College and Association of Respiratory Therapists of Alberta

2008

Annual Report

One of the most important ways we apply knowledge, insight, and innovation is through the work we do to strengthen Alberta communities

Corporate Profile

CARTA is a provincial regulatory body dedicated to delivering value added services to the public and members practicing in the health care industry. Our one and only focus is to protect the public through our members providing health services to Alberta communities.

Corporate Office

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Calgary AB, T3E 7H7

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Website: www.carta.ca

Auditor:	PF Turner Incorporated
Legal Counsel:	James B. Rooney QC
Principal Bankers:	Alberta Treasury Branch Financial
	Bank of Nova Scotia

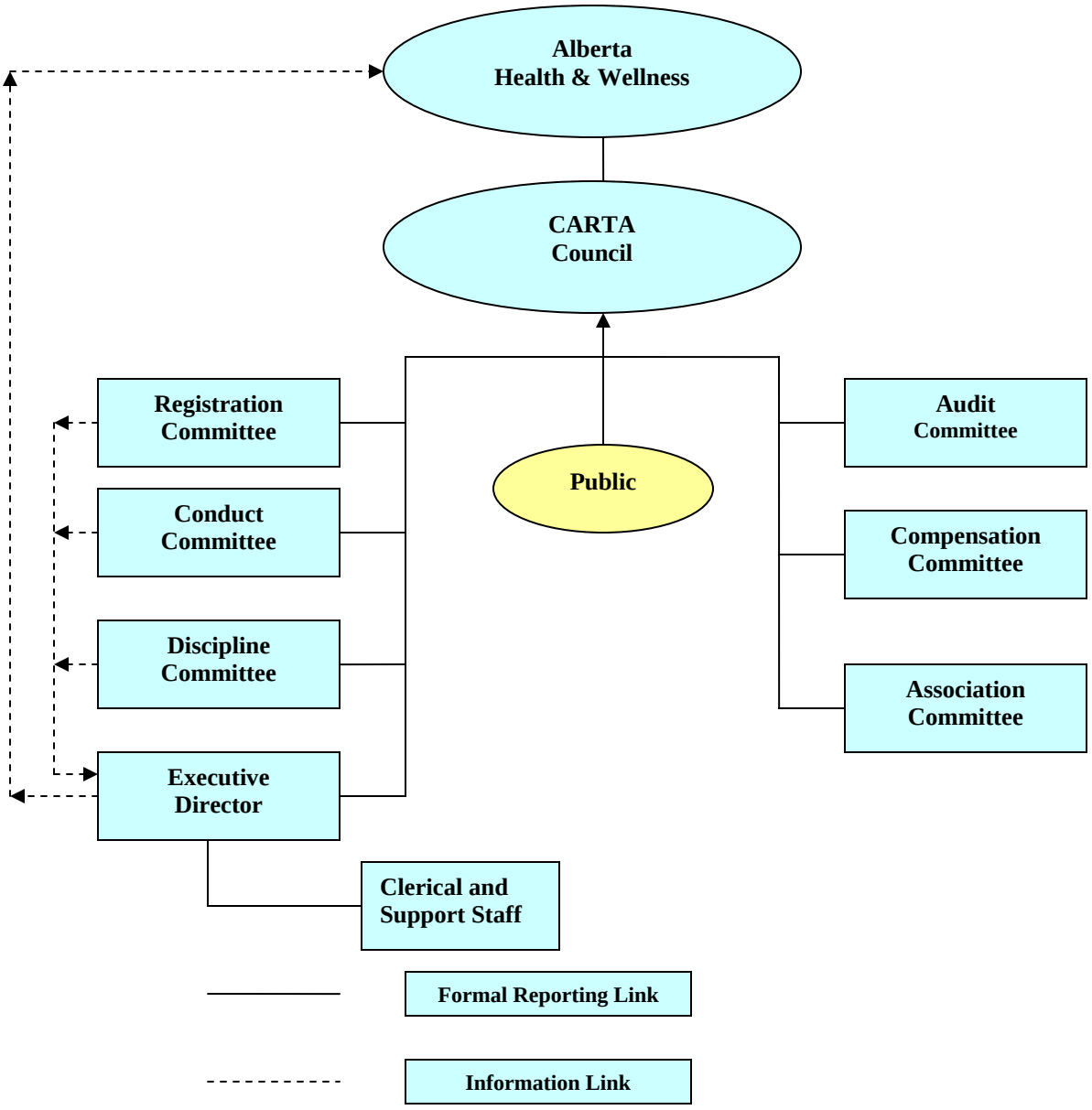
CARTA Council

President:	Mr. Cliff Seville RRT	St. Alberta
President Elect:	Mr. Allan Shemanko RRT	Edmonton
Executive Secretary:	Ms. Dallas Schroeder RRT	Edmonton
Treasurer:	Mr. Greg Hind RRT	Calgary
Director at Large:	Mr. Brent Wylie RRT	Calgary
Director at Large:	Mr. Jerry Hall RRT	Edmonton
Public Member:	Mr. Peter Murray	Wetaskiwin (appointed by Minister)
Public Member	Ms. Maryanne Kingma	Calgary (appointed by Minister)
Registrar	Mr, Bryan Buell RRT BGS	appointed by CARTA Council

Fiscal Year:	February 1st to January 31st
Registration Year:	April 1st to March 31st

Governance

Innovation, leadership and patient advocacy.



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Registered members offer powerful resources with a personal connection.

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President's Report

Cliff Seville RRT

As we embark on this exciting new chapter in the history of CARTA we view this as time of great opportunity for our profession.

HPA (Health Professions Act)

As with some other health professions, Respiratory Therapy is evolving at a rapid rate. Many of our members have taken on new and expanded roles. Some roles involve high tech procedures done in tertiary care settings. Others are carried out in the community in settings requiring more independent practice. In all cases we have worked very hard to ensure that the Respiratory Therapy Regulation under the Health Professions Act (HPA) will reflect the diversity and depth of practice of our membership. Council has been ready for proclamation under the HPA for approximately 2 years. We are concerned with the time delays in government due to the fact that the current legislation governing the practice of Respiratory Therapists (i.e. – the Health Disciplines Act or HDA) no longer accurately reflects the practice of most members. However, we do understand the changing priorities of government within a constantly challenged health system. A great deal of work has gone into preparing for HPA proclamation including new standards of practice, educational materials, a new code of ethics, bylaws, website design etc., all followed by broad based consultation with members and stakeholders. Our council is very hopeful that we will be proclaimed under HPA on or before our upcoming annual general meeting in October of this year.

Evolving Roles

Anesthesia

On of the most exciting developments has been the concept of an advanced practioner in anesthesia. This project was lead by Jerry Hall (Director at Large) and an expert working group comprised of RT's currently working in a variety of OR settings throughout the province. Driven by the widely acknowledged shortage of anesthetists / anesthesiologists in our province, specific reference to this situation in the Alberta Health and Wellness Health Workforce Strategy document published in 2006, the long history of involvement by Respiratory Therapists (RT's) working in OR / Anesthesia settings and awareness of initiatives involving RT colleagues that were evolving in other provinces in Canada at that time, CARTA Council discussed this item at strategic planning meetings during the fall of 2006.

Two additional factors were unique to Alberta. We were strongly encouraged by several leaders in anesthesia who are anxious to champion development of enhanced delivery models. Also, imminent proclamation of Respiratory Therapy under the HPA, and our understanding of some of the implications of the new regulatory framework, made it timely to think beyond the traditional term "assistance in anesthesia," and to propose a more collaborative practice model. A gap analysis and curriculum framework where developed.

The proposal was submitted to the Departments of Alberta Advanced Education and Technology and Alberta Health and Wellness in October, 2007.Our proposal had been shared in confidence with leaders in the Anesthesia community, and with the College of Physicians and Surgeons of Alberta, (the CPSA), prior to submission.

