RESPIRATORY CARE BOARD
OF CALIFORNIA

Public protection is our highest priority.

Agenda Item: 9a
Meeting Date: 3/13/24

Item: Consideration of, and Possible Action on, Comments Received During 15-Day Comment Period Regarding Proposed Regulation to Adopt Title 16, California Code of Regulations Section 1399.365 (Basic Respiratory Tasks and Services)

Item Summary: Staff are presenting the proposed modified regulatory language, previously approved by the Board at its meeting on October 14, 2024, and comments received during the 15-day public comment period with recommended responses for the Board's consideration and approval. If the proposed responses to public comment are approved, Board staff further seeks authority from the Board to take all steps necessary to complete the rulemaking process.

BOARD ACTION

President calls the agenda item and it is presented by or as directed by the President.

PRESIDENT REQUESTS A MOTION

- Move to reject the comments received during the 15-day public comment period and approve the proposed recommended responses to comments as indicated in Attachment 3 of the meeting materials for Item 9a, direct staff to take all steps necessary to complete the rulemaking process, including the filing of the final rulemaking package with the Office of Administrative Law, authorize the Executive Officer to make any non-substantive changes to the proposed regulations before completing the rulemaking process, and adopt the proposed regulations at Section 1399.365 as noticed.
- Any other appropriate motion.

SECOND THE MOTION
President may request if there is a second to the motion, if not already made.

BOARD MEMBER DISCUSSION/EDITS (if applicable)

CALL FOR PUBLIC COMMENT
Public comment should be specific to the motion.

VOTE
Repeat motion and vote: 1) aye, in favor, 2) no, not in favor, or 3) abstain

Background Update

At the Board's October 14, 2024 meeting, the Board passed a motion to accept staff recommended responses to comments received regarding the originally published text, during the public comment period from June 21, 2024 through August 6, 2024 and the hearing held on August 7, 2024. The Board also passed a motion to notice proposed modified text for a 15-day comment period. If no comments were received Board staff were directed to complete the regulation process.

Board staff noticed modified text on October 15, 2024 allowing for public comment from October 15, 2024 through October 31, 2024. The Board received 44 comments in the forms of letters/emails that culminated in a total of 20 issues that are presented along with staff recommended responses to the RCB for its consideration, at its March 13, 2025 meeting. Comments were compiled by issue regarding the modified text with an explanation of the reasons for rejecting the comments and making no changes to accommodate the comments.

Background

The Respiratory Care Board (RCB) enforces the Respiratory Care Practice Act at Business and Professions Code (B&P) sections 3700-3779 (Act) and oversees approximately 24,000 licensed respiratory care practitioners and respiratory care practitioner applicants.

In January 2022, the RCB submitted its Sunset Report to the Assembly Business and Professions Committee and the Senate Business, Professions, and Economic Development Committee. In the report the RCB detailed a chain of events that began in 1996 when the Board of Vocational Nursing and Psychiatric Technicians (BVNPT) drafted and disseminated to multiple healthcare agencies and education programs a "policy" that provided Licensed Vocational Nurses (LVNs) were permitted to adjust ventilator settings. Such a policy is contrary to the Vocational Nursing Practice Act (VN Act), which authorizes LVNs to perform tasks that require technical, manual skills. (B&P §2859). From the RCB's experience, adjusting ventilator settings exceeds the technical and manual skills limited to LVNs and goes beyond basic respiratory tasks because it is a higher functioning task associated with higher adverse risks. Adjusting ventilator settings includes setting the mode of ventilation, tidal volume, respiratory rate, oxygen concentration, and positive end-expiratory pressure. Adjustment of one setting can throw off other settings. It requires regular assessment including the synthesis of data, of the patient's lung function, blood gases and overall response to ensure optimal oxygenation and ventilation while minimizing risks such as lung injury or infection. Results of changing a ventilator can be instant and dire if not performed correctly.

Since 1996, there have been many incidents reported to the RCB of LVNs performing respiratory care outside the scope of the VN Act resulting in patient harm and even death. The RCB contends that, while LVNs are invaluable to health care

teams, some facilities in California have allowed LVNs to practice respiratory care to the detriment of patients (and LVNs). Since 1996, the RCB continued to push back and tried to rectify many issues through multiple avenues, though the problems persisted. Thus, the RCB requested the Sunset Committees' guidance and assistance.

SB 1436 (Chapter 624, Statutes of 2022) was the Sunset Committees' response. SB 1436 was signed by the Governor in 2022 which, among other actions, allows the RCB to codify and name basic respiratory tasks in an effort to reduce the unlicensed or unauthorized practice of respiratory care. That bill also laid out a pathway for exemption for LVNs employed by home health agencies, licensed by the California Department of Public Health, to practice beyond basic respiratory tasks.

In October 2022, immediately after the bill was signed, the RCB approved proposed regulatory language identifying basic respiratory tasks. Staff gave public notice of the proposed regulations and in December 2022, numerous comments were received in opposition. While it remains the RCB's position that unauthorized persons practicing respiratory care beyond these basic tasks, even now, is illegal and has a myriad of liability issues, the perception to these facilities was that the regulations were the catalyst to making unauthorized practice illegal. For emphasis, it is currently illegal for unauthorized or unlicensed persons to practice respiratory care at any level. The proposed regulations actually permit some very basic respiratory tasks to be performed by unlicensed and unauthorized personnel.

