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KENNETH J. POGUE
DIRECTOR

March 17, 2026

Emmalynn Chaubard
California Disability Services Association
Government Affairs Director
1107 9th Street
Sacramento, California 95814
Email: echaubard@cal-dsa.org

SENT VIA MAIL

Re: CTU2026-0116-01

Dear Emmalynn Chaubard:

The Office of Administrative Law (OAL) received your petition alleging that the Respiratory Care Board has issued, used, enforced, or attempted to enforce an underground regulation. OAL declines to accept your petition.

Our decision in no way reflects on the merits of the underlying issue presented by your petition. It does not constitute a judgment or opinion on any issue raised in your petition. Nothing in our decision restricts your right or ability to pursue this matter directly with the Respiratory Care Board or in court.

Sincerely,

Office of Administrative Law

cc: Christine Molina, Executive Officer

PETITION TO THE OFFICE OF ADMINISTRATIVE LAW CHALLENGING ALLEGED UNDERGROUND REGULATION

Use of this form is optional. It requests the information required by California Code of Regulations, title 1, section 260, for a petition challenging an alleged underground regulation. Whether you use this form or another format, the mandatory information required by California Code of Regulations, title 1, section 260, including the supporting documentation, must be included in your petition. If you create a separate petition, or if you use this form and need to add extra pages, ensure each page is clearly labeled.

Petitioner Contact Information (Title 1, Section 260(b)(1)):

Name: Emmalynn Chaubard

Address: 1107 9th Street, Sacramento, CA 95814

Telephone Number (if available): 408-858-3525

E-Mail Address (if available): echaubard@cal-dsa.org

Name of Challenged Agency (Title 1, Section 260(b)(2)):

Respiratory Care Board of California

Complete description of the Challenged Rule (Title 1, Section 260(b)(3)):

The challenged rule is California Code of Regulations, Title 16, Section 1399.365, titled “Basic Respiratory Tasks and Services,” adopted by the Respiratory Care Board of California and effective October 1, 2025.

Section 1399.365 defines and limits the respiratory-related tasks and services that may be performed without an assessment or evaluation by a licensed Respiratory Care Practitioner (RCP), as referenced in subdivision (a) of Business and Professions Code section 3702.5. The regulation establishes a categorical distinction between “basic respiratory tasks and services,” which do not require a respiratory assessment, and respiratory tasks that are excluded from that definition and therefore may not be performed absent RCP involvement.

Subdivision (a) defines “assessment” as making an analysis or judgment and making recommendations concerning the management, diagnosis, treatment, or care of a patient. The definition specifies that assessment exceeds the acts of documenting observations or gathering and reporting data to a licensed respiratory care practitioner, registered nurse, or physician.

Subdivision (b) identifies specific activities deemed to constitute “basic respiratory tasks and services” that do not require a respiratory assessment. These include patient data collection; application and monitoring of a pulse oximeter; aerosol medication administration that does not involve manipulation of invasive or non-invasive mechanical ventilation; replacement of heat moisture exchangers and oxygen tanks for patients using non-invasive ventilation; hygiene care related to tracheostomy sites; use of manual resuscitation devices and basic life support–level cardiopulmonary resuscitation skills in emergencies; documentation of care, including

transcribing ventilator data; and observing and gathering data through chest auscultation, palpation, and percussion.

Subdivision (c) expressly excludes from the definition of basic respiratory tasks and services a range of respiratory and airway-related procedures. These excluded tasks include manipulation of invasive or non-invasive ventilators; assessment or evaluation of observed respiratory data; pre- and post-treatment assessments; use of medical gas mixtures other than oxygen; preoxygenation and suctioning; adjustment of oxygen flow or concentration; initial setup or replacement of breathing circuits; and multiple tracheostomy-related procedures, including tracheal suctioning, cuff inflation or deflation, use or removal of external speaking valves, and replacement of tracheostomy tubes or inner cannulas.