President's Report
continued

We received a response to our proposal from Government in January of this year. We were very encouraged to learn that Alberta Advanced Education and Technology and Alberta Health and Wellness support the development of a post-graduate program to educate and train Respiratory Therapists at an advanced level. However, we were concerned with government's advice that this health practitioner be called a "Respiratory Care Assistant in Anesthesia" or "Respiratory Care Assistant in Anesthesiology" CARTA Council had proposed the term "practitioner" i.e. Respiratory Care Practioner in Anesthesia (RCP-A) versus "Anesthesia Assistant."

Following discussion at Council, CARTA developed the following positions and began correspondence with Alberta Advanced Education and Technology and Alberta Health and Wellness regarding our concerns.

Fundamentally, we feel that the continued use of the descriptor "assistant" understates the knowledge, skills and abilities that these people would possess. RT's are currently educated to perform basic clinical anesthesia assistance functions from an entry to practice perspective. We are concerned that RT staff currently working in the OR setting, many of whom are already routinely performing advanced clinical functions in that setting (consistent with the Health Disciplines Act Regulation), and in some cases are already known as anesthesia assistants, would not be motivated to undertake the work involved in pursuing additional post-grad training if the "assistant" designation is used. We also acknowledge that irrespective of the professional designation, departments of anesthesia and employers will choose any position title and draft any position description for use in the workplace that they feel is appropriate.

We believe there is a sensitivity regarding the misperception that RCP-A's would be allowed to work independently of anesthetists and / or anesthesiologists in the future. CARTA's vision is for a collaborative model of practice between RCP/A's and anesthetists. The requirement for an anesthetist to be readily available to consult on or to take over direct patient care in order to ensure quality and safe patient care practice in every case, is very clear in our proposal.

We believe the collaboration should be allowed to evolve in the same manner that RT practice in critical care environments in Alberta and elsewhere has evolved. RT's routinely establish and manage artificial airways and manage mechanical ventilation based on approved protocols, clinical and laboratory data, while working collaboratively with nurses and other members of the health care team. Physicians are always available for immediate consultation and intervention in this setting.

Since physicians have controlled the pace and nature of change in this regard, evolution of the RT scope of practice in critical care has not been controversial. The same type of evolution in terms of role has already occurred (albeit with significantly more variability) where RT's have been working with anesthetists in the OR setting over time, i.e. – clinical roles have expanded on a case by case basis (i.e. based on the interest and support of the physician, and the commitment and capacity of the individual RT staff member).

CARTA envisions that gradual expansion of the RCP-A role in anesthesia would be facili-

President's Report
continued

tated by their educational preparation, and would best occur in the same manner as RT practice in critical care. We fully understand that this new group of professionals would not reach their full capability until they have successfully established mutually respectful and trustful working relationships with the anesthetists that they work with. RCP-A's would need support and the opportunity to develop advanced clinical skills and abilities on a step-by-step basis. This would occur under the mentorship and supervision of anesthetists, to a level of competency that anesthetists would be satisfied with. Actual scope of RCP-A practice will evolve at different rates and in different areas, site to site and region to region across the province.

CARTA Council's understanding is that the generic term "assistant" is most often associated with unregulated healthcare professionals. We feel that the term suggested, i.e. – "Respiratory Care Assistant in Anesthesia," would easily be confused with RT's currently working with anesthetists as anesthesia assistants or anesthesia technologists, having variable clinical roles, on-the-job training, variable formal post grad training / certification, mentorship, supervised clinical practice and clinical experience. As a Council we could not support a title that may be confusing to patients, the public and other healthcare providers.

The title Respiratory Care Practitioner has been protected within HPA at our request. We originally requested this in anticipation of advanced practice models to alleviate system pressures and contribute to meeting increased demands due to the changing demographic of our population. On the basis of these factors, CARTA has requested that government reconsider their previous position and consider the title "RCP in Anesthesia" (or RCP-A) as an appropriate professional designation for those individual RT's who successfully complete the prescribed (advanced) course of study in anesthesia.

Finally, we were encouraged to learn that (Health Workforce) funding may be available for this initiative, providing it is requested by a proposal from a post secondary institute as part of the health workforce action plans. We look forward to collaborating in this regard to help bring the initiative forward, once we receive government's response.

Collaborative practice

Health professionals have a long-standing history of working together to deliver quality, sustainable health care for Albertans and to ensure the optimal use of resources. However as the demand for health care service increases, new patient care delivery models are being explored. Increasingly, care is being provided by collaborative teams employing the skills of the most appropriate health care provider for the care required. This new model of health care delivery has the potential to provide better outcomes for patients and improve the efficiency of the system overall.
From a patient safety point of view, well functioning teams have great potential to deliver superior care. Poorly functioning, in particular poorly communicating teams, increase safety risks for patients. CARTA is very supportive of these evolving models as they fit well with HPA and highlight the unique contribution of RT's to our system and regulation in the public interest. CARTA will continue to participate in initiatives which foster interdisciplinary collaboration and will work with other stakeholders to address any barriers that may arise.

President's Report
continued

Infection Control and Prevention

Our council continues to engage members and consult with stakeholders to heighten awareness and understanding regarding recently implemented infection prevention and control standards in all practice areas of our profession. CARTA council is concerned that there are respiratory homecare and sleep diagnostic and treatment companies who provide services to Albertans without a requirement to be accredited. In Alberta's "Action Plan on Health ' dated April 16th, 2008 it is stated that mandatory accreditation will be required by the health regions for any private health service providers. We are concerned that this may not be applied to private respiratory providers as many of these companies are typically funded through AADL under the Alberta Seniors Ministry rather than Alberta Health and Wellness. We believe this gap in accreditation standards may not have been noted during Alberta Health and Wellness review of infection prevention and control. CARTA has been corresponding with Alberta Health Wellness and the Senior's ministry to recommend mandatory accreditation for these important service providers. This would help to ensure that standards for infection prevention and control are being met. It would also promote planning for emergency preparedness and other initiatives which serve the public good.

National Alliance of Respiratory Therapy Regulatory Bodies - NARTRB

Foreign Credential Recognition (FCR) Program Project Update for All Canadian Approved Respiratory Therapy Programs

In the spring of 2007, the National Alliance of Respiratory Therapy Regulatory Bodies (NARTRB) received funding for a project to investigate issues related to the entry of foreign-trained practitioners into the profession of respiratory therapy in Canada, and to revise entry-to-practice examinations for competency assessments of foreign-trained and Canadian-educated individuals. The project is being funded under the auspices of the Government of Canada's Foreign Credential Recognition (FCR) Program. It consisted of two components.

The first component of the project consisted of research and information gathering with respect to the various issues that foreign trained HCPs face as they attempt to enter the profession of respiratory therapy in Canada. The research will also collect data on the current situation of respiratory therapy with respect to occupational demographics, education, regulatory standards etc. This data will be used in part to inform some of the policy decisions around the certification examination.

The project extends further to a second component, which involves updating the various examination processes to reflect the National Competency Profile, and addressing situations related to examination and assessment that may be different for Canadian versus foreign trained Respiratory Therapists. The output from this phase of the project was an examination blueprint that outlines the weight and importance of each of the competencies, which will be used to develop a nationally consistent competency examination process. This will include a validated bank of examination items that can be used in exam production.

The four specific objectives achieved to date are :

President's Report
continued

Identified the existing processes in Canada for recognition of respiratory therapy credentials.

Performed a situational analysis of the licensure / registration process for internationally educated respiratory therapy (IERT) applicants, identifying the various processes that are available for licensing, and the challenges that exist in each process.

