Standing Rules Committee was charged:

To further review the Standing Rules, with specific focus towards the financial sections and language
    - Status: Complete

To make recommendations for revisions to the Standing Rules attachments
    - Status: Complete

To reorganize and reformat the Standing Rules into a more user-friendly document
    - Status: This charge has not been completed and should carry over as a charge to the 2012-2013 Bylaws and Standing Rules Committee.

- At the May 2012 Board of Directors Meeting, a motion was passed to "add a conflict of interest statement as an attachment to the Standing Rules".
    - Status: As a result of the motion, the Committee makes the following recommendations:
        - Recommendation #1: To accept the attached revision of the Society Standing Rules with revisions as written to Sections A.37 and A.38. (Bold and Italicized font indicates language to be added. Strikethrough font indicates language to be deleted.)
        - There was no discussion and all were in favor of this recommendation and it shall be carried.
        - Recommendation #2: To accept the proposed Standing Rule Attachment M, entitled "Conflict of Interest Questionnaire" (included with this report) as a new attachment to the Society's Standing Rules.
        - There was no discussion and all were in favor of this recommendation and it shall be carried.
- There has been much discussion at our State Society level about the development of a Society Policy and Procedure Manual. This has also been a recommendation from the AARC. It is suggested that the 2012-2013 Bylaws and Standing Rules Committee include this as an activity, and that future Bylaws and Standing Rules Committees continue and refine this process.

9. Public Relations — Paula Mendenhall
    - PR has new merchandise for sale this week. The merchandise received from vendor ($2956.63) exceeded budget ($2750.00). Vendor was aware of budget. I feel confident we can sale most of it and turn a profit. This year we have visors, tank tops (for ladies), long and short sleeve t-shirts, and beautiful fleece jackets.

10. Education/Program — Lanny Inabnit, Shelbourn Stevens
    - The education and program committee is excited to present the 2012 NCSRC Symposium to be held in Concord, NC at the Embassy Suites from 9/26/12 to 9/28/12. The Houston Anderson and Rick Sells lectures are scheduled for Wednesday 9/26/12. Dr. Joe Coyle will replace Dan Grady as the inaugural Rick Sells lecturer. Jim Ginda will be our Houston Anderson lecturer. Wednesday will follow with lectures by Dr. Susan Evans and Dan Deaton. Poster presentations will be from 3:30 to 5:00 on Wednesday. Sputum Bowl will be help on Wednesday night. Thursday will be broken into four concurrent sessions with topics such as Adult Critical Care, Pediatric Critical Care, Management, and a Student session. Friday will be broken into four concurrent sessions with topics such as Sleep Medicine, Home Care, Diagnostics, and Cardiovascular. A party will be held Thursday evening with a DJ. I would like to thank all of the committee members for their hard work and dedication.

11. Judicial- No report — Jill Saye

12. Political Advocacy (Professional Standards) Lawson Millner
    - Lawson reiterated Gary's comments from the Delegates report.

13. Publications/Communications Lawson Millner
    - A policy needs to be in place to address Social Media. There was a lot of discussion concerning this issue. Kim Clark made a motion to table the Social Media for now and to continue discussion. Ricky Bowen seconded the motion and with no further discussion and all in favor, the motion was carried.

14. Membership Ricky Bowen

    1817 Total Members
    1 Inactive Member
    21 Industrial Members
    4 Life Members
    2 Associate Members
    269 Student Members

15. Long Range Planning Robin Ross
    - There is still research and discussion going on concerning document storage. Lucille Goddard is actively scanning documents. This is also new territory and Gary Dukes suggested a policy be developed for this form of storage. With no further discussion and all in favor, a policy will be developed.

16. Nominations-No report Wayne Trainor

Special Committee Reports **Presenter**

17. Awards and Scholarships Trisha Miller
    - Announcements went out via email and NCSRC Website for the call for nominations for the 2012 Practitioner, Physician, and Educator of the year. The original deadline for nominee submission was on April 15, 2012. That deadline was extended until September 10, 2012 with an email "blast" going out in order to make everyone aware. We received several nominations in the various categories. The award recipients were based on the information provided in the nomination form. All nominees were well deserving of the award but some really stood out in their accomplishments.
      We would like to have in place a more informational guideline for the chair and committee members. I would be glad to work on this having just gone through the process. Travis and I would like to thank everyone who submitted nominations and everyone that helped us get information out.
      The NCARE Scholarship committee had a tough job with 10 applicants from 6 different colleges. Thanks to the members of the committee - Lanny Inabnit, Lorraine Brodziak, Wendy Ayscue, and Cindy Wiggins. The Jim Whitley Memorial Scholarships went to NicholasHagler from Durham Tech and Jill Hoerr from Catawba Valley Community College.
      The winners will be announced at the Annual Business Meeting, September 26, which starts at 8:00 am.

18. Home Care/Alternate Site Care John Flynt
    - An explanatory handout from the American Association For Homecare (http://www.aahomecare.org/)was passed out. Basically this addresses H.R. 6490, the "Medicare DMEPOS Market Pricing Program Act of 2012." Letters need to be written to

support this bill and get it passed. The bottom line is the government saves money and quality patient is provided. Please do your part in supporting this bill.

19. Sputum Bowl — Ricky Bowen
    - There are 5 student teams and one half of a practitioner team. There was discussion concerning the lack of interest in practitioner participation. The Committee recommended that at least 3 teams were needed in order to have a competition. Kim Clark made a motion not to support the 1/2 practitioner team. There was discussion and due to no public notification, the motion was restated to read, a minimum of 3 teams must be in place and have met the requirements in order for participation in the competition but the practitioner team for 2012 will be supported this year. With no further discussion and all in favor, this will be carried.
    - Ricky informed the group of the AARC "Sputum Bowl" changes. These can be found on the AARC website.

20. Chartered Affiliate — Terry Smith
    - NC came in 2nd place after Washington.

21. Vendor Representative – No report — Tony Long / Les Foss

22. Research — Dan Grady/Terry Smith reported for Dan Grady
    - There are 16 abstracts for presentation.

Related Professional Organizations — **Presenter**

22. NC Association of Respiratory Educators (NCARE) — Lanny Inabnit
    - Mentioned the NCARE meeting that will held tomorrow. Thanked the Mentors and Mentees as well as Robin Ross, Tim King, and Bill Keiger for the initial footwork and their continued support.
    - Respiratory therapy lost a great educator recently to an accident. Gail Gain was the Director of Clinical Education at Robeson Community College. Kelli Heustess, Program Director informed Lanny of an Endowment Scholarship that has been set up for Gail.
    - Lanny made a recommendation to have a raffle during the conference for the Gail Gain Endowment Scholarship. All were in favor.

23. NC Respiratory Care Board (NCRCB) — Terry Smith
    - To view the AARC Position statement on staffing, go to the website and in the search box, type in "staffing and you will be directed to the statement. AARC is preparing to conduct a survey for Managers and Therapist.

24. Polysomnography — Bruce Warner/ Wendy Ayscue reported for Bruce
    - There is a push for all labs to be accredited. The Sleep Society is also working toward all states having licensure. NC is one of the states that does not have a license in polysomnography.

Old Business — **Presenter**

New Business	Presenter
o AARC Disaster Relief Fund AARC International Fellowship Fund	Garry Dukes Connie Paladenech

- Gary Dukes made a motion to donate $500.00 to the AARC Disaster Relief Fund and $500.00 to the AARC International Fellowship Fund. Myra Sterns seconded this motion and with all in favor, will be carried.

o Social Media Policy	Lawson Millner

- This was discussed earlier in the meeting.

o Central BOD vacancy	Kim Clark

- This was discussed earlier in the meeting.

o Symposium 2015- Tabled.	Kim Clark
o Lucille Goddard	Kim Clark

- Kim Clark made a motion for Lucille Goddard to continue as Executive Secretary until June 2013. All were in favor and this will be carried.

Kim thanked everyone and welcomed Robin Ross into her new position as NCSRC President. Kim motioned to adjourn the meeting. Myra Stern seconded the motion and with all in favor the meeting was adjourned 3:58 PM.

Respectfully Submitted,
Trisha Miller, RRT, RPFT, RCP

American Association for Respiratory Care

House of Delegates
Santa Fe, New Mexico
July 16-17, 2012

NCSRC Delegates Report
Connie Paladenech, RRT, RCP
Garry Dukes, RRT, RCP

The AARC House of Delegates convened in Santa Fe, New Mexico on July 16th thru 17th 2012. The following report is a somewhat lengthy summary of the events, initiatives, and discussions which will have on the practice and profession of Respiratory Care. The first section of this report contains an overall general summary. The second section of this report provides detailed information on a variety of specific subjects of interest. Please contact Garry Dukes and/or Connie Paladenech if more expansive detail is required for any of the items in the report below:

House of Delegates Meeting Summary

Credentials committee:

- Recommend changing state bylaws to reflect president elect, president or past presidenthas the ability to be a substitute delegate. (NOTE: NC Bylaws already reflect that the President-elect may optionally serve as a member of our delegation.)
- HOD presented with recognition plaque for support of International Fellows Program

Executive Director Report (Tom Kallstrom):

- States should take advantage of the revenue sharing /co-marketing agreement with the AARC that would bring additional money into your state
- AARC is currently planning a Prep Course for the NBRC registry exams
- AARC is planning a "new and improved" Sputum Bowl to include audience participation (audience response system).
- Disaster relief--$100,000 in distributed funds since its beginning
- Building a simulation tool box
- Post graduation courses done this year
- Convention update: (New Orleans, Nov. 10-13 2012)
    - 800 lecture proposals,with new and improved sputum bowl
- Future important dates:

HOD meeting New Orleans	November 8th and 9th, 2012
International AARC Congress	November 10th-13th, 2012
World COPD Day	November 14, 2012
AARC/PACT in Washington	March 11th and 12th, 2013
Summer Forum-Orlando	July 11th – 13th, 2013