Because the proposed regulations were perceived to restrict patient care, a quell of panic ensued among some patients and facilities. However misguided that was, the RCB agreed to stay within the spirit of the intent of SB 1436, and at its March 2023 meeting, moved to pursue legislative language that would provide additional exemptions for home and community-based settings. Following the March 2023 meeting, additional needed exemptions were identified, so the legislative language was not ready to progress.

At the RCB's June 2023 meeting, the RCB agreed to withdraw the proposed regulations identifying basic respiratory tasks allowing an opportunity to secure a legislative exemption on behalf of several home and community-based facilities.

At the RCB's October 2023 meeting, staff presented, and the RCB approved, a legislative proposal that stays within the spirit of SB 1436 by allowing LVNs a pathway to practice beyond basic respiratory tasks with patient-specific training at several home and community-based settings (6 beds or less). Staff secured an author, and SB 1451 was introduced in February 2024.

At its March 2024 meeting, the RCB was aware of its obligation to move forward with defining basic respiratory care tasks and services via regulation as required to implement SB 1436. This proposed rulemaking defines, by enumerating tasks, what is and is not meant by "basic

respiratory tasks and services." SB 1451 was signed by the Governor in September 2024, and it does not interfere with implementing these regulations. These regulations and SB 1451 are two separate and unrelated issues.

However, the introduction of SB 1451 showed a good faith effort above and beyond, to address fears of home and community-based facilities and patients and provide time for those parties to understand the difference between implementing regulations that define basic respiratory tasks and legislation that provides a pathway for LVNs to legally practice more advanced respiratory care with specific training requirements and in specific settings, which does not currently exist.

Section 2860 of the VN Act was amended in SB 1436 (statutes of 2022) to provide that no authority exists for LVNs to provide respiratory care services and treatment with the exception of what the RCB defines as "basic respiratory tasks and services that do not require a respiratory assessment and only require manual, technical skills, or data collection" (B&P §3702.5(a)). Both the proposed regulations and SB 1451 provide authority for LVNs to practice aspects respiratory care - they are not restricting services that may be provided.

At its March 2024 meeting, the RCB approved the proposed regulatory text for CCR section 1399.365 as presented, and directed staff to initiate the rulemaking process and take all steps necessary to complete the rulemaking process if no adverse comments were received during the 45-day comment period or at the public hearing.

The original regulation text that was presented at the RCB's March 2024 meeting was published on June 21, 2024 with a closing written comment period of August 6, 2024 and a hearing held for comment on August 7, 2024. The RCB received comments from five (5) commenters during the 45-day comment period for consideration.

Based upon further reflection in developing clearer recommendations, RCB Staff prepared and presented Modified Text for the RCB's consideration at its October 14, 2024 meeting.

RCB Mandate

The RCB's mandate is to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care (B&P §3701). Further, protection of the public shall be the highest priority for the Respiratory Care Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount (B&P §3710.1).

RCB Mission

To protect and serve consumers by licensing qualified respiratory care practitioners, enforcing the provisions of the Respiratory Care Practice Act, expanding the availability of respiratory care services, increasing public awareness of the profession, and supporting the development and education of respiratory care practitioners. (Strategic Plan 2023).

Legal References: Business and Professions Code

Vocational Nursing Practice Act

Section 2860

(a) This chapter confers no authority to practice medicine or surgery, to provide respiratory care services and treatment, or to undertake the prevention, treatment, or cure of disease, pain, injury, deformity, or mental or physical condition in violation of any provision of law.

(b) Notwithstanding subdivision (a), a licensed vocational nurse who has received training and who demonstrates competency satisfactory to their employer may, when directed by a physician and surgeon, perform respiratory tasks and services expressly identified by the Respiratory Care Board of California pursuant to subdivision (a) of Section 3702.5.

(Amended by Stats. 2022, Ch. 624, Sec. 1. (SB 1436) Effective January 1, 2023.)

Respiratory Care Practice Act

Section 3702.5

Except for the board, a state agency may not define or interpret the practice of respiratory care for those licensed pursuant to this chapter, or develop standardized procedures or protocols pursuant to this chapter, unless authorized by this chapter or specifically required by state or federal statute. The board may adopt regulations to further define, interpret, or identify all of the following:

(a) Basic respiratory tasks and services that do not require a respiratory assessment and only require manual, technical skills, or data collection.

(b) Intermediate respiratory tasks, services, and procedures that require formal respiratory education and training.

(c) Advanced respiratory tasks, services, and procedures that require supplemental education, training, or additional credentialing consistent with national standards, as applicable.

(Added by Stats. 2018, Ch. 180, Sec. 1. (SB 1003) Effective January 1, 2019.)

Attachments

1. Proposed Modified Regulatory Text of Title 16, CCR section 1399.365 Basic Respiratory Tasks and Services with double strikeout and underline for the RCB's consideration to approve.

2. Clean Copy of Final Proposed Text

3. Compilation of Comments Received During 15-Day Comment Period from October 15, 2024 through October 31, 2024 with Staff Recommended Responses.

California Code of Regulations
Title 16. Professional and Vocational Regulations
Division 13.6. Respiratory Care Board
Article 6. Scope of Practice

PROPOSED MODIFIED LANGUAGE

BASIC RESPIRATORY TASKS AND SERVICES

Legend:

Changes addressed in Notice of Proposed Regulatory Action (45-day comment period):
- Deleted text is indicated by ~~strikethrough~~
- Added text is indicated with an underline

Modified Text (15-day comment period):
- Deleted text is indicated by ~~double strikethrough~~
- Added text is indicated by double underline

Adopt Proposed Section 1399.365 as follows:

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~~Pursuant to~~ subdivision (a) of section 3702.5 of the B&P~~Business and Professions code~~, basic respiratory tasks and services ~~("tasks"), described more specifically below,~~ do not require a respiratory assessment~~,~~ and ~~only require manual, technical skills, or data collection. Basic respiratory tasks do not include manipulation of an invasive or non-invasive ventilator and do not include assessment or evaluation of chest auscultation. Basic respiratory tasks~~ include the following:

(~~a~~1) Patient ~~D~~data collection.