Development of an action plan which address's the issues identified, and an implementation plan for developing standardized assessment and recognition of foreign credentialed applicants.

Production of a final report for the NARTB which is now available titled "Access issues regarding Internationally Educated Health Professionals and the Respiratory Therapy Profession in Canada".

Information contained in the report includes:

Current respiratory therapy labour market demographics;

Respiratory therapy labour market supply and demand data;

Licensure requirements and processes in all regulated Canadian jurisdictions;

Primary source countries and educational background of IERT applicants;

IERT experiences and challenges identified in gaining licensure / entering professional practice in Canada;

Employer experiences and attitudes regarding IERTs; and

Promising practices in promoting access to professional registration for internationally educated health professionals.

Mutual Recognition Agreement -MRA

The original MRA was signed on November 17, 2002. A subcommittee of Alliance members has prepared a new draft agreement for consideration by the signatories. Proposed changes include: that a common national competency profile will be implemented by all signatories to this agreement, to increase the minimum number of practice hours from 720 to 1500 in the previous 4 years within that jurisdiction before being entitled to exercise the rights under the MRA in all regulated jurisdictions and in a non-regulated jurisdiction the minimum 1500 practice hours must be performed while holding a current registered membership with the Canadian Society of Respiratory Therapists (CSRT). The CSRT becomes a "supportive" signatory meaning it is an organization that while not delegated authority by law to regulate the profession, are mandated by its membership to set requirements/standards for membership and are committed to excellence in the practice of respiratory therapy, participated in the process to develop this MRA and are committed to the principle and facilitation of labour mobility.

During the May/2008 NARTRB meetings in Saskatoon I raised the issue of how CARTA is interpreting section 4.1 of the current MRA. Meaning that, those individuals who do not meet the minimum practice hours and other requirements under the MRA (including new graduates) must pass the CBRC exam in order to register outside of Quebec. This was not well received by representatives from Quebec but after some discussion it was determined that all other regulated jurisdictions interpreted the MRA in a similar manner. To that end all

President's Report
continued

members of the NARTB outside of Quebec have sent correspondence stating that we value and respect OPIQ's participation in both provincial and national relationships as a valued colleague and regulatory body within the profession. We would see it as part of our mandate in the near future to develop national standards regarding entry-to-practice examinations including standards related to psychometric integrity, degree of difficulty and compliance with the National Competency Profile and the recently developed exam blueprint (HRDSC project). We are hopeful that the OPIQ will remain an active member of the NBRTB to optimize labour mobility while serving the public interest and safety.

Degree for entry to practice in Respiratory Therapy

There are currently two Canadian programs offering degrees in Respiratory Therapy, the University of Manitoba and Dalhousie University in Halifax. In February 2007, the CRTO (College of Respiratory Therapists of Ontario) Council finished a study into the merits (or not) of changing the entry-to-practice requirement in Ontario for RT's from a diploma to a baccalaureate degree.

Their Council has recently approved a submission to the Deputy Ministers of Health and Long-Term Care and Training, Colleges and Universities requesting that a proposal to increase the entry-to-practice education requirements from a diploma to a baccalaureate degree for Registered Respiratory Therapists in Ontario be referred to the Pan-Canadian Process.

The final draft of the submission (letter of intent) is almost complete and the CRTO is seeking support of this initiative from members of the National Alliance. CARTA has given its support and is currently developing a formal position on degree as a requirement for entry to practice in Respiratory Therapy.

Conclusion

As this will be my last report in the 4 year term I have almost completed I would like to take this opportunity to thank all of you helped me during my term. A very special thank-you to my friends on CARTA council.

Countless hours of volunteer time from respiratory therapists, the time and expertise of our public members on the council, the dedication, time and expertise of consultants and experts in government and the private sector have gone into insuring we are a leader in Canada.

I also pass on a big thank-you to the other regulatory colleges and the CSRT, private healthcare providers, and other colleagues within and outside the province for their valuable consultation and collaboration that have helped us on our journey thus far. I hope I leave the "college" better than I found it.

Respectfully,

Cliff Seville
CARTA President

Secretary Treasurer's Report

Greg Hind RRT

"...Beware of little expenses - a small leak will sink a great ship". (Benjamin Franklin)

We end the 2007 - 2008 budget year with an operating surplus of $46,398. This exceeds our forecast surplus of $42,100. The key elements associated with our surplus include:

- A favorable rate of return on investments. Interest income exceeded our budgetary expectation by $10,841. We continue to maintain a low risk investment policy in order to safeguard member equity.
- Lower than forecast legal costs associated with conduct and competency issues. We expended $13,998 against our budgeted reserve of $40,000. Judicious use of investigational resources and alternative resolution practices reduced our need for costly legal services during this budget year.
- Operating expenses and administrative expenses were held to modest increases of $4551 and $1669 representing a variance of 1.7% over budget.

Council has approved a budget for the 2008 -2009 budget year that includes no provision for registration fee increases. Looking forward, council contemplates an increase in registration fees in the 2009 - 2010 budget year. This increase will be necessary to accommodate the increase in business activity, inflationary costs, and provision of expanded services to a growing membership. Members have not experienced an increase in registration fees since 1999 and our fees are, and will remain significantly lower than most Colleges of similar size and function.

When proclamation of Respiratory Therapists under the *Health Professions Act* occurs, we face very different financial accountabilities with respect to conduct and competency functions. Disciplinary decisions rendered by the College following proclamation will proceed directly to Court of Queen's Bench in the event of appeal. The importance of making and writing reasoned decisions greatly impacts the sustainability of decisions, and ultimately, the legal costs associated with them. A Hearing Officer is mandated under the legislation and council contemplates retaining an individual with legal training and related experience to perform this function on an *ad hoc* basis. It is anticipated that with proclamation, training of council members who participate in disciplinary hearings and retention of a Hearing Officer will be ongoing budgetary expenses.

With proclamation the college will launch a new website and I would like to see the approved budget and quarterly budget reports posted as they become available. Council approves the budgets, however in the interest of transparency I do feel it would be in the best interests of all concerned to demonstrate how we are performing financially on an ongoing and timely basis.

Unanticipated expenses do occur in the normal course of College business and the ability must exist to meet these expenses. In the interests of enhancing accountability and the protection of serving officers, I will be asking council to consider an amendment to the bylaws requiring a Notice of Motion to approve spending on unbudgeted expense items, or spending on line items that exceeds their budgeted amounts.

Registrar's Report

Bryan Buell RRT BGS

The opportunity is here and we are READY, perfecting expanding, and investing,

I am excited to be able to present my tenth annual report to the public and registered members of the College and Association. The highest priority this year has been collaborating with Alberta Health and Wellness in refining the proposed *Regulation* for the *Health Professions Act*. Significant resources have also been allocated to the providing anesthesia assistance initiative.

I have been actively participating on the National Alliance foreign applicant assessment steering committee to develop an accessible, transparent and uniform assessment of foreign trained applicants who immigrate to our country. The profession is very unique to North America and other countries have respiratory therapy programs that provide some of the competencies as they relate to technical applications. Our challenge is to identify all of the gaps in competencies and reconcile them so applicants are safe to practice in Alberta.

This could be achieved through a prior learning recognition program and integration into the approved education programs or by creating a foreign trained respiratory therapy bridging program. Another alternative would be to issue conditional or restricted registrations with expectations of greater levels of supervision upon entering practice. It is anticipated that additional funds will need to be sourced from the federal government to develop and implement an assessment and preparation program.

An emerging issue is the need to review the restricted activities schedule of the *Government Organization Act.* This list outlines potentially hazardous health services provided to patients. Similar lists exist in Ontario (controlled acts) and proposed for British Columbia (reserved acts). As patient access to the latest technologies is enhanced complex issues develop necessitating us to revisit the restricted activities and preferably identify mechanical ventilation as a restricted activity similar to what British Columbia proposes.