- Public event – There will be a "health education program" during International meeting in November. Need support from members.
- "Drive 4 COPD" effort has changed and is now supported through COPD Foundation. Events continue to be done. Working closer with VFW/ American Legion coordinating events.
- Peak Performance USA– over 900 schools in 36 states reached approximately 46,000 elementaryschool students.
- World COPD Day will be on Nov 14th, 2012.(World SpirometryDay was June 27th 2012.)
- Center for Disease Control – 2 RT's worked with them on "VAP Definition" working group
- Hospital Care Collaborative – meets yearly
- American Hospital Association-working on team building concepts
- Web Site Overhaul – Focus Group looked at alternatives; currently being worked on
- Projects:
    - COPD toolkit to use for preparing pts for discharge – Beta testing being started.
    - Aerosol Guides- Phillips to fund revision of all 3 documents – hoping to be done by Nov.
    - Safety checklists have been developed for transporting patients on oxygen throughout the hospital.
    - ICU Discharge scoring checklist – is the patient ready for discharge? Both available on website.
- Hosp to Home: serious of webcasts being developed. Teach patient how to use devices before leaving the hosp.
- New Pamphlet – Why Quit using Tobacco
- Alpha-One Course has been put together.A study is underway as to how RT's can make a difference in diagnosing.
- VAP Course is online and isiPOD Touch, iPhone and iPad compatible
- Hospital Readmissions – important and should be on everyone's radar screen. COPD is 3rd on readmission list, with pneumonia us high on the list as well. Focus should be made and programs developed by RT's to decrease readmissions is important. CMS has announced financial penalties for hospitals with higher than normal readmissions. Patients with a diagnosis of AMI, CHF, and Pneumonia will be targeted for 2013, and COPD and CABG for 2014.

- HB 941 (targeting Medicare Part B)
    - Reworking language in current bill to reflect the RT role in disease management.
    - After language of our bill being reworked, it will then be rescored and reintroduced.
- CPG – process started. Shawna Strickland taken leadership role in this effort
- 2015 and Beyond – process continues. Board to review and consider accepting the competencies needed by future graduates and RT workforce. Website updated.
- Black Lung Association and Pulmonary Fibrosis Association to join the AARC/PACT on the hill.

Treasurer

- With last years donations, the disaster relief fund balance just under $60,000

Consideration of Resolution

Resolution 23-12-01 – The AARC develop a position paper deeming the administration of bronchodilators tohospitalized patients for off-label use as Medicare abuse and waste.

Results of discussion and deliberation:

- Friendly amendment added: and or Medicaid (after Medicare).
- Friendly amendment added: in adults (after off-label use).
- Friendly amendment: That the AARC develop a position paper deeming the administration of bronchodilators to hospitalized patients be in accordance with evidence-based medicine and professionally based standards of care.
- Friendly amendment: Inhaled medications in place of bronchodilators.

Final disposition of Resolution

- Tabled for later in the agenda.
- *Resolution withdrawn by author.*

AARC President Report (Karen Stewart):

- AARC Disaster Relief Fund is at $60,000 level. Once the funds reach the $100,000 level, funding can increase to recipients. So far in 2012, the AARC has had no members apply for the funds.Once there has been a declared a state or federal national disaster, then the member can request some support.
- AARC is listening carefully to Management list serve concerning productivity and staffing issues. The new Position Statement on Best Practices in Respiratory CareProductivity and Staffing" will be soon posted on the Web Site. A white paper will be developed and will have evidence to support it. Once it has been developed and approved, there are tentative plans to send it to all CEO's across the country.
- 2015 and Beyond Activity: process is owned by the AARC BOD. There are 2 co-chairs – Lynda Goodfellow and John Hiser representing both the AS and BS interests. Last December, the AARC BOD approved a motion to endorse the previously published 2015 and Beyond Report that highlighted the proceedings of the first conference, Creating a Vision for Respiratory Care in 2015 and Beyond. The AARC took content of the second paper published in the May Respiratory Care magazine,with the information about the competencies for the future graduate and respiratory therapy workforce, to various stakeholders for review, discussion and input. Information from these meeting is currently being analyzed. The Ad Hoc Committee is charged with reviewing all information and making recommendations at the November BOD meeting. There is no predetermined conclusion and there is nothing specified about degree level. A Work Group is being planned for 2013. All current information is available on the AARC website.

- Clarification of policy – AARC BOD has the right to suspend a chartered affiliate in a situation where their affiliate Bylaws are in conflict with the AARC Bylaws, until that conflict has been resolved. The Bylaws Committee's role is to make recommendations to the AARC.

American Respiratory Care Foundation

- $100 fund raiser will be held at the International Meeting in November.
- Asking members to donate $5.00 each. Tax deductable donation.
- Short video being created to show the benefits if supporting the ARCF. Each member to receive this video after completion.
- Research grants available for aerosol delivery to the tracheostomy patient.

International Committee:

- International Fellowship program has been moved over to the AARC from the ARCF.(Checks for this purpose should now be made out to the AARC.)
- With this move, it will allow additional sponsorship of fellows. (Under the ARCF sponsorship,funding ratio had to be 2:1, and under the AARC sponsorship can be 1:1.
- Looking at a new program designed to determine how to affect respiratory care in other countries by bringing individuals to the USA and having them take back what they learned to their country.
- WakeForestUniversityBaptistMedicalCenter was chosen to be a host for this year's program. The International Fellow from Ecuador will spend 1 week in Winston-Salem this fall.

Legislative Affairs:

- Hospitals are not accounting for all items separately billed for pulmonary rehab. CMS has set the 2013 reimbursement at $39.58.
- The AARC has a pulmonary rehab tool kit for use. Need to work those in the hospital who do the charges to capture all charges associated with the pulmonary rehab, therefore, hopefully increasing reimbursement.Reimbursement for Pulmonary Rehab will increase by approximately $1.00 for FY 2013.
- AARC PACT "on the hill" will be March 11th and 12th, 2013
- Reworking HR941.Being drafted as Chronic Obstructive Disease Management by Respiratory Therapist. It will have a package of services provided by the RT. Similar to diabetes disease management. This bill will be rescored and may be introduced into this session or the next session.
- Michigan RT licensure is ear marked for de-licensing. Indiana license to be scrutinized later this year. There is a climate of de-regulation.
- There has been an increase in COPD Awareness "days" and "months" throughout the states.

Professional Mentorship and Volunteerism:

This Ad Hoc Committee is asking for members to join their AARConnect community. Trying to develop a forum to find what individuals are doing in there states. (Talk to your states let the members know we are highlighting those member doing good things.)

Chartered Affiliate:

- Recommendation outstanding affiliate – Debbie Linhart, from Illinois Society for Respiratory Care
- Life membership nominees submitted to Executive Office - John Hughes and Debbie Fox.

- Summit award winner – Washington Society for Respiratory Care
- Excellence states: North Carolina Society for Respiratory Care and Washington Society for Respiratory Care
- ***Would like to see more applicants.***
- Working on the Outstanding Affiliate Contributor and Life Membership award application similar to the summit award. A draft will be presented in November.

Open Microphone topics

Virginia – Natalie Napolitano

House bill entered into energy and commerce committee to allow Primatine Mist back on the shelf. Asthma inhaler relief act of 2012.

New York – SheriTooley

Photo contest—reminder. Talk it up at the state societies.

Suggest that we mail their gifts with a note that they were missed as a gesture of good will.

North Carolina- Garry Dukes

NCRCB passed a position statement on Staffing Standards and are looking at making it a Declaratory Rule. If any state is interested in doing the same let him know.

Affiliate Best Practice Presentations:

Best Practice: Group Discussion – State Use of AARC Website

- Many states are starting to use the AARConnect to create a "Community" for its state members to communicate.

Best Practice: Shawna Strickland, Missouri– MSRC Student liaison program

- Student sections at state meetings –topics/tracts just for students/ professionalism
- Scholarships up to 3/yr.
- Student leadership award.
- BOD developed program—Who were the stakeholders, solicit feedback. Drafted procedure- proposal passed. Criteria formulated with selection committee MSRC Executive Committee. Applications were blind to the committee. Committee members who were in education abstained.
- Winner complimentary three state meeting admissions- required to attend BOD meetings.
- Liaisons assist with the student section of the state meetings.
- Have decided to fund student liaisons to the HOD fall meeting.
- Students were excited that they could influence policy. Networking was fantastic.
- BOD like that the student body has a voice on the BOD, there is great mentoring potential.

Best Practice: Jo Dwan, Oregon– Experience with Polysomnography Licensure

- Oregon had sleep tech that were told they were in violation of the RT Licensure Act
- Licensed RT's should not need a separate license in your state.
- Be sure there is a RT exemption in the law. There will be distrust. Look at every line of an Act. Be extremelyclear. Allow RT supervision and remote supervision for the rural area.
- Credentials RPSGT and SDS were accepted.
- Look at CEU's, Medical direction.
- Knowledgeable people available as resources.

- Show of force, Respond to every "Comment Period".

Best Practice: Kerry McNiven, Connecticut - The pressure to make Sputum Bowl fun again!

- Why the Changes – Barriers – 1) Lack of participation and commitment to go to Nationals, 2) Fears toward being able to answers questions.
- Changes: individual competition and multiple choice questions.
- Sponsorships, with a raffle for door prizes. Particularly hard question with few correct answer on the honor system individuals were given prizes.
- Audience response systems. Renting approx $700 purchase cost $1000. Grant monies available.
- Freesoftware:WWW.einstruction.com—don't forget to Enable Add-Ins on your power point in order to change questions.
- Winners identified by clicker number.