(~~b~~2) Application and monitoring of ~~the~~a pulse oximeter.

(~~c~~3) Medication administration by aerosol that does not require manipulation of an invasive or non-invasive mechanical ventilator. ~~Basic respiratory tasks do not include pre-treatment assessment, use of medical gas mixtures other than oxygen, preoxygenation, endotracheal or nasal suctioning, or post-treatment assessment.~~

(~~d~~4) Heat moisture exchanger (HME) and oxygen tank replacement for patients who are using non-invasive mechanical ventilation. ~~Basic respiratory tasks do not~~

~~include the initial setup, change out, or replacement of the breathing circuit or adjustment of oxygen liter flow or oxygen concentration.~~

(~~e~~5) Hygiene care including replacement of tracheostomy ties and gauze and cleaning of the stoma sites. ~~Basic respiratory tasks do not include tracheal suctioning, cuff inflation/deflation, use or removal of an external speaking valve, or removal and replacement of the tracheostomy tube or inner cannula.~~

(~~f~~6) Use of a manual resuscitation device and other cardio-pulmonary resuscitation technical skills (basic life support level) in the event of an emergency.

(~~g~~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.

NOTE: Authority cited: Sections 3702.5 and 3722, Business and Professions Code. Reference: Sections 2860, 3701, 3702, 3702.5, 3702.7, 3703, and 3765 Business and Professions Code.

Clean Copy of Final Proposed Text
(removal of underline and strikeout)

California Code of Regulations
Title 16. Professional and Vocational Regulations
Division 13.6. Respiratory Care Board
Article 6. Scope of Practice

Adopt section 1399.365 as follows:

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.

NOTE: Authority cited: Sections 3702.5 and 3722, Business and Professions Code. Reference: Sections 2860, 3701, 3702, 3702.5, 3702.7, 3703, and 3765 Business and Professions Code.

Basic Respiratory Tasks and Services Regulations
MODIFIED TEXT COMMENTS
AND RECOMMENDED RESPONSES FOR CONSIDERATION
Compilation of Comments Received During 15-Day Comment Period from October 15, 2024 through October 31, 2024

Objections or Recommendations/Responses
The Respiratory Care Board (RCB or the Board) received 44 timely letters, emails, or facsimiles during the 15-day comment period. Comments received were from those representing three broad areas of interest that were grouped into a total of 20 issues regarding the modified proposal of section 1399.365 of Division 13.6 of Title 16 of the California Code of Regulations (CCR)[1] as follows:

1) K-12 Schools:
Issues numbered 1- 5 are from those representing the interest of Licensed Vocational Nurses (LVNs) working in or affiliated with K-12 schools.

2) LVN Scope of Practice:
Issues numbered 6-12 are from those advocating for LVN scope of practice.

3) Home and Community-Based Care
Issues numbered 13-20 are from those representing home and community-based care.

Board staff does not recommend making any additional changes to the text for the reasons detailed below.

The Administrative Procedure Act (APA) does not require the Board to review or respond to written comments in support of this regulatory action during the final rulemaking process. However, the Board is required to review or respond to timely written comments that object or make a recommendation regarding the regulatory action or the procedures followed by the Board in proposing the regulatory action. The Board is also required to respond to any timely written comments received regarding the changes made to the proposed regulatory text if the comments received during the public comment period concern the most recent modifications made to the text.

Below are summaries of the comments received, followed by the Board's response to comments.

COMMENTS FROM THOSE REPRESENTING THE INTERESTS OF LVNS IN K-12 SCHOOLS

ISSUE NO. 1 – Need for LVNs in K-12 Schools (Submitted by commenters: S1, S3, S4, S5, S6, S7, S8, S9, S10, S11, S12, S13, S14, S15, S16, S17, S18, S22, S23, S25, S26, S31, S32)
Comments received were in opposition from employees of K-12 schools or school districts, throughout California, some in rural areas, describing the need for unlicensed and licensed personnel, such as LVNs, to provide health services to students attending K-12 schools in California. Commenters suggested that there are 17,400-20,880 students who rely on respiratory care throughout the school day throughout 1,000+ California school districts.

[1] All CCR references are to Title 16 unless otherwise noted.

Commenters expressed concerns about proposed regulations to hinder, limit, or stymie the role of LVNs in relation to patient/student suctioning. Commenters noted that school nurses, as supervisors of health (California Education Code 49422), provide health services to California's 5.8 million children in over 1,000 school districts statewide. Based on commenters' experience, 10-12% of California's students have special care needs; of those 1-3% have suctioning needs. In the educational setting, it is not uncommon to interface with students on ventilators, with tracheostomies, or with oxygen needs. These students need tracheal support, including suction and emergency tracheal replacement, to ensure the maintenance of patent airways. Many of these students are in the general education setting where they are participating in coursework, sporting activities and social events with the assistance of LVNs.