Another emerging issue is the number of clinical practice hours in our approved education programs. Presently we require programs to deliver 1,600 hours of clinical programming for enrolled students to complete all of the competency-based learning objectives. An emerging national trend is for approved programs to reduce the number of clinical hours in their program in order to accommodate increased enrollments.

This annual report contains enhanced demographic data that will assist in workforce planning for the future. The data will also help in the development of employee recruitment and retention policies/ strategies to address labour challenges that currently exist. Our approved education programs have been increasing enrollments to address the supply side and I particularly appreciate registered members activities in the area of preceptoring students. It is our goal to create a regulatory environment that provides employer flexibility while considering registered member's needs for work-life balance.

We have attempted to provide leadership for our members and convened an important meeting at Red Deer in early March. Our managers and supervisors met to identify common issues

Registrar's Report
continued

and begin developing communities of practice for therapists with common clinical interests to consult and network with each other enhancing the bedside practice and patient service delivery. We have also attempted to engage members in dialogue pertaining to infection prevention and control. It seems logical to maintain a community of practice in this area as both patients and caregiver would benefit from such activities. The provincial infection prevention control standards have been loaded onto your website www.carta.ca .

As the baby boom generation of registered respiratory therapists approaches retirement, health care facilities and private businesses face a loss of experience and knowledge on an unprecedented scale. Despite both the risk and cost of losing intellectual capital, most organizations have no plan for the management and transfer of knowledge, and even fewer factor cross-generational challenges into business strategy. I see the establishment of communities of practice to be an appropriate strategy for knowledge transfer and look forward to facilitating such communities of practice.

Our business operations are being impacted by increasing costs related to products and services we consume. Merchants using credit card systems continue to experience increasing costs and pay among the highest credit card fees in the world. On merchant's behalf the Retail Council of Canada has met with card organizations to speak out against these changes and have told the federal government that they must ensure Canada has a fair and competitive payments system.

In closing I would like to thank all Council and committee members for their time expertise and enthusiasm executing their responsibilities with the public and registered membership in mind. It is very heartening to witness such volunteers in action who care so deeply about their patient care community and the profession.

Yours very truly,
Bryan Buell RRT, BGS
Executive Director

Conduct and Competency Report

The committee consists of the following members:

George Verghese RRT (Cardston);
Connie Brooks RRT (Edmonton);
Timothy Gill RRT (Grande Prairie);
Linda Sutherland RRT (Calgary);
Anne Ulrich RRT (Calgary).

The committee is mandated by section 17 of the *Health Disciplines Act* and meets when required to review the complaints referred to it by the Registrar. Referrals to committee occur if there are reasonable and probable grounds the events occurred and a regulation has possibly been contravened.

The conduct and competency committee has the authority to make finding s and if necessary issue orders pursuant with the *Act.* The committee has been moderately active this past year conducting hearings and attending professional development workshops provided by the Alberta Foundation of Administrative Justice.

The following data illustrates the committee's activity since 2000:

Registration Year	Complaints/ Investigations	Hearings	Appeals
2008	5	3	0
2007	3	1	0
2006	0	0	0
2005	3	2	0
2004	3	1	1
2003	3	0	0
2002	0	0	0
2001	4	2	0
2000	0	0	0

Continuing Competency Report

The committee consists of the following registered members:

Connie Kadey RRT (Calgary);
Dolores Rekunyk RRT (Calgary);
Gregory Hind RRT (Calgary).

Who meet to review audits referred to them by the registrar and to develop program reviews and recommend changes to the Council.

Registered members benefit from peer review and the committee provides relevant meaningful feedback to the registered members interviewed by the committee. During the interviews committee members seek clarification on the continuing competency activities by the member and the professional practice relevance of the activities. If necessary registered members may be requested to submit further documentation for the activities they have been involved in.

Every new registered member is provided a copy of the continuing competency program and additional resources and reporting summary sheets are downloaded from the website. Five per cent of the membership is randomly selected for audit purposes and members are requested to submit a summery of their continuing competency activities for the previous two years. An audit may automatically be initiated if a member reports hours below the minimum of 48 in the two year reporting period.

The following table summarizes the data of continuing competency audits for the previous four years:

Registration Year	Total Audited	Total Interviewed
2007-08	54	6
2006-07	48	5
2005-06	45	5
2004-05	45	5

Audit Committee Report

The following charter was approved by the Audit Committee and Council in November 2007

1. PURPOSE

The audit committee assists the Council in fulfilling its responsibility for monitoring risks and the corporation's control system, oversight of the quality and integrity of accounting, auditing and reporting practices of the corporation and the audits of the corporation's financial statements, and other such duties as directed by the Council. The committee is expected to maintain free and open communication with the independent auditors, the Treasurer and the Executive Director. In discharging this oversight role, the committee is empowered to investigate any matter brought to its attention, with full power to retain outside counsel or other experts for this purpose.

2. MEMBERSHIP

2.1 The audit committee shall be comprised of the treasurer, one public member and one additional council member. The executive director and account book-keeper will act as resources to assist the audit committee members.

2.2 The members of the committee shall be appointed by and serve at the discretion of Council. The Council shall appoint one member of the audit committee as chairperson. He or she shall be responsible for leadership of the committee, including preparing the agenda and presiding over the meetings. The chairperson will also maintain regular communications with the Executive Director and independent auditor.

3. RESPONSIBILITIES The audit committee's primary responsibilities include:

3.1 Being directly responsible, in its capacity as a committee of the Board of Directors for the appointment, compensation and oversight of the independent auditor. In so doing, the committee will request from the auditor a written statement delineating all relationships between the auditor and the corporation, and any other relationships between the auditor and the corporation, and any other relationships that may impact independence, shall discuss with the auditor any relationships that may impact the auditor's independence, and shall take such actions as are necessary to oversee the auditor's independence. The committee shall have the sole authority to retain (subject to ratification by the registered members) terminate when appropriate, and approve the engagement terms of and fees paid to, the independent auditor, which shall report directly to the committee.

3.2 Being available to assist and provide direction in the audit planning process when and where appropriate;

3.3 Meeting with the auditor as necessary and prior to release and approval of financial statements to review audit, disclosure and compliance issues;

3.4 Where necessary, reviewing matters raised by the auditor with appropriate levels of management, and reporting back to the auditor their findings;

3.5 Making known to the auditor any issues of disclosure, corporate governance, fraud

Audit Committee Report

or illegal acts, non-compliance with laws or regulatory requirements that are known to them, where such matters may impact the financial statements or auditor' report;

3.6 Providing guidance and direction to the auditor on any additional work they feel should be undertaken in response to issues raised or concerns expressed.

3.7 Making such enquiries as appropriate into the findings of the auditor with respect to corporate guidance, management conduct, cooperation, information flow and systems of internal controls; and

3.8. Reviewing the draft financial statements prepared by management, including the presentation, disclosures and supporting notes and schedules, for accuracy, completeness and appropriateness, and approve same to be passed to directors for approval.

3.9 Reviewing and reassessing the adequacy of this charter at least annually and performing an evaluation of the committee's performance at least annually to assess whether it is functioning effectively.

4. MEETINGS

The audit committee shall meet at least quarterly, and all committee members are expected to be present at all meetings. The committee shall report regularly to the Council with respect to its activities.

5. OUTSIDE AUDITORS

The audit committee shall have the authority to retain such outside counsel, accountants, experts, and other advisors as it determines appropriate to assist it in the performance of its functions and shall receive appropriate funding, as determined by the Committee, from the Company for payment of compensation to any such advisors.