As written and applied, Section 1399.365 functions as a scope-limiting regulation that restricts the performance of respiratory-related tasks absent an RCP assessment. In doing so, the regulation specifically limits the scope of practice of Licensed Vocational Nurses (LVNs) by prohibiting LVNs from performing respiratory and airway-related tasks they previously performed pursuant to existing medical orders unless those tasks fall within the narrowly defined category of “basic respiratory tasks and services.” The rule therefore directly affects the authority of LVNs to provide routine respiratory care in community-based, residential, and other non-acute or exempt care settings.

The regulation was developed through a rulemaking process initiated in March 2024, with an initial 45-day public comment period beginning in June 2024, followed by a 15-day comment period after issuance of modified text in October 2024. The Board adopted the regulation without further modification in March 2025, and the Office of Administrative Law approved and filed the regulation with the Secretary of State in June 2025.

Following approval and implementation, substantial concerns were raised by affected providers, families, and professional organizations. The Board reported at its November 14, 2025 meeting receiving approximately 200 letters and written statements and more than 100 phone inquiries regarding the regulation’s implementation. Testimony and correspondence described widespread confusion regarding LVN authority to perform routine respiratory care under existing orders and raised concerns about reduced access to essential services, workforce disruption, and risks to medically fragile patients who rely on trained LVNs for daily respiratory support.

Attach an original or photocopy of the challenged rule. If the challenged rule is found in an agency manual, identify the specific provision of the manual alleged to comprise the challenged rule.

1399.365. Basic Respiratory Tasks and Services

(a) For purposes of this section, “assessment” means making an analysis or judgment and making recommendations concerning the management, diagnosis, treatment, or care of a patient or as a means to perform any task in regard to the care of a patient. Assessment as used in this section is beyond documenting observations, and gathering and reporting data to a licensed respiratory care practitioner, registered nurse, or physician.

(b) For purposes of subdivision (a) of section 3702.5 of the B&P, basic respiratory tasks and services do not require a respiratory assessment and include the following:

1. Patient data collection.
2. Application and monitoring of a pulse oximeter.
3. Medication administration by aerosol that does not require manipulation of an invasive or non-invasive mechanical ventilator.
4. Heat moisture exchanger (HME) and oxygen tank replacement for patients who are using non-invasive mechanical ventilation.
5. Hygiene care including replacement of tracheostomy ties and gauze and cleaning of the stoma sites.
6. Use of a manual resuscitation device and other cardio-pulmonary resuscitation technical skills (basic life support level) in the event of an emergency.
7. Documentation of care provided, which includes data retrieved from performing a breath count or transcribing data from an invasive or non-invasive ventilator interface.
8. Observing and gathering data from chest auscultation, palpation, and percussion.

(c) For purposes of subdivision (a) of section 3702.5 of the B&P, basic respiratory tasks and services do not include the following:

1. Manipulation of an invasive or non-invasive ventilator.
2. Assessment or evaluation of observed and gathered data from chest auscultation, palpation, and percussion.
3. Pre-treatment or post-treatment assessment.
4. Use of medical gas mixtures other than oxygen.
5. Preoxygenation, or endotracheal or nasal suctioning.
6. Initial setup, change out, or replacement of a breathing circuit or adjustment of oxygen liter flow or oxygen concentration.
7. Tracheal suctioning, cuff inflation/deflation, use or removal of an external speaking valve, or removal and replacement of the tracheostomy tube or inner cannula.

Description of the actions of the challenged agency showing that it has issued, used, enforced, or attempted to enforce the challenged rule. (Title 1, Section 260(b)(4))

The Respiratory Care Board of California has attempted to enforce California Code of Regulations, Title 16, section 1399.365 (“Basic Respiratory Tasks and Services”) by treating the regulation as binding and controlling authority over respiratory care practices following its effective date, despite the regulation having been promulgated without adequate stakeholder notification and input as required by the Administrative Procedure Act.