Commenters from various California school districts provided the following district specific facts:

- Though not often in commenter's rural school district of Pollock Pines Elementary School District, they do sometimes encounter students on ventilators, with tracheostomies, or with oxygen needs.
- The Anaheim Elementary School District school nurses, as supervisors of health, provide health services to district's 15,000 students daily. The district currently has 7 students at various school sites that require suctioning support to ensure the maintenance of their airway and allow them to receive their education alongside peers.
- School nurse and nursing coordinator for El Dorado County Office of Education supports six school districts with multiple LVNs and medical assistants (MAs) that keep the county's health offices running in these rural districts. These districts have only a handful of students who have respiratory needs including oxygen and tracheal care (including suctioning), but these are within some of their most remote districts.
- Santa Clara County Office of Education (SCCOE) school nurse's cohort serves the county's most critical students including those who require respiratory care along with 1:1 attention and in-class/on bus care. SCCOE students are located in classrooms in separate schools as well as integrated sites throughout Santa Clara County. SCCOE has 13 school nurses who serve a number of students at 55+ sites. Following are the current numbers of students receiving suctioning, tracheostomy and ventilator care and includes designated staff providing Specialized Physical Healthcare Services:
    - Suctioning: 33 Tracheostomies: 14 UAPs providing care: 32
    - Ventilators: 3 Cough assist/ other: 6 Licensed Nurses providing care: 31
- Currently in Special Education Programs operated by the San Joaquin County Office of Education (SJCOE), there are 15 LVNs either hired or contracted for student care including suctioning under the supervision of the credentialed school nurses.

RESPONSE TO ISSUE NO. 1[2]

The RCB reviewed and considered the opposing comments and declines to make any amendments to the proposed text based thereon because the statutory changes that were the result of Senate Bill (SB) 1436 (statutes of 2022), and which prompted this regulatory action, do not give the Board discretion to apply a definition of basic respiratory tasks and services (alternatively, collectively referred to herein as "tasks") different from what is commonly understood by the RCB's licensing population or inconsistent with the RCB's experience and understanding of the practice of respiratory care in California.

[2] Parts of the response are essentially the same for other responses.

Further, the RCB is fully committed to ensuring equal access for all students, including those with disabilities or medical impairments. However, this regulatory proposal is specifically designed to further define, interpret, or identify basic respiratory tasks and services, not to determine who may provide them. The determination of which allied health professionals may practice respiratory care rests with the legislature, not the Board.

As detailed on pages 1 and 2 in the Initial Statement of Reasons (ISOR), SB 1436 was passed in response to the RCB's *2022 Sunset Oversight Review* report (item 2 of the underlying data in the ISOR, beginning at page 87), which summarizes the longstanding lack of alignment between the BVNPT and the RCB regarding the scope of respiratory care performed by LVNs, dating back to 1996.

SB 1436 amended the Vocational Nursing Practice Act (B&P §§ 2840 et seq.) (VN Act), specifying that the VN Act confers "no authority" to provide respiratory care services and treatment (B&P §2860(a)). However, LVNs who have received training and demonstrate competency satisfactory to their employer, when directed by a physician and surgeon, may perform respiratory tasks expressly identified by the RCB pursuant to B&P §3702.5(a) of the Respiratory Care Practice Act (B&P §§ 3700 et seq.) (Act) (B&P §2860(b)).

B&P §3702.5 stipulates that the RCB is the only state agency statutorily authorized to define or interpret the practice of respiratory care in California. B&P §3702.5(a) provides that the RCB may adopt regulations to further define, interpret, or identify basic respiratory tasks and services that do not require a respiratory assessment and only require manual, technical skills, or data collection. The tasks outlined in this regulatory proposal are those deemed by the RCB to be basic respiratory tasks consistent with the RCB's experience and understanding of the practice of respiratory care in California for licensed RCPs, as authorized by B&P §3702.5(a).

Among other things, the Act indicates the practice of respiratory care in California is to be subject to regulation and control in the public interest to protect the public from the unauthorized and unqualified practice of respiratory care (BPC §3701). As explained on page 5 of the ISOR, endotracheal and nasal suctioning were excluded as basic respiratory tasks because they are often performed when providing medication by aerosol, especially for patients on ventilators. These tasks require assessment, evaluation, or both based on complete respiratory education and training, and the Board believes it is important to make the distinction to ensure patient health care is not compromised. As explained on page 6 of the ISOR, tracheal suctioning was excluded as a basic respiratory task because such task may require assessment, evaluation, or both based on complete respiratory education and training.

Overall, in the Board's experience, suctioning is beyond a basic respiratory task due to the potential risks posed when performed improperly, including pulmonary hemorrhage, arrhythmias, bronchospasm, atelectasis, cardiac arrest, or respiratory arrest. Even when performed correctly, complications such as blood pressure instability, mucosal trauma, or hypoxemia can still occur. It is crucial that the care provider performing suctioning possess comprehensive education and training to not only perform the task but also to assess and interpret data in real-time. Additionally, the provider must be equipped with the knowledge and skills to promptly address any complications that may arise during the procedure.

While the RCB acknowledges concerns about efficiency, it also recognizes the risks associated with unlicensed personnel, which may include LVNs, performing respiratory care. Despite this, the RCB believes that families and individuals should retain the right to choose the care that

best aligns with their needs and priorities. At present, it is not feasible to place an RCP in every home or community-based setting, even if this would provide the highest quality care.

Aligning laws with the safe practice of respiratory care in California is an ongoing and complex process. The RCB has been engaged in legislative and regulatory efforts for several years, including the following:

- 2021: RCB Sunset Report is filed highlighting the history on this issue and proposed legislative language to remedy the situation.

- 2022: Passage of SB 1436 – Codifies in B&P §2860 that LVNs do not have legal authority to practice respiratory care except under certain conditions, including an exemption for LVNs employed by home health agencies.