Independent Auditor's Report

PF Turner Incorporated

COLLEGE AND ASSOCIATION OF RESPIRATORY

THERAPISTS OF ALBERTA

FINANCIAL STATEMENTS

JANUARY 31, 2008

P.F. TURNER PROFESSIONAL CORPORATION
Chartered Accountant

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

To the Members of College and Association of Respiratory Therapists of Alberta

Management has the responsibility for preparing the accompanying financial statements and ensuring that all information in the Annual Report is consistent with these statements. This responsibility includes selecting appropriate accounting principles and making objective judgements and estimates in accordance with Generally Accepted Accounting Principles.

In discharging its responsibility for the integrity and fairness of the financial statements, as well as for the accounting systems from which they are derived, management maintains the necessary system of internal controls designed to provide assurance that transactions are authorized, assets are safeguarded and proper records maintained.

The ultimate responsibility to members for the financial statements lies with the Board of Directors. The Board reviews the financial statements with management in detail prior to its approval to publish the financial statements.

The Board appoints an external auditor to audit the financial statements and to meet with management to review his findings. The external auditor reports directly to the members; his report is attached. The external auditor has full and free access to management to discuss his audit, as well as his findings concerning the integrity of the organization's financial reporting and the adequacy of its system of internal controls.

Calgary, Alberta
August 21, 2008

PRESIDENT

AUDITOR'S REPORT

To the Members of
College and Association of Respiratory Therapists of Alberta

I have audited the statement of financial position of College and Association of Respiratory Therapists of Alberta as at January 31, 2008, and the statements of operations and changes in net assets and cash flows for the year then ended. These financial statements are the responsibility of the college and association's management. My responsibility is to express an opinion on these financial statements based on my audit.

I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In my opinion, these financial statements present fairly, in all material respects, the financial position of the organization as at January 31, 2008 and the results of operations and cash flows for the year then ended in accordance with generally Canadian accepted accounting principles.

Calgary, Alberta
August 21, 2008

Original signed
CHARTERED ACCOUNTANT

COLLEGE AND ASSOCIATION OF RESPIRATORY THERAPISTS OF ALBERTA

STATEMENT OF FINANCIAL POSITION
AS AT JANUARY 31, 2008

	2008	2007
ASSETS		
CURRENT		
Cash in bank	**$ 376,830**	$ 325,872
Accounts receivable, officer	**-**	4,472
Prepaid expenses and deposits	**1,897**	1,019
	378,727	331,363
EQUIPMENT (Note 3)	**8,533**	9,384
	$ 387,260	$ 340,747
LIABILITIES		
CURRENT		
Accounts payable and accrued liabilities	**$ 7,437**	$ 7,323
Deferred revenue	**333**	333
	7,770	7,656
NET ASSETS		
NET ASSETS INVESTED IN CAPITAL	**12,013**	9,384
NET ASSETS	**367,477**	323,707
	379,490	333,091
	$ 387,260	$ 340,747

APPROVED BY THE EXECUTIVE:

_____ President

_____ Treasurer

P.F. Turner Professional Corporation
Chartered Accountant

COLLEGE AND ASSOCIATION OF RESPIRATORY THERAPISTS OF ALBERTA

STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS
FOR THE TWELVE MONTHS ENDED JANUARY 31, 2008

	2008	2007
REVENUE		
Membership revenue	**$ 376,956**	$ 339,503
Provincial symposium	**(275)**	97,646
Interest	**20,841**	10,696
Other	**4,926**	5,384
	402,448	453,229
EXPENSES		
Accounting services	**9,871**	14,462
National Alliance	**5,357**	6,787
Agreement on Internal Trade	**87**	29
Amortization	**2,626**	2,308
Awards	**1,227**	275
Bank Charges	**8,472**	8,773
Computer services	**496**	359
Conduct Committee	**13,998**	6,147
Continued Competency	**2,079**	430
Council	**15,882**	23,202
Employee Costs	**163,762**	116,954
Equipment Leasing	**10,731**	10,825
Contracted services	**23,189**	50,227
Insurance	**1,809**	1,700
Memberships	**3,616**	3,258
Miscellaneous	**21**	50
Newsletter (Resport)	**21,969**	17,138
Office	**11,879**	10,159
Postage and courier	**7,294**	7,930
Promotion and Web Page	**11,627**	28,656
Provincial Symposium	-	116,117
Registration Committee	**1,151**	522
Rent and operating.	**26,557**	22,970
AGM - Expenses	**11,526**	-
	355,226	449,278
Gain or loss on disposal of assets	**823**	193
EXCESS OF REVENUES OVER EXPENDITURES	**46,399**	3,758

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COLLEGE AND ASSOCIATION OF RESPIRATORY THERAPISTS OF ALBERTA

STATEMENT CHANGES IN NET ASSETS
FOR THE TWELVE MONTHS ENDED JANUARY 31, 2008

	Invested in capital assets	Unrestricted	Total 2008	Total 2007
BALANCE, beginning of year	$ 9,384	$ 323,707	$ 333,091	$ 329,333
Excess of revenues over expenditures	(3,449)	49,848	46,399	3,758
Capital asset additions	6,078	(6,078)	-	-
BALANCE, end of year	$ 12,013	$ 367,477	$ 379,490	$ 333,091

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COLLEGE AND ASSOCIATION OF RESPIRATORY THERAPISTS OF ALBERTA

NOTES TO THE FINANCIAL STATEMENTS
JANUARY 31, 2008

The College and Association of Respiratory Therapists Of Alberta (CARTA) is a self-governing professional organization established for the certification and governance of respiratory therapists in Alberta.. It is a not-for -profit organization and as such is not subject to federal or provincial income taxes.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The organization's accounting policies and the standard of its disclosure are in accordance with the recommendations of the Canadian Institute of Chartered Accountants:

a) Capital Assets

Office furniture and equipment are recorded at cost and amortized on the straight line basis at a rate of 20% per year (10% in the year of acquisition).

Computer hardware is recorded at cost and amortized on the straight line basis at a rate of 30% per year (15% in the year of acquisition).

Computer software is recorded at cost and amortized at 50% per year.

b) Revenue Recognition

Membership fees are recognized as revenue in the year they are received.

c) Donated Services

Donated services are provided to the CARTA in the form of volunteer time. Donated services are not recorded in the financial records of the organization.

2. MEASUREMENT UNCERTAINTY

The preparation of the financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. By their nature, these estimates are subject to measurement uncertainty and the effect on the financial statements of changes in such estimates in future periods could be significant.

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3. EQUIPMENT

	Cost	Accumulated Amortization	Net 2008	Net 2007
Office furniture and equipment	$ 23,143	$ 17,545	$ 5,598	$ 5,958
Computer hardware and software	19,063	16,128	2,935	3,426
Symposium Equipment	2,855	2,855	-	-
	$ 45,061	$ 36,528	$ 8,533	$ 9,384

4. COMMITMENTS

At January 31, 2008 the society was committed under a non-cancellable lease for office premises at $12,213 per year plus operating costs of an estimated $10,937 until the year 2010. Equipment has been leased for $14,208 per year until 2010.

5. FINANCIAL INSTRUMENTS

The Organization's financial instruments recognized in the balance sheet consist of cash, accounts receivable, and all liabilities. The fair values of these financial instruments approximate their carrying amounts due to the short-term maturity or current market rate associated with these instruments. The Organization does not have significant credit risk exposure to any individual party.