After the regulation became effective on October 1, 2025, the Board applied Section 1399.365 as enforceable and operative, resulting in immediate changes to respiratory care delivery and to the scope of services that LVNs were permitted to perform under existing medical orders. Providers, facilities, families, and professional associations contacted the Board seeking clarification regarding continued LVN authority to perform routine respiratory and airway-related care. In response, the Board relied on Section 1399.365 as controlling and indicated that tasks excluded under subdivision (c) could not be performed, thereby compelling compliance with the regulation's restrictions.

The Board's attempt to enforce the regulation brought to light the fact that affected stakeholders had not been meaningfully notified or engaged during the rulemaking process. This failure is reflected in the limited number of timely public comments received during rulemaking, followed by a substantial and immediate reaction only after the regulation was treated as enforceable. As documented on the Board's publicly noticed agenda for the November 14, 2025 meeting, the Board reported receiving approximately 200 letters and written statements from affected individuals, families, providers, and professional associations statewide, as well as an estimated 100 phone inquiries related to implementation of the regulation.

The correspondence and testimony described widespread confusion regarding LVN authority and reported that providers were altering or discontinuing respiratory services in response to the Board's application of Section 1399.365. These concerns arose only once the regulation was treated as enforceable, underscoring that affected stakeholders were not adequately aware of or engaged in the rulemaking process prior to adoption.

Legal basis for concluding that the guideline, criterion, bulletin, provision in a manual, instruction, order, standard of general application, or other rule or procedure is a regulation as defined in Section 11342.600 of the Government Code and that no express statutory exemption to the requirements of the APA is applicable. (Title 1, Section 260(b)(5))

No express statutory exemption to the requirements of the APA applies to California Code of Regulations, Title 16, section 1399.365. Although the Respiratory Care Board of California pursued a formal rulemaking process, the regulation was promulgated in a manner that failed to comply with essential APA requirements, most notably the obligation to provide adequate notice and a meaningful opportunity for input to a representative number of affected stakeholders.

Government Code section 11346.4 requires that, at least 45 days prior to the close of the public comment period, proposed regulatory action be mailed to a representative number of small business enterprises or their representatives that are likely to be affected by the proposed action. The statute expressly includes trade associations, industry associations, professional associations, and other organizations representing affected providers or employees. This requirement is a substantive component of the APA's notice and participation framework and is not discretionary.

That requirement was not met here. Affected stakeholders, including providers, facilities, and professional associations employing or representing LVNs and serving medically fragile patients, were not meaningfully notified of the proposed regulation during its development. The

lack of required outreach is reflected in the unusually limited number of timely public comments received during the rulemaking process, despite the regulation's broad and immediate impact on care delivery and workforce practices.

The procedural deficiency became apparent only after the regulation was implemented and treated as enforceable. Following the effective date, the Board received an immediate and substantial volume of correspondence and inquiries from providers, families, and professional associations expressing confusion and concern regarding the regulation's effect on existing care practices. The magnitude and timing of this response demonstrate that affected stakeholders were not adequately informed or engaged during the rulemaking process and first became aware of the regulation once compliance was required.

The existence of a rulemaking record does not cure this defect where the APA's mandatory stakeholder notification and engagement requirements were not satisfied in practice. Because Section 1399.365 is a rule of general application that the Board has attempted to enforce as binding authority, and because no express statutory exemption from APA requirements applies, the Board's enforcement of the regulation despite procedural noncompliance renders it an underground regulation within the meaning of Government Code section 11340.5.

Information demonstrating that the petition raises an issue of considerable public importance. (Title 1, Section 260(b)(6))

This petition raises an issue of considerable public importance because the challenged rule has triggered an unusually large and immediate statewide response, has direct implications for patient health and safety including life-or-death consequences for medically fragile individuals, and has prompted the Respiratory Care Board of California itself to pursue emergency regulatory action, underscoring the severity of the impacts.