- 2022: Regulatory Proposal Noticed- In November 2022, the RCB noticed a regulatory proposal similar to the current rulemaking but withdrew it in 2023 following comments from those in the in-home and community-based settings, who misunderstood the regulations as restricting LVNs' ability to practice respiratory care.

- 2024: The RCB responded to these concerns by pursuing legislative exemptions (SB 1451) for home and community-based facilities. This legislation, signed in October 2024, amended B&P §3765 to extend implementation deadlines to January 2028, and provide for future identification of tasks and services that LVNs can perform in home and community-based settings, including required training.

- 2024: In June 2024, prior to the passage of SB 1451, the RCB resumed the regulatory process to further define, interpret, and identify basic respiratory tasks and services as authorized by B&P 3702.5. The 45-day comment period for this regulatory proposal closed on August 6, 2024, and a public hearing was held on August 7, 2024.

On September 18, 2024, over a month after the close of the 45-day comment period and public hearing, the RCB became aware of concerns from K-12 schools through a letter from the California School Nurses Organization (CSNO). Had these concerns been raised earlier, the RCB would have urged the K-12 schools to request a legislative amendment to SB 1436 in 2022 or SB 1451 in 2024.

However, at this point, the RCB believes that it is the responsibility of K-12 school advocates to pursue a legislative remedy. Further amendments to the proposed regulations to accommodate K-12 schools would be unfeasible, would delay compliance with legislative and regulatory timelines, and is not the appropriate avenue to remedy their concerns.

Moreover, modifying the list of basic respiratory services and tasks based on the role of LVNs in K-12 schools or otherwise -not unlicensed personnel- to allow performing respiratory care beyond basic tasks and services is dangerous and could result in harm to California respiratory patients. The highest priority of the RCB is protection of the public. When the RCB finds itself in a situation where the protection of the public is inconsistent with other interests, the protection of the public will always have priority (BPC §3710.1).

ISSUE NO. 2 - Services Provided and Authority/Legal Citations for K-12 Schools
(Submitted by commenters: S1, S3, S4, S5, S6, S7, S8, S9, S10, S11, S12, S13, S14, S15, S16, S17, S22, S23, S25, S26, S27, S29, S30, S31, S32)

The RCB received comments in opposition to the proposed regulation from employees of K-12 schools and school districts across California expressing concerns that prohibiting LVNs from performing suctioning tasks would disrupt established systems and negatively affect student care. Multiple commenters referenced California Education Code (EDC) §§ 49422, 49423, and 49423.5, as well as §§ 3051.12 and 3015.12(C) of Title 5 of the CCR, which grant authority for both licensed and unlicensed personnel to provide healthcare services, including suctioning, in K-12 schools. Commenters claim that what is permitted by the EDC is on top of what exists in the B&P, which allows trained LVNs to provide airway support.

Commenters note that in addition to the logistical and financial challenges, the proposed regulations would undermine the system that has been in place for years—one that has worked well in ensuring that students receive the care they need from qualified LVNs and trained personnel. Commenters claim LVNs have been safely and effectively performing suctioning in schools, as allowed by both the EDC and the B&P. Commenters indicate under EDC §49423.5, school districts statewide depend on LVNs and trained, designated school personnel, supervised by registered, credentialed school nurses to provide suctioning support for students, G-tube feedings, dressing changes, positioning, and medication administration. Commenters assert the move by the RCB to prohibit suctioning by LVNs is null as it has already been codified in EDC §49423.5, which provides that LVNs and trained, unlicensed personnel can perform suctioning when supervised by a registered credentialed school nurse. Commenter notes that "qualified personnel" is defined in Title 5 of CCR §3015.12(C).

Commenters state unlicensed personnel and LVNs provide safe care to students with suctioning, oxygen, and/or tracheostomies needs and LVNs provide safe care to students with ventilators and in other "advanced" respiratory treatments such as cough assist vests, with supervision by school nurses. Commenters indicate these procedures, under the umbrella of Specialized Physical Healthcare Procedures, are administered by designated trained staff, whether unlicensed personnel or licensed nurses (LVN/RN), under direct and indirect supervision of the school nurse, as prescribed by the physician and authorized by the parent.

Commenters urge the RCB to modify CCR §1399.365 related to basic respiratory tasks and services. Commenters indicate that unlike in years past, students with special educational needs are mainstreamed with general education students and are not necessarily segregated to special education sites. Further, schools are required to provide healthcare services so students can attend and remain in school. Commenters cite to the requirement under Section 504 of the Federal Rehabilitation Act for schools to provide a Free Appropriate Public Education (FAPE), arguing that LVNs are essential to delivering respiratory services to students with special needs. Commenters wrote many outside the school setting fail to understand that FAPE requires even those students with ventilators, tracheostomies and/or oxygen needs to be provided FAPE. Thus, for these students to attend school in a safe environment LVNs play a key role in commenter's school setting to care for the needs of these students. Commenters state schools have developed appropriate staffing structures using registered credentialed school nurses, RNs, LVNs, and unlicensed staff to meet the healthcare needs of students during the school day. Commenters state most school districts staff LVNs to care for their students with trachs and suctioning needs, as this level of care is safest for students. Per commenters, there are a very limited number of students with trachs who can be appropriately cared for by qualified designated school personnel. Commenters assert the proposed modifications will mean students are not able to get the care needed to attend school.

Commenters indicate the CSNO created standards for training LVNs and designated, unlicensed assistive personnel to suction students and change trachs. Within the scope of these regulations, LVNs that have been trained as required by the EDC should be grandfathered in until clean-up bill language can be provided.