Best Practice: Rick Weaver, Colorado – Bylaws Best Practice

- ***Know when your affiliate's bylaws are due for review by the AARC.***http://www.aarc.org/state/aarc_hod/bylaws_status.html
- Start revision one year prior to review.
- Follow proper stepsin the Chartered Affiliate Handbook: http://www.aarc.org/aarc_hod/chartered_affiliate_handbook.pdf***Print these documents and have them available in an Affiliate Policy and Procedure manual given to new board members.***
- Submit 90 days prior to next HOD meeting.
- Date your Bylaws!!!!!! Take a look at the AARC Bylaws page and be sure your most current copy is on both your state's and the AARC's web pages.
- Affiliates are now starting to include an Affiliate Life Member in their bylaws.
- Consider having a AARC Bylaws link on the affiliate website.
- Consider including term limits, committee composition and duties, agenda format and election timelines and details in a Policy and Procedure Manual (and not in Bylaws).

Best Practice: Tony Lovio, AARC Office-Understanding Financial Reports

- This presentation included a basic overview of the various types of financial reports, with accounting definitions provided. It also included information about tax returns—Annual informational, income taxes, sales taxes, unemployment taxes.
- AARC Financial Reports sent to AARC BOD, House Officers, Finance Committee, Audit Committee
- Budget preparation for each new year begins in August.
- This information will become part of the delegate orientation information.(Note: This may be something that the NCSRC would want to "borrow" to include in our BOD packets for new BOD Members.)

Membership Committee Report:

- Active members – 42,124
- Total members – approximately 50,000
- Specialty sections need 1000 members to have a seat on the AARC BOD
- Goal – Want the majority of the RT's in your state to be members of the AARC.
- ***AARC members have been challenged to reach out to one person to become a member of the AARC***.

- Campaign – Find department leaders who were not AARC members and invited them to join. 759 Department heads were identified who were not AARC members.Only got 4 new members during the "1st round".
    - Invitation letters went out in June. Minimal or no hits to site to join.
    - Offer – Try for 30 days free, with membership you get a 1 year free membership to Management section.E-mails sent out in July.
- New campaign. General membership campaign that is not snail mail.
    - ***State Affiliates to get campaign information to all leaders, members and non-members.***
      Work on increasing membership:
      Membership versus Licensure Targets
      If <25% shoot for 25% more
      If >25% and<50% shoot for 50% more
      If >50% and<75% shoot for 75% more

Specialty Sections Update:

Management – membership 1806

- Improved library features on AARConnect.
- Working with Home Care Section on the "Hospital to Home" project
- AARC BOD passed a Position Statement on "Best Practices in Respiratory Care Productivity and Staffing".
- AARC BOD also passed a motion that gave a directive for an Ad Hoc task force to develop a white paper on same subject.

Home Care– membership 900

- Pressure on reimbursement. Competitive bidding is an issue.
- Home care will be very important to the hospitals.
- Hospital to Home Program:what can we do with RT led programs to prevent re-admission
- Little data available on what works best for home care patient. AARC exploring conducting a survey of home respiratory patients to get their viewsand perspective towardsthe care they receive.
- Webinar planning – talking about re-admissions.
- Looking at possibility of combining the Home Care and Long Term Care sections.

Adult CC – membership 1378

- Publishing a monthly newsletter and have a Journal Club of 235 members.
- Currently presenting case studies by Skype.
- Working on a product to allow members to prepare for the Adult Critical Care specialty exam.

Neonatal Pediatrics – membership 2117

- Forming a new journal club by August with bi-monthly topics. Topics based on what is foreseen as the big topics at National congress.
- Increasde interest in research. Abstracts are of better quality.

Education: membership 1175

- Changes and challenges in education.
- Read the information about the 2015 and Beyond project
    - In May, AARC BOD approved the first paper related to competencies.

- In July, the AARC BOD passed a motion to investigate ways to achieve competencies.

Sleep: membership <1000

- Membership greater than 1000 was not maintained, and this section will not have a seat on the AARC BOD next year
- Society for Sleep Medicine is actively working every state, especially those states without "sleep licensure". Currently North Carolina has registration only.

Diagnostic:

- Diagnostic specific Webinar in the works.

Surface to Air transport:

- Reaching out to active duty transport teams to increase membership.

AARC Management and Education Update (Bill Dubbs):

- 2015 and Beyond link on the AARC website.
- Professor's Rounds has a great line-up.
- Webcasts are available only to AARC members and free CRCE for members of a section the presentation was created for.
- This is the 9th year for benchmarking, and now with 140 subscribing institutions. Information on the website. The cost is $700 for the first year, and down to $495 subsequent years if you are putting in data.
- Productivity and TimeStandardDevelopmentResourceCenter – available to AARC members.
- AARC Uniform Reporting Manual – system to help you look at productivity. This year's survey included other areas of service that RT's find themselves in(Out-patient facilities, Pulmonary Diagnostics, ABG, Rehab and more). Response to the survey was the highest ever. Survey results are currently being analyzed with publication of new manual expected in the fall (possibly September). The publication with also include tips to developing productivity systems based on RVU's and determining FTE's.
- "Content areas" will now appear on AARC CRCE transcripts.

Affiliate donations made at HOD Meeting:

- $6500 to Disaster Relief
- $4100 to International Fellows program

AARC BOD update (Report on additional activity occurring at July AARC BOD Meeting)

- Requested that resolution activity be sent to the AARC BOD electronically for faster disposition.
- Approved Position statement on "Respiratory Therapists in the Emergency Department"
- Motion made to amend the AARC bylaws to state that the immediate past-speaker be a voting member of the AARC board of directors.

The following reports included expansive details submitted to the House of Delegates by:

1. AARC Executive Director Report
2. AARCState Government Affairs Office Report
3. AARCState Government Affairs Committee Report
4. AARC Federal Government Affairs Office Report
5. AARC President's Report
6. American Respiratory Care Foundation Report
7. National Board for Respiratory Care Report
8. AARC Board of Medical Advisor's Report
9. CoARC (see attached separate file)

Executive Director Report

Reporter: Thomas Kallstrom MBA, RRT, FAARC

The following are highlights from the Executive Office since the spring meeting in Dallas in April.

Membership

Since January of this year our membership efforts with the Membership Committee chaired by Frank Salvatore have focused on managers. We have been able to identify hospitals where a manager or director is not a member. In early June the membership committee sent directed messages to managers who are not members to join the AARC with an offer of complimentary management section membership while describing the many benefits of AARC to the operation of their department. We will be prepared to provide you with an update on this initiative in Santa Fe.

At last report (June 28th) our membership numbers are at 50,861. This compares to 51,054 a year ago (June 30, 2011). As happens every year at this time we see a drop in our numbers in late spring due to student membership adjustments. This tends to reverse itself in August when student members engage with the AARC. We have kicked off the web student program for this scholastic year with a letter to all program directors and faculty names are being submitted.

July is the first month that we will be offering our new membership rates. There are three membership rates (all of which are full memberships). The change allows members the choice of how to receive the two publications (AARC Times and Respiratory Care Journal). The incentive for our members is that they can actually get the same benefits and publications at a lower membership rate.

Digital only	$78.50/annually
Receive one publication	$84.25/annually
Receive both publications	$90.00/annually

All members automatically have access to both publications on line regardless of which option they decide upon. Again this change will not change the revenue sharing agreement. The AARC will continue to provide the affiliates with $12.00 for each active and associate member. We are

also upgrading our web platform so that the member will be able to take advantage of features that are not available in the print medium.

In 2013 the AARC will begin the "Senior Discount Membership". Members will retain their current member category (Active, Associate, etc) and retain the rights of that membership type. To be eligible the member must be 65 or older with 20 years of consecutive AARC membership. A 10% discount will be given for any dues tier. Membership will be made aware of this change later in 2012.

Co-Marketing Opportunities with our State Affiliates
There are 33 affiliates who have signed revenue sharing agreements and 32 who have opted for co-marketing agreement with the AARC. This program allows the affiliates more financial support in addition to the revenue sharing program. We will be rolling out more co-marketing opportunities for the Affiliates this year.

Professional Advocacy
1) AmericanHospital Association
As noted at the spring board meeting the AARC was invited to participate in a meeting hosted by American Organization of Nursing Executives and the Human Resources Section of the American Hospital Association in Washington, DC. Many hospital-based professional organizations were in attendance. President Stewart and I represented the AARC. The purpose of the meeting was to discuss current needs and future projections for each organization in the provision of health care. This invitation was significant because it was the first time we were asked to the AHA to sit at the table for such a meeting. It was the 90's when the AHA actually was working to phase out our profession.

One of the first initiatives will be for all hospital-based health care professions to share with their organizations, consumers, and patients a clear message that the provision of care in the hospital is provided by a health care team who all recognize and respect what each discipline provides to our patients. The theme of this meeting is consistent with the AARC vision, noting that the AARC is also a member of the Hospital Care Collaborative, the direction of which the Board of Directors reaffirmed at their meeting this spring. Other health care organizations represented at this meeting were:

- American Society of Clinical Pathology
- Academy of Nutrition and Dietetics
- American Occupational Therapy Association
- American Society of Health-System Pharmacists
- American Society of Radiologic Technologists
- American Physical Therapy Association
- American Organization of Nursing Executives

2) Adventures of an Oxy-phile 2
The book authored by Dr. Petty and associates was audio recorded at a professional sounds studio. Patrick Dunne is the narrator. The AARC will make these available for download from YLH and AARC.org. This is a unique way to spotlight his last book, which will be a treasure to many that knew him and knew of his work.

3) Drive4COPD
The Drive campaign has been officially turned over to the COPD Foundation. The AARC will play a more significant role this year and moving forward. In fact the AARC is a major partner in this new effort. As was presented at the spring BOD meeting we have received grant money from COPD Foundation for the purpose of filling a new position with the Drive. This position

will be a COPD Coordinator. Her/his role will be to coordinate public Drive events as well as to expand the current venues. The position was posted on the AARC Job Site and interviews are being conducted. We will be working closer with the American Legion, VFW, and Am Vets organizations moving forward. We will continue to work with the House as we evolve the Drive4COPD campaign in the coming years.