COLLEGE AND ASSOCIATION OF RESPIRATORY THERAPISTS OF ALBERTA

CASH FLOW STATEMENT
FOR THE TWELVE MONTHS ENDED JANUARY 31, 2008

	2008	2007
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash received from membership dues	**$ 376,956**	$ 339,503
Payment for newsletters, mail outs and other	**4,926**	5,384
Received from provincial symposium	**(275)**	97,646
Interest income	**20,841**	10,696
Cash payments to suppliers and employees	**(348,892)**	(447,799)
	53,556	5,430
CASH FLOWS FROM INVESTING ACTIVITIES INVESTING ACTIVITIES		
Additions to capital assets	**(2,598)**	(6,078)
	(2,598)	(6,078)
INCREASE (DECREASE) IN CASH AND EQUIVALENTS	**50,958**	(648)
CASH AND EQUIVALENTS, beginning of year	**325,872**	326,520
CASH AND EQUIVALENTS, end of year	**$ 376,830**	$ 325,872

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Corporate Social Responsibility

Registered Respiratory Therapists are making a difference for a better world

Corporate Social Responsibility (CSR) is defined as an organization's commitment to operating in an economically, socially and environmentally sustainable manner, while recognizing the interests of its stakeholders, including registered members, employees, stakeholders, business partners, local communities, the environment and society at large. CSR goes beyond good works such as volunteerism and charity. Organizations that practice CSR develop policies and programs in areas such as employee relations, community development, environmental stewardship, market place practices, fiscal responsibility, transparency of processes and accountability.

The following are some of the CSR practices members of your regulatory body have been actively engaged in this year:

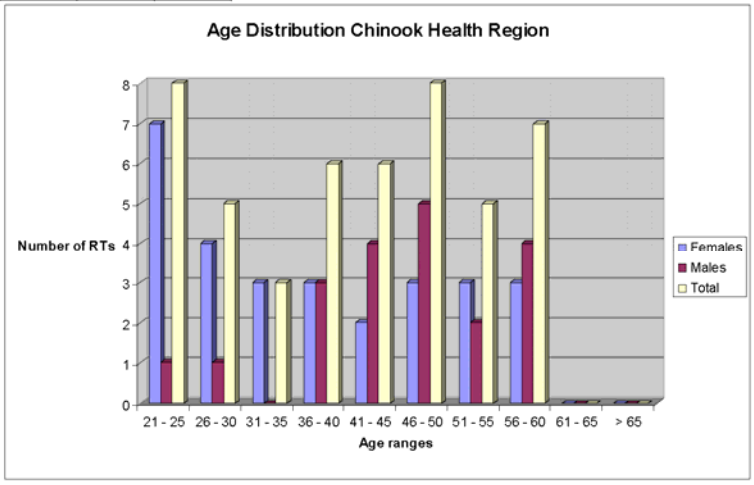
- The University of Alberta Hospitals Respiratory Therapy Department are recipients of the Respiratory Therapy Week 2007 contest conducted by the Canadian Society of Respiratory Therapists. Congratulations to Julie Mitchell RRT,
- The Great Ventilator Relay raised over $5,000 for the Alberta Lung Association, the winners were the alveolar avengers including Tricia Zwarich RRT, Dave Reid RRT, Cheryl Rogers RRT, Terry Wright RRT and Oomen Thomas RRT all from the University of Alberta Hospital Respiratory Therapy Department,
- Respiratory Therapy Week shopping mall display for public awareness was presented by Flora Ducharme RRT in Lethbridge,
- Individual Respiratory Therapy Week displays for the public were created by Cheryl Adams RRT at Capital Health Homecare and Lisa Lem RRT at the Cross Cancer Institute,
- Fund-raising for Make a Wish Foundation by conducting the sixth annual June softball tournament in Calgary, thanks Ben Asuchak RRT and Lorne Howie for your sustaining commitment to this project,
- We maintain a informative user friendly website to provide relevant practice information including the recent Provincial Infection Prevention and Control Standards. Special recognition to Kip Panesar RRT for his efforts on this important service extending our information sharing on the world wide web,
- We source product/service providers who treat us fairly and respect our mission to protect the public in a fiscally responsible manner as stewards of our member's limited resources,
- We treat our employees and service providers with respect and recognize their value in contributions to a positive innovative profession,
- We lease a highly energy efficient BOMA certified building that meets or exceeds extensive environmental practice standards,
- We source where possible 30-100% recycled paper products for our office operations and membership publications,
- Our office practices include use of both sides of all paper surfaces, obsolete transitional records are cross-shredded prior to being recycled with the building recycling program.

Demographic Information

Chinook

Number of Respiratory Therapists (May 2008)											
Age (years)	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 – 50	51 - 55	56 - 60	61 - 65	> 65	Totals
Females	7	4	3	3	2	3	3	3	0	0	28
Males	1	1	0	3	4	5	2	4	0	0	20
Total	8	5	3	6	6	8	5	7	0	0	48

	Hours Worked 2007	FTE 2007
Females	32080	16.5
Males	35011	18.0
Total	67091	34.4

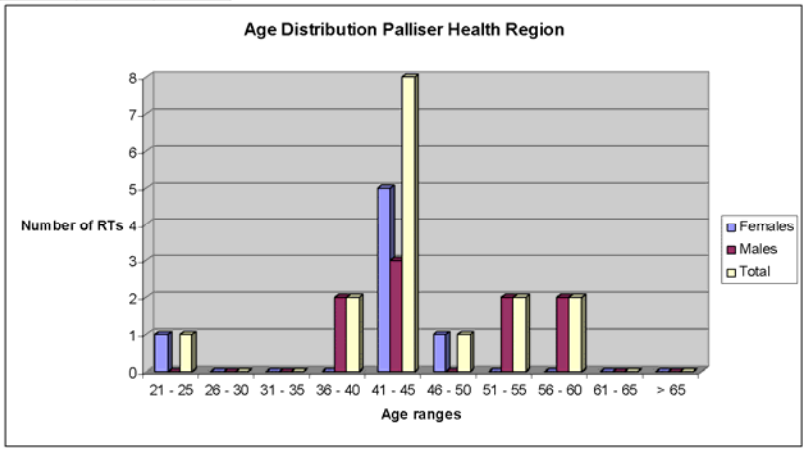


The ratio of Respiratory Therapist Full Time Equivalents (FTE) per 10,000 people is 2.22.

Palliser

Number of Respiratory Therapists (May 2008)											
Age (years)	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 - 50	51 - 55	56 - 60	61 - 65	> 65	Totals
Females	1	0	0	0	5	1	0	0	0	0	7
Males	0	0	0	2	3	0	2	2	0	0	9
Total	1	0	0	2	8	1	2	2	0	0	16

	Hours Worked 2007	FTE 2007
Females	8526	4.2
Males	16314	8.1
Total	24840	12.3



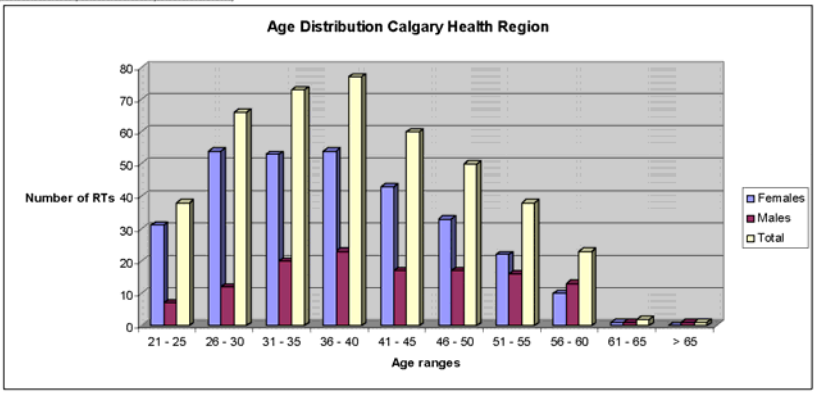
The ratio of Respiratory Therapist Full Time Equivalents (FTE) per 10,000 people is 1.22.