The magnitude of stakeholder response following implementation of California Code of Regulations, Title 16, section 1399.365 is extraordinary. As reflected on the Board's publicly noticed agenda for its November 14, 2025 meeting, the Board reported receiving approximately 200 letters and written statements from affected individuals, families, providers, and professional associations statewide, as well as more than 100 phone inquiries related to the regulation's implementation. This level of response far exceeds what is typical for occupational licensing regulations and reflects widespread disruption across healthcare and community-based service systems.

During the initial development of the regulation, the Board received fewer than 25 comments from stakeholders. After additional amendments were proposed, a subsequent public comment period generated fewer than 50 responses. In contrast, once the regulation was implemented, the Board received more than 300 inquiries seeking clarification or assistance. This sharp increase highlights that the initial consultation process failed to meaningfully engage the appropriate stakeholders, resulting in widespread confusion and the need for post-implementation guidance.

The substance of this response highlights the gravity of the issue. Providers and families consistently reported confusion regarding LVN authority to perform routine respiratory and airway-related care under existing medical orders, as well as immediate changes to care delivery in response to the Board’s application of the regulation. For medically fragile individuals who rely on daily respiratory support such as suctioning, oxygen management, and tracheostomy care interruptions or delays in care are not merely administrative or operational concerns; they can result in acute respiratory distress, medical emergencies, hospitalization, or death.

The public importance of the issue is further demonstrated by the Board’s own response to the volume and severity of concerns raised. Following implementation of the regulation and receipt of extensive stakeholder feedback, the Board has acknowledged the urgency of the situation and has taken steps to adopt emergency regulatory changes in response to the reported impacts. The pursuit of emergency action reflects the Board’s recognition that the regulation, as implemented, has created immediate and significant consequences that could not wait for the ordinary regulatory timeline. An agency’s decision to explore emergency amendments is itself strong evidence that the issue is serious, time-sensitive, and of statewide importance.

However, while the emergency regulations may provide limited clarification for some providers, they do not resolve the underlying issues that prompted widespread concern. Without a more inclusive response that reopens the issue for discussion among all affected stakeholders, the amendments are unlikely to resolve the broader confusion or address public impacts.

Optional: Please attach any additional relevant information that will assist OAL in evaluating your petition.

Confirmation Pursuant to Title 1, Section 260(b)(7):

A copy of this petition and all attachments were submitted to the challenged agency.

Challenged Agency: Respiratory Care Board of California

Name of individual at Challenged Agency to whom petition was sent:

If submitted by mail, commercial or hand delivery:

Address: _____

If submitted by email:

Email Address: rcbinfo@dca.ca.gov

Please Note: When a petition is submitted to OAL and the challenged agency concurrently in the same e-mail, and the e-mail address of the recipient at the challenged agency is visible to OAL, the e-mail satisfies the written confirmation requirement. (Title 1, Section 260(b)(7)(B).)

If the state agency whose rule you are challenging is the California Department of Corrections and Rehabilitation (CDCR) or any prison or facility within the CDCR, you may want to send a copy of the petition to:

Regulations and Policy Management Branch
CDCR
P.O. Box 942883
Sacramento, CA 94283-0001

Additional information, including status of petitions under review, may be found on the OAL web site at www.oal.ca.gov.

If you have additional questions, contact the OAL Reference Attorney by calling (916) 323-6815, or by sending an e-mail message to staff@oal.ca.gov.

Deliver this petition and all supporting documentation to:

Attention: CTU
Office of Administrative Law
300 Capitol Mall, Suite 1250
Sacramento, CA 95814

Or by email to staff@oal.ca.gov

Petitions and accompanying documentation may be submitted to OAL in hard copy, either through the mail, or by hand delivery in person or by a commercial delivery service (FedEx, UPS, etc.), or by e-mail.