4) Peak Performance USA (PPUSA)
AARC's National Asthma Education and Prevention Program (NAEPP) representative, Delegate Natalie
Napolitano has promoted PPUSA to the NAEPP coordinating committee members and asked that they share information about the program to their perspective members and constituents. NAEPP leadership fully supports PPUSA. We continue to promote in AARC communication vehicles including our web site, News Now, and AARConnect. PPUSA has reached an estimated 45,978 children with asthma. It has been implemented in 885 schools in 34 states.

5) HOSA
HOSA's 2012 Annual National Leadership Conference was held June 20-22, 2012 in Orlando, FL. Members and students from the ValenciaCollege in OrlandoFL staffed our booth and represented the AARC at this meeting. A report will be posted on AARC website soon.

6) Tobacco Cessation Booklet
Our second grant for the Tobacco Cessation booklet was received and an additional 200,000 copies printed. We are reviewing our options for distribution to assure that all members have access to a reasonable number for free, and can then purchase additional copies. We expect the program to become self-sustaining, based on the initial response.

7) Joint Commission Field Reviews
The AARC continues to participate in the Joint Commission Standards Field Review process. The volume of standards so far this year continues to be substantially less than in previous years. Since the last board report we responded to these reviews relevant to respiratory therapy:
• Clinical Alarm Management Environmental Assessment (03-26-12)
• Proposed revisions to the Disease-Specific Care (DSC) Certification Program Standards (4-27-12)

Meetings and Conventions
1) AARC Congress 2012
Logistical planning for AARC Congress 2012 is progressing as scheduled:

- 150 (+) speakers
- ~ 275 unique presentations
- Several first time speakers to the AARC Congress have been invited to present; creating a portal for new talent into the AARC.
- All specialty sections are represented in the Congress program with representation from most roundtables.
- Two pre-course offerings are scheduled one day prior to the Congress
    - o Patient Safety
    - o Post-graduate mechanical ventilation course

2) Summer Forum 2012

- A full 2.5 day Program has been created to address educational needs of educators and managers
- There is a continued emphasis on creating course offerings for hospital-based educators (an untapped demographic for the Summer Forum)

- Two post-graduate course offerings have been scheduled.
    - Pre-course: “Building a Simulation Toolbox”
    - Post-course: “Getting the Best Return on Your Investment: Maximizing Patient Education”
- A smartphone application is offered in conjunction with the meeting. It will include a schedule, course descriptions, and add sessions to your personal calendar, speaker bios, and ability to rate speakers.
- Pre-registered attendance is on schedule to meet budget.

3) Summer Forum 2013

- Summer Forum 2013 will be held in Orlando, FL at the Marriott Renaissance: Orlando at SeaWorld.
- This property is located adjacent to and within walking distance to Orlando SeaWorld.
- The last Summer Forum held in Orlando drew record attendance and we anticipate that trend to continue in 2013.
- Orlando is a prime vacation destination with multiple options for recreation and entertainment. We anticipate many attendees will travel with family.

Projects Update

1) COPD Toolkit

The COPD Toolkit is completed and has been submitted for legal review. At the time of this submission, all supporting documents have been approved with anticipated approval of flip chart at the time of this meeting. Beta test is tentatively scheduled to include 20 hospitals, each using the Toolkit on 100 COPD patients per hospital. Participating hospitals have been identified. Data will be collected from patients to identify whether or not teaching via the materials provided were effective, and if so, to what degree. Estimated Completion Date: Fall 2012

2) Patient Safety Checklists

The Patient Safety Checklist project is now complete. Phase One (Oxygenation and Patient Transport) was completed in February, with Phase Two (Respiratory and ICU Recidivism) was completed in June.

Three patient safety checklists are now available for download off of the AARC website (http://www.aarc.org/resources/safety_checklist/). Both Phase One and Phase Two rollouts to membership included a story on the website, an article in the AARC Times, and a webcast. These checklists will reinforce the importance of the respiratory therapist as members of the team in promoting patient safety.

3) Hospital-to-Home

The Hospital-to-Home initiative continues to move forward in educating hospital-based RTs on issues facing patients as they transition into the home environment. This includes best practices, equipment in the home, disease management and patient education, and discharge planning. The end goal is to create improved relationships between hospital-based RTs, homecare RTs, and the patient. Educational webcasts are scheduled to take place in August.

4) High Flow Heated Humidity

Identifying that there are knowledge gaps, a lack of evidence, and potential misuse of this technology, this project is designed to encourage RTs using this therapeutic modality to engage in research so that adequate evidence is available to draft a white paper/clinical practice guidelines. An IRB template that participating RTs can use to submit to their respective hospital IRB has been completed and submitted to Midland IRB for review. RTs will be encouraged to use this template and submit a research application to their own IRB. Once approved, the

research study would collect evidence on the clinical effectiveness and safety of this technology. Once adequate data is collected, the AARC could draft a clinical practice guideline/white paper on the proper use of this technology.
Target completion date:
• IRB template: July 2012.
• Rollout to Membership: September 2012
• Data collection: ongoing.

5) Office Spirometry
We have been asked to extend our clinical trial Spirometry QA program through Feb 2013. It was scheduled to expire in August. Our train-the-trainer program has been well received and produced good results. We have trained about 160 health care professionals to provide training in primary care offices. They have conducted training for over 100 people, with 38 out of 39 successfully passing the online test.

6) Benchmarking
As of June 1, there were 139 facilities participating in the benchmarking service. Our persistent monthly follow-up continues to yield a higher percentage of subscribers with current data. Members of the benchmarking committee continue to personally contact new subscribers within one week after they have gained access to the system and offer personal assistance to facilities that are within 4 months of their expiration date and have not entered at least one quarter of data. We continue to encourage subscriber engagement by holding monthly teleconferences.

Education
1) Professors Rounds
9 topics and speakers (including one bonus program) constitute the 2012 Professor's Rounds series. All production dates have been completed except for the last two, which will be completed by the end of July. Following that we will begin planning the 2013 series.

2) Web Casts
By the end of June we will have conducted 10 webcasts. We have dates for 6 more and have commitments for 2 more at this time but dates for those have not yet been established. We continue to attract a large number of participants.

3) 2015 and Beyond
As per the BODs direction a 2015 and Beyond placement on our web site (aarc.org) was added. In the first week after it was put on the web site there were over 11,000 views. This will be housed permanently on our main page so that anyone who wishes to learn about this project as well as to get current updates will have access.

4) AARC Research Fund
The BOD approved $88,020 to fund a research proposal from BarnesHospital for a respiratory therapist to serve as an advanced patient care coordinator for patients discharged from the hospital with COPD/asthma. Their role would be to oversee the discharge of the patient to insure that respiratory treatments and medications are appropriately prescribed for outpatient therapy, that adequate follow-up occurs post discharge in a medical clinic, that outpatient access to medications is available, and that other social services are involved as needed. They will also monitor study patients to assure adherence to COPD/asthma management guidelines during their inpatient stay. The desired outcome would be to reduce readmissions to the hospital and visits to the emergency department while at the same time documenting the value of the respiratory therapist in this critical role. A payment schedule has linked acceptable periodic performance

reports to payments has been agreed upon. The study began on June 1 and the first report is due September 12, 2012.

Communications Update
We continue to monitor communications between our roundtables and section members. Attachment #1 indicates that some groups are more engaged then others. The Roundtable members are using this communication tool far less then section members.

Membership Analysis
Membership numbers from other medical organizations are review annually.

State Government Affairs Report

Reporter: Cheryl A. West, MHA, Director Government Affairs

A significant number of state legislatures have adjourned for the year, although several legislatures, such as Michigan, New York and California remain in session year round. The tentative economic recovery has not mitigated the budgetary pressures on state finances. Unlike the federal government, states must balance their budgets every year. Thus, states continue to search for new revenue sources (raising licensure fees and tobacco excise taxes, increased state higher education tuition as examples); revising Medicaid payments (ex. moving towards competitive bid payments for DME); diverting tobacco prevention and cessation funds to other state health programs and amending eligibility requirements for state services.

Legislation
As always noted, legislation introduced is never guaranteed to be enacted into law. The bills listed below highlight key legislation that are of particular interest for the respiratory therapy profession. Please note, because of the volume of activity from the many states that pass legislation raising tobacco taxes or restricting smoking in public places I have not included these bills in this report. Although there are two bills that are "interesting": **Arizona**legislation that will classify electronic cigarettes as tobacco products, and a bill in **West Virginia**that would prohibit employers from discriminating against smokers… just FYI.

Michigan Government Recommends Repeal of MI RT Licensure
Nearly a year ago, Michigan Governor Rick Snyder rather quietly tasked staff from the Office of Regulatory Reinvention to review and make recommendations that, in the name of "over-regulation" would present a list of professions that this panel recommends to be "de-licensed", i.e. removing the state from oversight and regulation. The final report from the Commission included respiratory therapy as one of the 18 professions recommended to be "de-licensed". (Also on the list of health professions slated to be "de-licensed" are occupational therapists, speech therapists and dieticians/nutritionists). According to the Deputy Commissioner of the Office of Regulatory Reinvention the these professions were selected because "We found that there were at least 18 occupations that did not require regulation. These regulations provide little or no significant protection to the public". The rationale given in the Report to "de-license" MI RTs is that the NBRC credential is sufficient to "provide employers of the qualifications of the respiratory therapists."