RESPONSE TO ISSUE NO. 2

The RCB reviewed and considered the opposing comments and declines to make any amendments to the proposed text based thereon for the same reasons detailed in the Response to Issue No. 1 above and Response to Issue No. 5 below.

The RCB also notes that comments requesting the RCB "grandfather" those LVNs trained as required by the EDC until clean-up bill language can be provided is beyond the RCB's authority. The power to provide statutory exemptions and exceptions rests with the legislature, not an individual board, such as the RCB. However, in Response to Issue No. 5 below, the RCB discusses a possible alternate interpretation of EDC §49423.5 for LVNs working in K-12 schools.

Further, while many commenters, citing the EDC, assert that K-12 schools already have the legal authority to use LVNs (and unlicensed personnel) for respiratory care, they also assert, indirectly, that this authority was affected by the passage of SB 1436 in 2022. The appropriate way to resolve this conflict in legal authority is through the legislative process, also discussed in Response to Issue No. 1 above. This regulatory proposal focuses on further defining, interpreting, and identifying basic respiratory tasks and services consistent with the RCB's experience and understanding of the practice of respiratory care in California for RCPs and does not address or alter the legislative authority regarding who is permitted to practice respiratory care.

ISSUE NO. 3 - Respiratory Therapist Access/Shortage in Schools (Submitted by commenters: S1, S2, S3, S5, S6, S7, S8, S9, S10, S11, S12, S13, S14, S15, S16, S18, S19, S22, S23, S25, S26, S27, S29, S31, S32)

The RCB received comments in opposition from employees of K-12 schools or school districts, throughout California, some in rural areas, expressing concern that prohibiting LVNs from performing suctioning tasks in schools would create significant logistical and financial challenges. Commenters argue that LVNs are essential for providing specialized care, such as suctioning, to students with complex medical needs, as they can support multiple students throughout the day, unlike respiratory therapists (RCPs) who may be required only on an as-needed basis. Commenters claim the shortage of RCPs, especially in rural areas, would make it unrealistic and cost-prohibitive for schools to hire additional RCPs, further straining the already limited healthcare workforce. Additionally, commenters highlight that LVNs are already trained and supervised by credentialed school nurses to perform complex medical tasks, including catheterization, ventilator, oxygen, suctioning and tracheostomy care. Commenters warn that limiting LVN responsibilities could lead to gaps in care, delays in critical treatment, and increased stress on other school staff, negatively impacting student health and safety. Furthermore, commenters emphasize that requiring higher-level practitioners like RCPs would exacerbate existing staffing shortages and create unnecessary barriers to providing care.

Commenters indicate unlike other specialized healthcare that is performed on a schedule, the procedure of suctioning is typically done on an "as needed" basis, which would require the RCP to remain with a student all day, just in case they required suctioning. Commenters state expecting nearly 1,000 school districts to hire multiple RCPs to provide exclusive suctioning

services on a standby basis when an LVN or trained unlicensed assistive personnel can provide these and other services would be unrealistic, cost-prohibitive, and unnecessary. Commenters note that unlicensed personnel and LVNs in school districts can typically support and provide specialized physical health care services to support the whole student's medical needs for multiple students within their day, whereas an RCP would only be able to provide respiratory support, which may not be required daily. Commenters noted it is unclear whether RCPs would be willing to be 'trained' to provide other specialized health care services.

While another commenter claims that failure to hire and utilize LVNs in schools to effectively support students with complex medical needs will lead to school districts turning to qualified designated school personnel who possess minimal training for suction and trach care and pose a risk to students' health. In addition to respiratory support for students, LVNs can also provide additional specialized physical health care services to support the whole student's medical needs under the supervision of the credential school nurse. Currently, schools can legally train designated unlicensed personnel in schools to perform respiratory care, however, some students' medical needs are more complex, and a higher level of medical training, such as an LVN is often determined to be necessary. For example, an LVN may be hired to provide services to a student with a tracheostomy, who also requires a gastrostomy tube feeding twice a day, toileting assistance, and suctioning as needed. For the safety of the student and continuity of care, the best practice would be to have an LVN perform all services for this student. The service of suctioning for students is unpredictable and not typically a scheduled event. This new change creates an obstacle for LVNs to provide the necessary level of care for students with complex medical conditions.

Commenters note the training/supervision of LVNs and provide that LVNs must demonstrate competence in providing all specialized health care services, perform tracheostomy care under the direct supervision of RNs and cite that this collaborative approach ensures students receive high-quality care while allowing RNs to focus on more complex tasks. RNs possess the training to oversee LVNs effectively, ensuring that the standards of care remain high and that any potential complications are promptly addressed.

Commenters claim without LVNs, their students will be left with significant gaps in care or are at risk of delayed critical care when needed immediately, due to lack of availability or a shortage of RNs or RCPs in the school setting. Commenters also claim that such delays can lead to serious health complications, undermining the very purpose of providing a supportive educational environment, as well as increase stress on staff, affecting both the health of students and the morale and effectiveness of the nursing team. One commenter suggested the change may necessitate the hiring of additional RNs, which is not a simple task and that shortages or diminished professional opportunities for staff, run the risk of significant morale and retention issues.

Commenters of a rural area note that to require schools to obtain a practitioner with greater credentials than an LVN is not only expensive but nearly impossible due to the rural nature of their schools. Challenges to retaining employees include location, inclement winter weather, and competing wages with larger cities/districts. Commenters express this change would cause an extreme hardship for their districts given they already experience difficulty maintaining LVNs and MAs.