Demographic Information

Calgary

Number of Respiratory Therapists (May 2008)											
Age (years)	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 - 50	51 - 55	56 - 60	61 - 65	> 65	Totals
Females	31	54	53	54	43	33	22	10	1	0	301
Males	7	12	20	23	17	17	16	13	1	1	127
Total	38	66	73	77	60	50	38	23	2	1	428

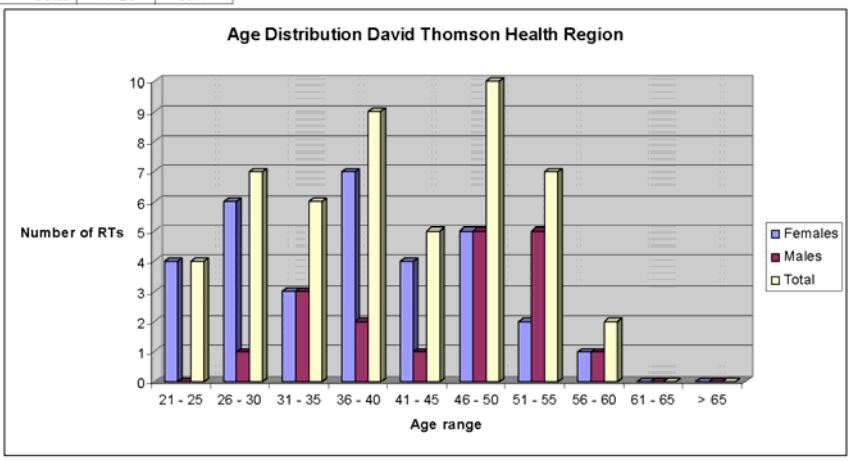
	Hours Worked 2007	FTE 2007
Females	563793	289.1
Males	282744	145.0
Total	846537	434.1



David Thomson

Number of Respiratory Therapists (May 2008)											
Age (years)	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 - 50	51 - 55	56 - 60	61 - 65	> 65	Totals
Females	4	6	3	7	4	5	2	1	0	0	32
Males	0	1	3	2	1	5	5	1	0	0	18
Total	4	7	6	9	5	10	7	2	0	0	50

	Hours Worked 2007	FTE 2007
Females	49103	25.2
Males	28318	14.5
Total	77421	39.7



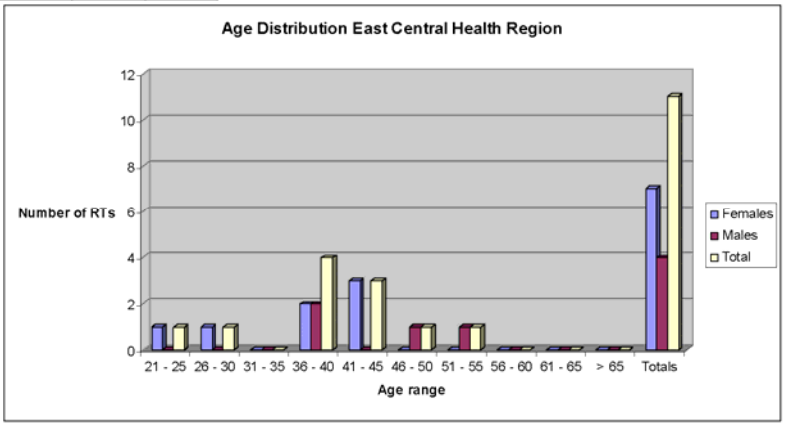
The ratio of Respiratory Therapist Full Time Equivalents (FTE) per 10,000 people is 1.35.

Demographic Information

East Central

Number of Respiratory Therapists (May 2008)											
Age (years)	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 - 50	51 - 55	56 - 60	61 - 65	> 65	Totals
Females	1	1	0	2	3	0	0	0	0	0	7
Males	0	0	0	2	0	1	1	0	0	0	4
Total	1	1	0	4	3	1	1	0	0	0	11

	Hours Worked 2007	FTE 2007
Females	6092	3.1
Males	7726	4.0
Total	13818	7.1

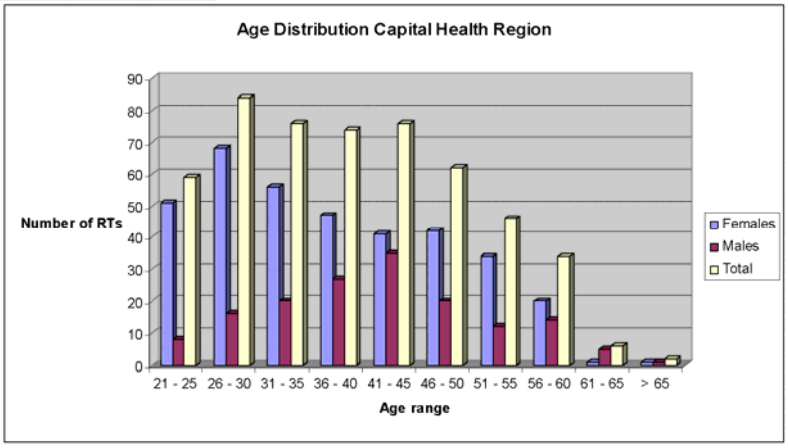


The ratio of Respiratory Therapist Full Time Equivalents (FTE) per 10,000 people is 0.64.

Capital

Number of Respiratory Therapists (May 2008)											
Age (years)	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 - 50	51 - 55	56 - 60	61 - 65	> 65	Totals
Females	51	68	56	47	41	42	34	20	1	1	361
Males	8	16	20	27	35	20	12	14	5	1	158
Total	59	84	76	74	76	62	46	34	6	2	519

	Hours Worked 2007	FTE 2007
Females	470878	241.5
Males	254127	130.3
Total	725005	371.8



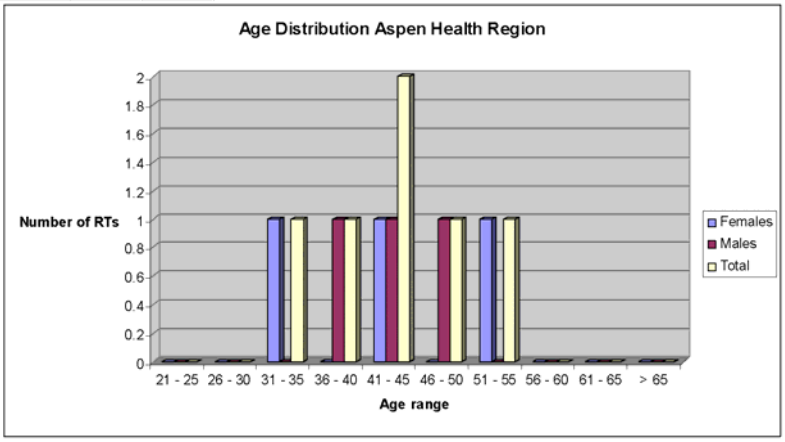
The ratio of Respiratory Therapist Full Time Equivalents (FTE) per 10,000 people is 3.70.