To put it mildly the Michigan Society for Respiratory Care –MSRC (see attachment 1), the AARC (see attachment 2) and the NBRC (see attachment 3) adamantly oppose this recommendation. The MSRC has organized an all out coordinated response to this initiative. The Governor has the discretion to remove any profession that is on the recommendation list. For those professions not removed by the Governor and thus remain on the list, the set of

recommendations will be sent to the Michigan legislature for debate and decision. Therefore, the MSRC's first plan of attack is to approach the Governor with the rationale why it is imperative to remove RTs from the list. If the Governor fails to act on the persuasive arguments, the MSRC's considerable efforts will turn to the legislature where an all out lobbying effort by MI RTs will get under weigh. I want to take a moment to commend the MSRC's exceptionally well coordinated, organized and strategically planned response to this threat not only to the RT profession, but one if implemented will jeopardize the health and safety of Michigan patients. As this report is written the outcome of this situation is very fluid and I will provide an update at the July meeting.

RT Licensure Legislation

1) Iowa- legislation was enacted that permits "qualified health care providers" defined in this bill as physician assistants and advanced nurse practitioners to write RT orders (in addition of course to physicians).

2) Nebraskaenacted a similar bill, but permits NPs and PAs, and CRNAs to write RT orders.

3) Missouri – again similar legislation as in Iowa and Nebraska, but bill would only extend RT order authority to advanced practice nurse.

Comment: These 3 legislative initiatives result from the relaxing of Medicare Hospital Conditions of Participation for RC Services. These new rules permit RTs to take orders from a select set of non physician practitioners (termed by CMS as "qualified health care providers") without the need of a physician co-signature. However, one of the stipulations by CMS for this more lenient policy is that this must be "in accordance with state laws". If RT licensure laws permit RTs to take orders only from physicians, then this less restrictive Medicare policy cannot be implemented. Therefore, the intent of these bills in MO, NE and IA, (where the original RT licensure law language permits only physicians to write RT orders) is to revise the laws in order to meet the requirements of CMS's more flexible policy on RT orders.

4)WashingtonStateenacted a similar revision to the RT practice act in 2011.

5) Ohioexpands the authority of CRNAs to direct a list other professionals including RTs to administer drugs.

6) Arizona, Idaho, Mississippi and Wisconsin-technical corrections to RT licensure law.

7) Louisiana– (**enacted**) Legislation addressing paramedic regulatory personnel requirements was introduced. The actual paramedic revisions had no impact on the RT profession. However, what was noticed when reviewing the legislation was that current law (not undergoing any revisions) had explicitly listed the health care professionals permitted to ride as ambulance transport personnel. Respiratory therapists were not listed in the law. Recognizing that if some "entity" were to raise the legal issue of whether RTs could be part of transport teams (no as they are not listed in the law), the LSRC inserted a provision into the law that now legally allows for RTs to be part of a transport team, thus averting any future questions or disruption of transport teams.

8) Florida- a staffing bill focused on medically fragile children under 21who are in need of skilled care. The bill specifically requires 5 hours a day of skilled care which must be provided by a list of health care professionals including RTs.

9) California-a bill that would fine up to $100,000 and 1 year in jail if someone impersonates a licensed RCP or buys or sells a RCP license

10) Oklahomawill raise RT license fee from $75 to $100. Also, a bill requiring RTs to maintain a valid NBRC credential for license renewal was introduced. This NBRC credential bill did not move forward but it is of interest that this requirement is under consideration.

11) Oregonwill raise RT license fees an additional $50 to $100

Generic Health Profession Licensure Legislation that Includes RespiratoryTherapists

1) Colorado (enacted), **Nebraska, Ohio, &Oregon (enacted) -** these states have legislation that would permit in some fashion military personnel or the spouses of those in the military to more

easily obtain a health professional license. In essence, the education or testing requirements for licensure, in some manner would be waved for these individuals and their experience accepted in lieu of formal education and testing
2) Florida-a bill requiring all licensed health professionals to wear name badges with showing professional credentials when providing health services
3) Oklahoma-revises several provisions of various health profession licensure laws, including RTs. The intent is to consolidate disciplinary violations under one "roof" for most licensed health professions

Other Legislation of Interest to the Profession of Respiratory Therapy
1) Alabama (enacted) California, Connecticut, Florida, Georgia, Mississippi, New Hampshire, New York, Pennsylvania, Washington State, West Virginia (enacted) Wisconsin - would require pulse oximetry testing (among other tests) for newborns.
2) Colorado(enacted) would study the need for pulse ox for newborns
3) Connecticutlegislation was originally introduced to establish a small 5 site Medicaid pilot program to provide skilled home care for vent dependent patients with the services to be provided only by LPNs and RNs. The CSRC contacted state legislators with their concerns over the omission of RTs and the bill was amended to remove nurses and insert RTs (and advanced nurse practitioners). This bill has been enacted.
4) New Jersey a bill requiring oxygen providers to provide notice to the local fire department or company whenever they stop supplying or delivering oxygen or an oxygen delivery system to a particular patient and the O2 system has been removed from the residence.
5) Florida (adopted), Hawaii (adopted), Illinois, Kansas (adopted), New Jersey, New Mexico (adopted), Mississippi (adopted) and Utah- - a variety of legislation thatfocuses specifically on COPD, requesting more study on the causes of COPD and/ordeveloping strategies for prevention and management of COPD or recognizing the effortsof the state COPD Coalition (**North Carolina**-adopted).
6) Alabama (adopted) , Georgia (adopted) Florida, Illinois, Indiana, Iowa (adopted), Louisiana (adopted), South Dakota (adopted) all have legislation that eitherdesignates a COPD Day or a COPD Month
7) New York-a bill permitting nebulizers on school grounds. Another **NY** bill requires when teaching CPR in high school, the instructors must include the training on the proper use of nebulizers and these instructors must in turn be certified by a nationally recognized entity in the use of nebulizers. Another **NY** bill would require an asthma action plan forpupils who are permitted to use asthma meds on school grounds

Respiratory Related Rules/Regulations
A change in the rules and regulations for the profession of respiratory therapy may have just as much impact on how respiratory therapists practice as does amending the licensure laws for RT.
1) Florida-tweaks how to account for continuing education credits for license renewal.
2) Iowa and Delawarealso make technical changes to continuing ed credits.
3) Louisianamakes long anticipated and expected changes to RT regs, however these changes were not unexpected by the LSRC
4) Nevada- amends RT license expiration, technical change
5) Tennesseeis changing the fee for RT license
6) Alabama-will increase reimbursement for nursing facilities that care for vent or trach patients.
7) Maryland- decreases Maryland Medicaid reimbursement for oxygen and related respiratory equipment from 98 percent to 90 percent of Medicaid's reimbursement rate. The new reg also requires providers of oxygen and related respiratory equipment to document face-to-face encounters with Medicaid recipients within 6 months prior to ordering oxygen services, supplies, and equipment

8) Oklahoma-removes the requirement for a certificate of medical necessity for positive airway pressure devices (BiPAP and CPAP) because CMNs are no longer used for authorization decisions

Concerns or Challenges from Other Occupations

We continue to monitor legislative and regulatory activities by other professions and disciplines. Seemingly small changes such as who may provide a service, qualifications of the personnel to provide a service, what is permitted to be provided as a service and where services can be provided, can greatly impact and potentially diminish the respiratory therapy legal scope of practice. States continue to introduce legislation that expands the role of paraprofessionals.

1) WashingtonState-legislation was introduced to expand the scope of practice for unlicensed medical assistants, including providing "respiratory testing", which among other points of contention, is not defined.

2) Iowa- legislation that would create a new provider category termed "direct care professional". These individuals would care for patients in the home and community settings. Limited definitions of what would be required in terms of education, scope or competency testing. However, one point was clear- this new category would not be required to be licensed.

Sleep Disorder or PolysomnographyState Legislative Activities

1) Maryland

As noted in previous State Update Reports, the Maryland Polysomnography licensure law,was enacted (2006) prior to the availability of A Step, the American Academy of SleepMedicine-AASM(sleep physicians)- 80 hour OJT training course. The MD Polysomlicensure law requires polysom personnel to be graduates of CAAHEP accreditededucation programs. Being unable to meet this education standard, mandatory licensureor polysoms has been delayed by the legislature several times (now slated for October2013).

The original law did not include a specific exemption for RTs, but rather a general exemption for other licensed health professionals who are practicing within their own scope of practice. About 2 years ago, a statement from the MD Polysomnography
Licensure Board and confirmed by MD State Attorney General, that if the RT were to provide any service or procedure listed in the Polysomnography scope of practice (task specific) but not specifically listed within the RT scope of practice (purposefully general) the RT would require a polysom license.

The MD/DC Society engaged a lobbyist to advance a bill that would provide an exemption for the RTs from the requirements of the Polysom licensure law. A panel of RTs testified in at a February hearing in support of a RT exemption. The panel included Dr. Cliff Boehm (BOMA rep and Maryland physician – and RT). The bill was passed by the legislature and signed into law by the Governor.

In the meantime, the Sleep Society had its own bill going through the legislature that would add the A Step 80 hour OJT training course as an acceptable "education" pathway, comparable to an accredited CAAHEP accredited education program in polysomnography. This separate bill was passed and signed into law.

2) Iowa

The "standard" polysom licensure bill was introduced in this legislative session in Iowa.The bill contained objectionable provisions including no explicit exemption for RTs;insertion of the AASM's OJT A Step course as comparable to CAAHEP accreditedpolysom education programs; and a provision that would provide a backdoor giving thePolysom Licensure Board the authority to accept the American Academy of SleepMedicine's (AASM) non accredited test for the Registered Sleep Technologist as ameasure of clinical competency.

The Iowa Society for Respiratory Care engaged in an open dialog with the IA SleepSociety, and a number of the concerns (education and testing) had been, more or less,satisfactorily addressed. However, the key issue of an explicit RT exemption was rejectedby the IA Sleep Society.