Commenters claim that the demand for healthcare services continues to rise, and the availability of qualified nursing personnel is a pressing issue. By enabling LVNs to carry out tracheostomy

care, healthcare facilities and school districts can maximize their workforce efficiency. LVNs are already trained in essential nursing skills and can be quickly oriented to tracheostomy care protocols, allowing for a more responsive healthcare environment.

Commenters cited to estimates that 92,000 RCPs nationwide will retire by 2030 (Drager, 2023), suggesting a clear RCP shortage. Commenters noted the National Bureau of Labor Statistics (BLS) (2023) projects that the profession of respiratory therapy will grow by 14% by 2031, with a vacancy rate of 9,400 positions annually. Commenters state it is unclear how, on top of the current shortage, where an additional 10,000 RCPs will be available for RCP services on school sites.

RESPONSE TO ISSUE NO. 3

The RCB reviewed and considered the opposing comments and declines to make any amendments to the proposed text based thereon for the same reasons detailed in the Response to Issue No. 1 above and Response to Issue No. 4 below.

ISSUE NO. 4 – LVN Scope of Practice in K-12 Schools (Submitted by commenters: S20, S21, S23, S24, S28 ,S29, S30, S31, S32)

The RCB received comments in opposition from employees of K-12 schools or school districts across California, asserting that LVNs are legally authorized to provide respiratory care under the B&P and argued that the regulations would unduly restrict the LVN scope of practice. However, one comment highlighted that it was SB 1436 that amended B&P §2860, codifying restrictions on LVNs performing respiratory care. Another comment referenced specific sections of the B&P (§§ 2518.5 and 2840 et seq.), arguing that these provisions support LVN authority to provide respiratory care. This argument emphasized that such practices are rooted in LVN training standards and evidence-based nursing care, and that the "LVN Board, in concert with respiratory care practitioners, have ensured alignment." One comment falsely asserts that maintaining a patient's airway is both a nursing and respiratory care function supported by B&P §2725(a)(1). Commenters stressed that limiting the LVN scope of practice would negatively impact students' access to essential healthcare services in educational settings.

Commenters wrote they were in strong opposition and had deep concern to the recent decision by the RCB to redefine, diminish, or limit the scope of practice for LVNs regarding suctioning and tracheostomy care. Commenters believe that limiting these essential tasks to only technical health care assistants (THCAs)/RCPs will not serve the best interests of their students, many of whom require specialized care. Commenters allege that while THCAs can provide valuable support, they lack the comprehensive training and scope of practice to fully address the complex needs of their students who may require more than suctioning and trach care. Commenters wrote this change posed significant challenges for their school health services and their students who depend on their care. Commenters assert LVNs are incredibly essential for student health and wellbeing in a complex educational setting. Their versality and range of support to students is absolutely vital. Commenter states restricting the scope of practice for LVNs, risks compromising the quality of care provided to their most vulnerable students. LVNs, with their extensive training and experience, are well-equipped to handle these procedures safely and effectively. Limiting their ability to perform these tasks will undoubtedly impact the continuity of care.

Commenters claim that LVNs receive comprehensive education regarding suctioning and tracheostomy care, which are an integral part of their educational programs. Comments suggest that the proposed regulation prevents the LVN from having the opportunity to work in their full

capacity in which they were trained. Comments state the B&P empowers trained LVNs to provide airway support, encompassing suctioning procedures. Commenter finds LVNs to consistently demonstrate excellence in licensed care nursing procedures, such as tracheal suctioning.

Commenters expressed strong opposition to the regulatory change amending B&P section 2860 of the VN Act, which states LVNs may not provide respiratory care services and treatment. They claim the legislation has inadvertently impacted LVNs providing suctioning and trach care and negatively impacts children's access to medically necessary health care services in the educational setting. Commenters claim LVNs have been able to provide suctioning support and trach care for students under the B&P (§§ 2518.5 and 2840 et seq since 2001). Commenters contend LVN training standards around respiratory tasks have not diminished and in fact are fundamentally rooted in evidence-based practice. Commenters state the LVN Board, in concert with RCPs, have ensured alignment and note that the Joint Commission database reports no incidents related to suctioning. Commenters provide that LVNs can provide essential medical procedures for the most vulnerable, medically fragile students and claim that maintaining a patient's airway is both a nursing care [B&P 2725a(1)] and respiratory care function coupled with other professions, paramedic, qualified designated school personnel, etc. It is commenters' understanding that the RCB has voted to make it outside of the scope of practice for LVNs to suction or replace trachs by changing the wording of "basic respiratory tasks and services."

Commenters provide that many of their students with complex medical needs rely on consistent and competent care for their tracheostomy needs. The ability of LVNs to perform basic respiratory tasks, including suctioning and trach care, is crucial for their daily health and well-being. They claim that if this ruling takes effect, there is a risk in creating gaps in essential care and forcing districts to rely solely on RCPs for these services and claim this shift could lead to significant delays in care and ultimately compromise student safety.

RESPONSE TO ISSUE NO. 4

The RCB reviewed and considered the opposing comments and declines to make any amendments to the proposed text based thereon for the same reasons detailed in the Response to Issue No. 1 above.

The RCB notes comments opposing the "regulatory change" amending B&P section 2860 of the VN Act (which states LVNs may not provide respiratory care services and treatment) is a mischaracterization, as the amendments to B&P §2860 were statutory changes made by the legislature. Accordingly, although comments indicated opposition to the amendments to B&P §2860, such comments are not specifically directed at the proposed modifications made to the text that was noticed to the public on October 15. 2024, so the RCB declined to make any amendments to the proposed text based on the comments, pursuant to Government Code section 11346.8(c).