Demographic Information

Aspen

Number of Respiratory Therapists (May 2008)											
Age (years)	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 - 50	51 - 55	56 - 60	61 - 65	> 65	Totals
Females	0	0	1	0	1	0	1	0	0	0	3
Males	0	0	0	1	1	1	0	0	0	0	3
Total	0	0	1	1	2	1	1	0	0	0	6

	Hours Worked 2007	FTE 2007
Females	4894	2.5
Males	4697	2.4
Total	9591	4.9

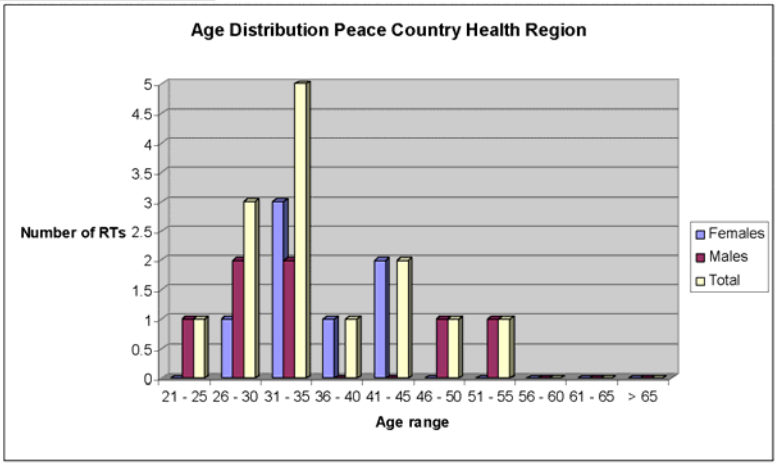


The ratio of Respiratory Therapist Full Time Equivalents (FTE) per 10,000 people is 0.28.

Peace Country

Number of Respiratory Therapists (May 2008)											
Age (years)	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 - 50	51 - 55	56 - 60	61 - 65	> 65	Totals
Females	0	1	3	1	2	0	0	0	0	0	7
Males	1	2	2	0	0	1	1	0	0	0	7
Total	1	3	5	1	2	1	1	0	0	0	14

	Hours Worked 2007	FTE 2007
Females	15414	7.9
Males	9658	5.0
Total	25072	12.9



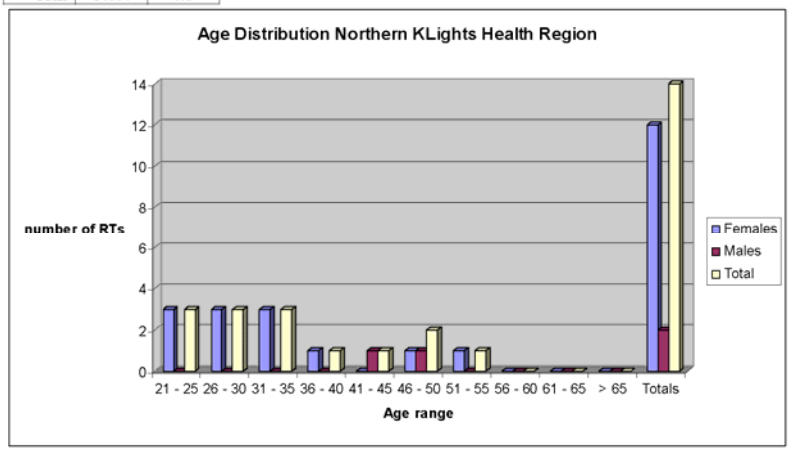
The ratio of Respiratory Therapist Full Time Equivalents (FTE) per 10,000 people is 0.95.

Demographic Information

Northern Lights

Number of Respiratory Therapists (May 2008)											
Age (years)	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 - 50	51 - 55	56 - 60	61 - 65	> 65	Totals
Females	3	3	3	1	0	1	1	0	0	0	12
Males	0	0	0	0	1	1	0	0	0	0	2
Total	3	3	3	1	1	2	1	0	0	0	14

	Hours Worked 2007	FTE 2007
Females	12789	6.6
Males	2015	1.0
Total	14804	7.6



The ratio of Respiratory Therapist Full Time Equivalents (FTE) per 10,000 people is 1.03.

Nelson Kennedy Lectures
and
Examination Preparation Workshops

A speech may last sixty minutes, *its impact can last forever!*

The purpose of the lectures and examination preparation workshops is to honor the professional career of Mr. Nelson Kennedy RRT and enhance leading edge clinical practice in respiratory therapy while assisting graduates from approved education programs who have been unsuccessful in writing the approved entry to practice examination. The College and Association annually sponsor a distinguished speaker(s) recognized for their accomplishments in a variety of lecture themes which include, distinctive clinical excellence, vision and humanitarian activities.

The inaugural *Nelson Kennedy Lecture* was convened in Edmonton Alberta on October 29th, 2004 with a theme of Distinctive Excellence in Clinical Practice. Participating in a panel discussion on the *Clinical Application of Airway Pressure Release Ventilation* (APRV) was the founder of APRV Dr. Stephen Downs from the University of Central Florida, Dr Neil McIntyre from Duke University, Durham North Carolina, Mr. Robert Kacmarek PhD, MSc, RRT, from Harvard Medical School, Cambridge Massachusetts and Ms. Roberta Hales RRT, RN Philadelphia Children's Hospital, Philadelphia Pennsylvania also participated on the panel which was moderated by Ms. Linda Fontaine-Tymchuk RRT from the University of Alberta Hospitals in Edmonton Alberta.

Edmonton was the venue again on June 3rd 2005 when Mr. Stephen Lewis Secretary General Kofi Annan's special envoy for HIV and Aides in Africa spoke on the humanitarian theme of *Compassion in Action*. Speaking in Calgary on November 3rd, 2006 Mr. Preston Manning presented on *Vision*. On September 28th, 2007 in Edmonton John B. Izzo one of North America's most sought after thinker, advisor and retreat leader presented on *Creating the Buzz Workplace: spirited teamwork.*

The examination preparation workshops were initiated in October of 2004 and are provided free of charge to candidates who have been unsuccessful on the approved examination. The workshops are customized to meet specific individual learner's needs. Workshop content includes a customized review and analysis of each individual's examination candidate profile, identification of specific examination category strengths and opportunities for improvement to succeed on the subsequent writing of the examination. The specific competency profile objectives of the examination subject domains are also provided to sharpen the candidate's focus.

Information is presented on multiple choice examination preparation and exam writing strategies dos and don'ts, decoding difficult questions, strategic guessing, don't change your answers, managing exam anxiety, concentration strategies, time and stress management, performance reflection, 350 content specific practice multiple choice and case study questions are also provided. Two experienced volunteer facilitators recognized by the National Institute for Staff and Organizational Development (NISOD) at the University of Texas Austin for excellence in education provide the support and assistance with an overall success rate of 92% for 24 participants to date.

Sourcing Report Summary

The following organizations compose the supply chain of goods and services utilized to fulfill our mission and regulatory functions under the *Health Disciplines Act.* These organizations have been selected by virtue of being low cost industry leaders in their respective markets:

- Alberta Foundation of Administrative Justice (platinum membership)
- ATB Financial
- Scotiabank,
- PF Turner Chartered Accountant,
- Lynda Baker Corporate Accounting Services,
- National Alliance of Respiratory Therapy Regulatory Bodies
- Committee on Accreditation in Respiratory Therapy Education,
- Canadian Board for Respiratory Care,
- Committee on Accreditation for Respiratory Care,
- National Board for Respiratory Care,
- SunLife Financial,
- Bentall Real Estate Services,
- The Cooperators Insurance,
- Marsh Canada Limited,
- American Express,
- Enterprise Car Rentals,
- West Jet,
- Air Canada,
- Mayfield Inn and Conference Centre,
- Red Deer Lodge Hotel and Conference Center,
- Staples Office Depot,
- Cashmere Company,
- New Dog Apparel,
- Human Resources and Social Services Development Canada,
- Edmonton Public Library,
- Bison Security Group,
- Lexis Reporting Group,
- Fraser Milner Casgrain Licensed Law Practice,
- Canada Lawbooks,
- Carswell Publishers,
- IKON Office Solutions,
- Techsquad,
- Trinity Equipment and Office Maintenance
- Impark,
- Paymentech,
- Red Engine,
- Telus,
- Visa,
- Canada Post Venture One,
- Neopost
- Retail Council of Alberta

Support Respiratory Therapy Week October 2008

Thanks to Julie Mitchell RRT et al University of Alberta Hospitals