With the refusal to accept the RT exemption provision, the ISRC leadership expressed its concerns to legislators and testified at a legislative hearing stating that without the RT exemption the society regretfully had no choice but to oppose the bill. The ISRC launched a statewide RT grassroots campaign with information and requests that went out to all IA RTs asking them to contact their own legislators and oppose the polysom licensure legislation. As a result of these efforts, the ISRC lobbyist has reported that the polysom licensure legislation was killed in committee (at least for this year).

Again, it should be noted that the leadership of the Iowa Society and the Iowa RTs were exceptional well organized and committed to addressing this issue and resolving it in a such a way as to protect the integrity of the respiratory therapy legal and long standing scope of practice.

3) Delaware
In mid April the all too familiar "standard" polysomnography licensure bill was introduced. Chief among the concerns of the Delaware Society was the absence of an explicit exemption for RTs. Fearing that what occurred in Maryland, (a general exemption, not an explicit one for RTs) the Delaware Society has taken its' concerns to the Delaware Sleep Society. At this writing a constructive dialog has occurred, with the Sleep Society offering to amend their bill to include an unambiguous exemption for the RTs. The DSRC leadership should be commended for its rapid and thorough response in addressing this legislation and thus far the positive interaction with the DE Sleep Society.

4) New Hampshire and Louisiana
Both state legislatures had technical changes to thecurrentpolysom licensure laws (NH polysoms are licensed under the RT Licensure Bd). Originally neither bill revisions had any impact on the RT profession. However, in **Louisiana,** unknown special interests inserted unacceptable revisions into the otherwise benign technical change legislation. The LSRC was able, through intense negotiations with the legislators to revoke the newly inserted changes and then include wording that would permit RTs to supervise RT students going through a polysom rotation.

State Government Affairs Committee Report

Reporter: Tom McCarthy RRT, Chair

1) Senate Bill 350, in Maryland provides "*that a licensed respiratory care practitioner has the right to practice respiratory care within the scope of practice of the respiratory care practitioner's license, including practicing respiratory care in a sleep laboratory*". Thebill passed and will become law once signed by the Governor.
2) The other legislative initiative in Maryland that is of concern to the Respiratory community is Senate Bill776. Essentially, the language in SB 776 would allow individuals who may, or may not, be graduates of an accredited education program and who may, or may not, have passed a Nationally Accredited Credentialing Board competency examination to be licensed in the State to practice Polysomnography with patients. The concern with this language is that, by default, these individuals will be practicing Respiratory care as well. The legislation passed and will become law.

By becoming law, SB776 will allow the Maryland Board of Physicians to approve educational programs such as ASTEP that are not accredited by a National Educational Accreditation Board. Further, the legislation will also allow the Maryland Board of Physicians to approve a certification exam that is not accredited by a Nationally Accredited Credentialing Board.

3) Issues that remain ongoing in States such as Michigan are being monitored.

Federal Government Affairs Activity Report

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

The Congress

The second session of the 112th Congress was convened in mid-January. For the most part, we have seen and will continue to see debate on legislation to continue to be along Party Lines. As the date for the country's general election draws closer there is no reason to expect cooperation among Democrats and Republicans for the reminder of this short legislative year.

Certain of the "must pass" legislation such as payroll tax extension, unemployment insurance continuation, and the "doc fix" have already been extended through the rest of 2012. However, by the early fall or in a post-election Lame Duck session, these issues, specifically the "doc fix", will once again be on the agenda and will have to be addressed before January 1 2013, thus necessitating some action on the part of Congress.

Legislation

1) The Medicare Respiratory Therapy Initiative The AARC's Congressional advocacy efforts remain focused on legislation that will expandpatient access to respiratory therapists in the physician's office. We have pushed this effort vialegislation, HR 941, the Medicare Respiratory Therapy Initiative.

However, our greatest challenge in moving our bill forward has been score or cost analysis by the Congressional Budget Office (CBO). There have been several versions by CBO as to what this cost will be to the Medicare Program over the next 10 years.

We are in the process of revising the language of the bill to tighten up the provisions, while keeping the intent of HR 941.

We are currently in discussions with Senator Crapo's office to have Legislative Counsel draft new bill language based on specifications AARC has provided to his staff that can be introduced as new legislation and therefore garner a new CBO estimate.

The intent of this new tact is the same as HR 941, that is, to create greater patient access to respiratory therapists in the physician's office. As you know, ACCP, ATS and NAMRC have already gone on written record in supporting the Medicare Initiative and we expect their continued support with the revised bill language.

2) AARC Hill Lobby Day

Over a dozen years ago the AARC organized a group of politically active RTs, called the Political Advocacy Action Team (PACT) representatives who are appointed by their state societies to act as coordinators when state or federal political action is required.

A key component to moving our legislative agenda through the Congressional process has been the RTs who come to DC once a year to lobby their Congressional delegations. For this, our 13th year, AARC

respiratory therapists were joined by pulmonary patients from the Alpha 1 Foundation, the COPD Foundation, the Alpha 1 Association and a new partner – the Pulmonary Hypertension Association. We had over 350 scheduled Capitol Hill Office visits. This number of scheduled meetings is the highest number we have ever achieved and it is a great accomplishment. This year we had 136 RTs from 46 states and the District of Columbia advocating for our legislative agenda.

Our lobby day also generated three Congressional Offices to respond to the request from the visiting RTs to contact the CBO and inquire about the high score for HR 941. We provided additional data for these offices to present to CBO for a recalculation of the cost. Unfortunately, in spite of the additional data, CBO stands by their original score.

3) Virtual Lobby Week
The AARC launched another successful Virtual Lobby Week at the end of February. This event is where we generate nationwide support from RTs, patients and caregivers to email their members of Congress in support of our legislative agenda. We scheduled this event, with much fanfare, just prior to our Hill Day. We generated over 12,500 emails that supported our RT legislation and showed support from "back home' before the PACT RTs met with their Congressional delegations.

This year we coordinated our launch of VL Week with the Alpha 1 Association, the COPD Foundation and the Pulmonary Hypertension Association. These important patient associations also geared up their members to use the AARC's Capitol Connection to email in their support of our legislation.

4) Veterans Affairs Bill on COPD
HR 168, which is the legislation directing the Secretary of Veteran's Affairs to improve prevention, diagnosis and treatment for COPD, is still active. As reported in the past this bill was introduced by Congressman Cliff Stearns and John Lewis and has no known opposition.

5) NIH to Take Over COPD Plan from CDC
The Senate included language in their appropriations bill that directs the NIH, NHLBI to convene a planning meeting with the goal of producing a National Action Plan for COPD. This is a strategic shift from the previous request that this activity be undertaken by the Centers for Disease Control and Prevention. COPD advocates working with the US COPD Coalition felt that we stood a better chance of having this activity take place under the auspices of the NIH due to significant budget cuts at the CDC. All meetings have been suspended after a GSA meeting in that took place in Las Vegas was reported to have cost tax payers close to a million dollars. The
NIH was planning to convene a two day conference but has now reported that if a meeting takes place prior to the end of the fiscal year, which is September 30, 2012, it will be with internal government participants only. We may have to go another round with the government to get this meeting and important agenda item accomplished.

6) Technical Change to Medicare Outpatient Pulmonary Rehabilitation Benefit
When CMS wrote regulations to provide the details for implementation of the new Medicare outpatient pulmonary rehabilitation benefit, it held strictly to the wording of the statute passed by
Congress which requires the programs to be physician supervised (applies to cardiac programs as well).

Senators Schumer (D-NY) and Crapo (R-ID) have introduced S 2057, a no-cost technical amendment that would permit physician assistants, nurse practitioners, and clinical nurse specialists to supervise pulmonary rehab (and cardiac programs). This is consistent with other Medicare outpatient therapeutic supervisory requirements.

The legislation is being supported by all of the physician professional associations that practice pulmonary care and the AARC.

7) Legislative Actions on Competitive Bidding
When the Home Medical Equipment (HME) industry first introduced legislation to repeal the competitive bidding program (HR 3790), it had considerable support from 259 co-sponsors but never made it out of

committee or picked up a Senate companion bill. It also had been offered without an offset to the $20 billion cost to repeal estimated by CBO.

In March 2011, a new repeal bill was introduced by Reps Jason Altmire (D-PA) and Glenn Thompson (R-PA). This time the bill language included a "pay for" by rescinding $20 billion in unobligated balances of all discretionary appropriations. However, it does not appear that the second attempt at appeal is moving forward.

With competitive bid implemented in 9 areas of the country and poised to expand to 91 areas by July 2013, AAHomecare is promoting an alternative proposal to preserve more of the HME industry, save the government money and provide better service to Medicare beneficiaries. They are waiting for CBO to score the legislation in hopes of showing that it will yield the same Medicare savings as the current competitive bidding model. A recent Congressional hearing with CMS and industry staff did not yield a consensus on whether the program should be expanded, modified or replaced.

8) Coalition Activities
The AARC continues its practice of participating in a number of Coalitions of like-minded associations and organizations to advance particular legislation and/or regulations. In previous years our participation with certain Coalitions was focused on urging greater funding for health and/disease research to promoting issues that will enhance the clinical support of patients with particular illnesses.

As was the case in 2011, Congress is again focused on cutting funding for domestic programs. And as in 2011, most Coalitions are again focused on simply maintaining current budgets and limiting potential cuts to the programs of interest.

9) Friends of Cancer Research
AARC signed onto a joint letter to Congress requesting that legislation be passed that would designate as a "Breakthrough Product" drugs and biologicals that show benefits in early trail phases thus speeding up the FDA approval process.

10) Air Quality Control Coalition
AARC joined a lose coalition that supports clean air initiatives. AARC signed onto a letter to Congress opposing Senate Resolution 37 which would employ the Congressional Review Act to reverse the U.S. Environmental Protection Agency's (EPA) Mercury and Air Toxics Standards for Power Plants.

11) Asthma Control Funding in the CDC
Organized jointly by the American Lung Association and the Asthma and Allergy Foundation of America, the AARC is one of the many organizations to participate in efforts to enhance asthma education, management and control AARC signed on to a joint letter requesting that the CDC maintain it's current funding for asthma control initiatives.

12) Tobacco Partners
The AARC continues its long-time relationship with the many organizations who participate in the Tobacco Partners Coalition (a Coalition organized and supported by the American Heart Association, the American Lung Association and the American Cancer Society). AARC has signed on to a letter to the House and Senate Appropriations Committees requesting that the Committees continue to support FDA funding of the Centers for Tobacco Products(CP) at the full authorized level and reject any efforts to weaken CTP's authority.

Regulations and Other Issues of Interest

Updates to the Medicare physician fee schedule and inpatient and outpatient prospective payment systems, which are the primary vehicles for policies affecting the pulmonary community, are generally proposed in the spring and finalized in early fall. Several regulations have been published recently that are of interest.

1) Proposed FY 2013 Update to Inpatient PPS
The proposed rules to update the annual prospective payment rates for acute and long-term care hospitals (LTCH) were announced on April 24. Key among the provisions is the Hospital Readmission Reduction Program established by the Accountable Care Act which kicks in for discharges on or after October 1, 2012, CMS is required to reduce payments to hospitals with readmissions in excess of an expected level for three selected conditions: heart attack, heart failure and pneumonia (AMI/HF/PN). The payment reduction amounts to a 1% reduction to the hospital's base operating DRG payments. CMS estimates that this will result in an overall 0.3 percent decrease in payments to hospitals, or approximately $300 million.

To provide a broader assessment of a hospital's quality of care, especially for hospitals with too few AMI/HF/PN readmissions, CMS is also proposing for FY 2015 a Hospital-Wide Readmission (HWR) measure as part of the Hospital Inpatient Quality Reporting Initiative (HIQR). This new measure assesses unplanned, all-cause readmissions for any eligible condition within 30 days of hospital discharge. The focus will be on readmissions for acute diagnoses or complications of care. COPD is one such diagnosis in this category.

The Value-Based Purchasing Program (VBP) proposes to add a Medicare "spending per beneficiary" measure that would include all Part A and Part B payments from 3 days prior to an inpatient hospital admission through 30 days post discharge with certain exclusions. Final rules for the overall program were published last year but are not effective until October 1, 2012. Asreported earlier, hospitals will receive an incentive payment if they improve performance in 5 specific measures. (NOTE: The measures, which overlap those reported under the Hospital Quality Reporting, include pneumonia).

Although two new conditions are proposed in tracking health-care associated infections, ventilator-associated pneumonia (VAP) is not one of them. However, CMS recognizes that VAP is costly and that 10% - 20% of patients receiving greater than 48 hours of ventilation will develop VAP. Consequently, a ventilator care-bundle process measure consisting of four components is being proposed for LTCHs since ventilator patients are a large segment of the LTCH patient population.

2) Hospital Conditions of Participation – Burden Reduction
Final regulations that revise various sections of the Hospital Conditions of Participation were published recently by CMS. The changes are aimed at cutting burdensome red tape for hospitals to give them more flexibility to improve patient care while lowering costs. Proposed changes were reported to the Board at its last meeting. Some of the final changes, namely those dealing with protocols, could improve access to respiratory therapists as some hospitals prior to the change restricted protocols to rapid response teams only.

Among the noteworthy changes are 1) encouraging use of nationally recognized, evidence-based pre-printed and electronic standing orders, order sets and protocols that ensure consistency and quality of care provided to all patients; 2) permitting orders for drugs and biologicals to be prepared and administered on the orders of a practitioner other than a doctor in accordance with hospital policy and state law; 3) allowing the option of a single nursing plan of care or a comprehensive interdisciplinary plan that includes nursing and other disciplines such as respiratory care; 4) eliminating the 48-hour timeframe for authentication of verbal orders, deferring instead to applicable State laws; and 5) permitting either the ordering practitioner or a practitioner who is responsible for the care of the patient and authorized to write orders to date, time and authenticate the medical record.

3) FDA to Consider a New Paradigm for Drugs
The FDA held a public hearing on March 22 to hear presentations and comments on a new paradigm under consideration whereby FDA would approve certain drugs for over-the-counter use that would otherwise require a prescription as long as conditions of safe use are met. Since future proposed rules are incumbent on what is presented at the hearing, it is unclear at this time what specific policies will be proposed. Under consideration are rescue medications, such as inhalers for asthma patients or epinephrine for allergic reactions. Also being considered are medications for certain diseases or conditions that are currently only available by prescription or certain classes of drugs based on a review by FDA of each New Drug Application. Pharmacists would see an increased role in the process.

AARC has expressed concerns about the potential impact on asthma and COPD patients, noting that there are nationally accepted peer-reviewed guidelines for the coordinated management of these diseases. We caution FDA that a shift in the paradigm must be weighed against the negative consequences of removing the input and clinical intervention of health care professionals in the
care regimen of these respiratory patients.

4) Medical Device Tax
The Accountable Care Act requires manufacturers of medical devices to pay a 2.3% tax at the time of sale in order to offset the costs of implementing health care reform measures. The sales tax is aimed at large purchases that are used primarily in a medical institution or office or by a medical professional. Exempt from the sales tax are eyeglasses, contact lenses, hearing aids, and items that are generally purchased by the general public at retail for individual use (i.e., the retail exemption). Certain safe harbor rules allow for additional exemptions.

When the IRS/Treasury published proposed rules in early February, they listed Anesthesiology Devices classified by the FDA as meeting the sales tax criteria. Although there is no argument that a number of items in this device classification meet the device tax criteria, the category also includes oxygen concentrators and portable oxygen systems, as well as nebulizers and other respiratory devices and accessories designed for home use which should be exempt. To demonstrate that these devices should be exempt requires the manufacturer to go through a lengthy “facts and circumstances” test in which a final decision can be made.

The AARC sent comments to IRS recommending that Anesthesiology Devices be removed from the non-exempt list and a new safe harbor for retail exemption be established for all devices in that category, including oxygen concentrators, portable oxygen systems and other respiratory care devices and accessories, that are specifically designed for and intended to be used in the home by individual consumers who are not medical professionals. Individual home medical equipment companies, AAHomecare and NAMDRC submitted similar comments. A hearing by the IRS regarding these provisions was held on May 16. Final rules have yet to be published.

Conclusion
The AARC will continue our efforts on Capitol Hill to advance our legislative agenda. We believe our increased efforts to partner with patient organizations and other like minded associations will provide forward momentum in achieving our goals. We will also maintain our vigilance on the regulatory side responding to both challenges and opportunities.

AARC President’s Report

Reporter: Karen J. Stewart, MSc, RRT, FAARC

Work continues with the project 2015 and Beyond. At the December BOD meeting the Board voted to accept the proceeding of the first conference, Creating a Vision for Respiratory Care in 2015 and Beyond. The approval of this document allows the AARC to follow a course of action, which will enable the association to further planning and design programs for the future. The work is far from finished; the committee continues to obtain information need for the next set of recommendations for which action will be taken.

Work continues on the Respiratory Care Medicare initiative. Somewhat disappointed the AARC was not successful in getting the bill restored by the CBO. Lobby day in WashingtonDC was successful with record numbers of visits on the hill. Efforts now are being made to reword the bill with more emphasis on the disease management aspect of care. It is hopeful that this action will create a new look and perhaps new scoring from CBO. The effort remains a high priority for the association.

I recently attended a meeting in Washington with the AHA and their organization, the American Organization of Nurse Executives. The meeting was convened to address workforce needs. This new group, Allied Health Professions Workforce Planning Meeting, is an effort to bring a wide variety of health professions together as a multidisciplinary group to understand and consider workforce needs and how care may be delivered in the future. Attending the meeting were representatives from physical therapy, nutrition and dietetics, radiological technologists, clinical pathology, occupational therapy, health care human resources, and health system pharmacists. The group identified 3 areas to start the work and has agreed that there is a need for this level of collaboration.

The AARC continues to identify educational opportunities for its members. The leadership program is still in development stages and other new programs. Education requests continue from the Middle East and two programs were delivered early in the year.

American Respiratory Care Foundation Report
Reporter: Michael Amato

The American Respiratory Care Foundation has been busy in their intervening months since I last submitted a progress report to you. Please accept the following items of information as highlights of activities currently under active consideration which are all in addition to administering the extensive array of education recognition awards, fellowships, and grants.

A few weeks ago ARCF's Board of Trustees convened its annual meeting and I am delighted to report a host of actions you will find of interest. ARCF's strategic plan has been reviewed and a revised draft was submitted to the Trustees for additional input. That input has been received and we are now finalizing the strategic plan. Not only will it continue to closely parallel the goals and activities of the respiratory care community, but we have also established a strategic planning committee which will review the plan on an annual basis. This will facilitate a regular and frequent review of the plan and its subservient tactical objectives.

We will once again host a fundraising reception at the AARC 2012 International Congress in New Orleans. I want to take this opportunity to thank those of you who donated to the fundraiser and were able to attend the reception. As you may recall, this reception is the only face to face fundraising event undertaken by ARCF. We will once again honor International Fellows, City Hosts, ICRC, and AARC's International Committee. You will all be receiving an invitation to attend. The Trustees have set the minimum donation at $100 per person. For those of you who may not have attended in the past, I encourage you to take advantage of this event. It's a tremendous opportunity to get to know our colleagues from all over the world as well as enjoy some excellent food and beverages. This is a great way to show your support for the profession's philanthropic arm.

As you may recall, the Trustees voted to transfer the International Fellowship program to the AARC last year. I know that many of you want to support our International Fellows and I encourage you to do so. The only difference between this year and years past is donations should now be made directly to the AARC which has established a restricted fund for this purpose. The ARCF will continue to support international activities. Under active consideration at this time are the development of a fundamental respiratory care course that can be replicated and utilized in countries all over the world that do not currently have respiratory therapists or the infrastructure to train respiratory therapists. We are currently exploring ways to fund development of the course.

The Foundation is also considering developing a support plan for international visitors who are highly placed within their country's healthcare system. These individuals may be invited to participate in a brief, but intensive, visit to the United States in order to learn of the advantages of establishing a formal respiratory care delivery system including an educational and credentialing infrastructure. This project is in its preliminary phase. I will provide you with updates as details become available. The Foundation continues to fund RESPIRATORY CARE Journal Conferences. Last September it funded a Conference focusing on the "Chronically Critically Ill". The preceedings from that special Conference were published in the June issue of the Journal. This past spring the Foundation funded a Conference focusing on all aspects of oxygen delivery and we are now in the midst of soliciting for funds for the next Journal Conference to be convened in September 2012 focusing on Adult Mechanical Ventilation.

As some of you may recall, ARCF applied for, and received, several grants from the Environmental Protection Agency to develop an educational course relating to the identification of indoor asthma triggers. Beginning this year we transferred operation of the course to the AARC. It is currently available online through AARC and continues to be free to AARC members.

As with all charities, funding remains a challenge. Last year we developed, and published, an article for AARC Times describing the work and value of the Foundation. This year we are developing another article and also producing a brief video. We will distribute the video to all of you when it's completed and hope that you will share it so that many more in our community will come to appreciate the benefit of supporting our community's only charitable organization organized for the support of the profession.

During its recent Board meeting, the Trustees discussed at some length the desirability and viability of organizing a scholarship fund to encourage respiratory therapists to expand their skills portfolio in order to play a larger role in critical care units. The Trustees are aware that many of our colleagues leave the profession in order to expand their clinical job responsibilities as physician assistants. The Trustees feel that, given all the changes in healthcare, there may be an opportunity to develop an advanced level respiratory therapist who would have, in addition to the traditional advanced level RT skills portfolio, other skills putting them on equal footing with PAs but without having to leave the profession. Work on this concept is in its earliest phase and I will keep you posted as the idea evolves.

Recently, the Trustees voted to support a research grant which will focus on aerosol delivery to tracheotomized patients. Support of applied research is felt to be of high importance amongst Trustees and grant proposals will continue to be reviewed and funded consistent with the goals of our various research endowments.

We were delighted to be asked to provide input to the AARC's International Mission Statement. The Trustees continue to believe that international activities undertaken by AARC, NBRC, ICRC, and CoARC are extraordinarily important and go a long way towards validating the need for respiratory therapists throughout the world.

Summary

I hope that you find the forgoing items and activities of interest. I want to thank all of you who support the Foundation. Please consider making a tax deductible donation to ARCF. Your support is indispensable to our success. Thank you

National Board for Respiratory Care Report

Reporter: Kerry George, NBRC President

I appreciate the opportunity to provide you an update on the activities of the NBRC. Since the last report, the Board of Trustees and its committees met April 23-28, 2012 in Kansas City to conduct examination development activities and discuss business related items pertinent to the credentialing system. Additionally, a group of content experts convened in early June to conduct a cut-score study for the new Adult Critical Care Specialty Examination. The following details the mcurrent status of examinations and significant activities in which the Board and staff are currently involved.

Adult Critical Care Specialty Examination

The much awaited Adult Critical Care Specialty Examination is set to launch on July 17, 2012. Registration and scheduling for this examination are now available. Details regarding admission policies, fees, test specifications, practice and self assessment examinations can be found on the NBRC website, www.nbrc.org, under the Examinations tab. Individuals who apply and schedule an examination appointment prior to August 31, 2012 will receive a free self assessment examination.

Ohio Examination Requirements Workgroup

I served as the NBRC representative to the Ohio Examination Requirements Workgroup since early 2011. The workgroup's purpose was to evaluate whether the Ohio Respiratory Care Board should amend OAC 4761-5-01 and related rules to require the candidates for licensure in the state of Ohio to pass the written and clinical simulation portions of the RRT Examination as a condition for initial licensure issuance in the state of Ohio. The Ohio Board has now accepted this workgroup's recommendations and is in the process of drafting amendments to its rules to require the RRT be the minimum credential for initial licensure in the future. As you are likely aware, the NBRC supports the CRT credential as the minimum requirement for licensure and we submitted a minority report opposing the proposed recommendations, as well as made a personal appearance at their February 2012 public hearing. We continue to be involved in a stakeholder group providing input into the rule drafting process.

California Respiratory Care Board Meeting

At the request of the California Respiratory Care Board, we also traveled to their February 2012 board meeting to discuss their interest in elevating the credential requirement for licensure in that state. It is not likely they will be proposing any change to their existing requirements.

Credentialing System Evolves

As a result of extensive, ongoing internal research the NBRC conducts regarding testing and measurement, the Board of Trustees voted at its December 2011 meeting to evaluate implementing significant changes to the respiratory therapy credentialing system beginning in 2015. These changes are coincidental with, and not in response to information arising from the Respiratory Care 2015 and Beyond process. Changes will include a single multiple choice examination with separate passing points for the CRT credential and eligibility for the Clinical Simulation Examination which will include a larger number of shorter simulation problems. Details regarding these significant changes will be announced during the Jimmy Young Memorial Lecture at the AARC Summer Forum in Santa Fe, New Mexico on July 15, 2012.

Examination Statistics – January 1 – June 15, 2012

The NBRC administered over 18,000 examinations for the period January 1 – June 15, 2012. Pass/fail statistics for the respective examinations follow:

Examination	*Pass Rate*	
CRT Examination – 6,542 examinations		
	Entry Level	Advanced
First-time Candidates	65.6%	82.9%
Repeat Candidates	15.5% 2	6.1%
Therapist Written Examination – 6,024 examinations		
First-time Candidates	67.6%	
Repeat Candidates	31.6%	
Clinical Simulation Examination – 5,016 examinations		
First-time Candidates	66.5%	
Repeat Candidates	52.6%	
Neonatal/Pediatric Examination – 346 examinations		
First-time Candidates	65.6%	
Repeat Candidates	46.5%	
Sleep Disorders Specialty Examination – 27 examinations		
First-time Candidates	88.5%	
Repeat Candidates	0%	
CPFT Examination – 134 examinations		
First-time Candidates	78.5%	
Repeat Candidates 3	2.5%	
RPFT Examination – 43 examinations		
First-time Candidates	84.2%	
Repeat Candidates	40.0%	

Your Questions Invited

I look forward to continuing to work with you during my term as President. If you have any questions or concerns about any credentialing related matter, the NBRC and I are interested in providing whatever information you need. In addition, the Board of Trustees is committed to maintaining positive relationships with the AARC and all of the sponsoring organizations of the NBRC, as well as the accrediting agency. We have significant issues to consider in the future, and I am confident that by working together and promoting understanding of the topics under discussion we will continue to advance the profession and ensure the integrity of the credentialing process.

Board of Medical Advisors Report

Reporter: Lori D. Conklin, MD

First, let me begin by saying, I assumed the position of BOMA Chairman following the unexpected death of our current Chairman, Dr. Philip Marcus. Second, let me offer my apologies for not attending this meeting. With Dr. Marcus' unanticipated passing, I had already made vacation plans with my daughter to travel into Yellowstone's Backcountry during the time of this meeting. I am already making plans to attend next year's meeting. Finally, I would like to highlight one area of discussion regarding the format for our summer BOMA meeting. This year

we will be participating in online webinars as a possible format change for the June BOMA meeting. It has come to our attention that time constraints and travel budgets require more creative meeting formats and integration/utilization of internet technology can assist in alleviating some of the issues surrounding business travel in today's economy.

RECCOMENDATION

Finally, BOMA recommends that the AARC Board of Directors form an Ad Hoc Committee to place information on the different schools on their website specifically giving benchmarks, such as, but not limited to, first time pass rates and job placement and possibly faculty strengths and weaknesses with input from CoARC and NBRC.

Sincerely,
Lori D. Conklin, M.D.
BOMA Chairman
Associate Professor of Anesthesiology
University of Virginia Health Care System

NCSRC Conflict Of Interest Questionnaire

Attachment M

Pursuant to the purposes and intent of the Bylaws and Standing Rules adopted by the Board of Directors of the North Carolina Society for Respiratory Care, requiring disclosure of certain interests, a copy of which has been furnished to me, I hereby state that I or members of my immediate family have the following affiliations or interests or have taken part in the following transactions that, when considered in conjunction with my position with, or relation to, the Society, might possibly constitute a conflict of interest. (Check "none" where applicable.)

1. ***Outside Interests***: Identify any purchases or sales or property or property rights, interests or services by yourself or your immediate family that might be deemed to have been in competition with the Society.

_____

_____

_____

None _____

2. ***Outside Activities***: Identify any instances in which you or any member of your immediate family have rendered directive, managerial or consultant services to any outside concern that does business with, or competes with, the services of the Society or have rendered any other services in competition with the Society.

_____

_____

_____

None _____

3. ***Gifts, Gratuities and Entertainment***: Neither I nor any member of my immediate family have accepted gifts, gratuities or entertainment from any outside concern that does, or is seeking to do, business with, or is a competitor of the Society except as listed below:

_____

_____

_____

None _____

4. ***Inside Information***: Neither I nor any member of my immediate family have disclosed or used information relating to the Society's business for the personal profit or advantage of myself or my immediate family, except as listed below:

_____

_____

_____

None _____

5. ***Other***: List any other activities in which you or your immediate family are engaged in what might be regarded as constituting a conflict of interest.

_____

_____

_____

None _____

I hereby agree to report to the President of the North Carolina Society for Respiratory Care, any further transactions that may develop before completion of my next questionnaire.

_____
Name

_____
Position

_____
Date