Further, the RCB disagrees with the premise that the B&P authorizes LVNs to practice respiratory care. The RCB maintains that LVNs have never been authorized to practice respiratory care, and which led to the RCB seeking legislative clarification. As detailed on pages 1 and 2 of the ISOR and as noted in Response to Issue No. 1, SB 1436 amended the VN Act, explicitly stating that the VN Act confers "no authority" to provide respiratory care services and treatment (B&P §2860(a)). However, LVNs who have received training and demonstrate competency satisfactory to their employer, when directed by a physician and surgeon, may perform certain basic respiratory tasks expressly identified by the RCB pursuant to B&P

§3702.5(a) (B&P §2860(b)).The RCB is the only state agency statutorily authorized to define or interpret the practice of respiratory care in California, as outlined in B&P §3702.5 of the Act. The tasks identified in this regulatory proposal are those deemed by the RCB to be basic respiratory tasks for licensed RCPs that do not require a respiratory assessment and only require manual, technical skills, or data collection, consistent with the RCB's experience and understanding of the practice of respiratory care in California.

Claims that LVNs' ability to provide respiratory care is rooted in LVN training standards or evidence-based nursing care are unsupported. No commenter has provided substantive evidence, and the RCB has not found evidence to substantiate the claim that respiratory care is part of every LVN training program. Additionally, the required curriculum content under CCR §§ 2533 and 2534 do not include respiratory care or related tasks.

Even if some training on respiratory care is offered as part of an LVN training program, it does not grant LVNs legal authority to provide respiratory care, particularly given that B&P §2860 was amended to specify that LVNs are not authorized to do so. Training in respiratory care does not automatically extend the LVN's scope of practice. For instance, even if LVN programs included training for minor surgeries, it would not make those procedures part of the LVN scope of practice. Furthermore, this regulatory proposal does not limit LVN classroom instruction nor does the curriculum of an LVN education program have any relevancy in determining what the RCB considers "basic respiratory tasks and services that do not require a respiratory assessment and only require manual, technical skills, or data collection."

Further, the RCB did not find, and was not presented with, any scientifically validated evidence that specifically evaluates the appropriateness of LVNs providing respiratory care. As outlined in the ***RCB 2022 Sunset Oversight Review*** report (item 2 of the underlying data in the ISOR, beginning at page 87), there has been a longstanding lack of alignment between the BVNPT and the RCB regarding the scope of respiratory care performed by LVNs, dating back to 1996. The RCB continues to reject guidance issued by the BVNPT concerning respiratory care, emphasizing the importance of clear legal boundaries.

Finally, the argument that "maintaining a patient's airway" constitutes both "nursing care and respiratory care" is flawed or reflects differing interpretations across professions. A commenter suggests support for this argument by citing B&P §2725(a)(1) (Registered Nursing Act), but it should be noted that B&P §2725 does not have a subdivision (a)(1). Turning to subdivision (a) of B&P §2725, that subdivision merely indicates the "legislative intent" to recognize overlapping functions between physicians and RNs, allowing for shared functions within organized healthcare systems that foster collaboration between these two professions. Furthermore, B&P §2840.5 establishes the practice of vocational nursing but clarifies that LVNs are not to be considered part of the professional scope of registered nursing or as professional employees as defined by the Government Code. It is also important to note that respiratory care is not classified as a "skilled nursing service" for the purposes of meeting legally required patient-to-nurse ratios.

ISSUE NO. 5 – Feasibility for K-12 Schools (Submitted by commenters: S1, S2, S3, S4, S5, S6, S8, S9, S10, S11, S12, S13, S14, S15, S17, S19, S20, S21, S22, S23, S24, S25, S26, S27, S28, S30, S31, S32)

The RCB received comments in opposition, many of which expressed concerns that requiring K-12 schools or school districts – particularly those in rural areas – to hire RCPs or RNs would strain or even cripple school budgets. Commenters noted that these positions would be difficult to fill, inefficient for the as-needed nature of the tasks, and divert resources from other critical

educational and health services. Several commenters argued that the regulations would impose a substantial fiscal burden on the state. Instead, commenters strongly advocate for allowing LVNs, to continue providing respiratory care, emphasizing that this approach is cost-effective, feasible, and maintains student safety.

Specifically, commenters provided an estimate of cost, stating that given the similar amount of education required, RCPs would make monthly schedule amounts similar to that of an LVN, which is approximately $5,175-$6,278 monthly. In calculating a mean salary $5,727 x 12 months=$68,724 annually X 10,000 RCPs=$687,240,000.00 additional educational costs in salaries. The RCPs would be placed on the PERS salary schedule @ .45% of salary cost=$309,258,000. Salary and benefits cost would total $996,498,000 or nearly $1 billion dollars. Commenters note this does not include charter schools. Commenter states they fundamentally believe that RNs and RCPs, who are in high demand in medical settings, will not leave their high paying hospital jobs (at $47/hour for RCPs) for school district salaries to simply stand-by to suction students, or it is unlikely that enough would be available or willing to take on school-based positions for the salaries typically offered. Commenters add that the average RCP salary in CA is $59,878 and $103,060 according to the BLS. With consideration of the shortage of RCPs in the healthcare industry and higher salaries expected, it would be prohibitive for students to receive the suctioning and other higher level respiratory care needed if the provider is restricted to an RCP. Commenter states the current nationwide shortage of RCPs will result in districts being likely unable to hire and retain RCPs due to the competitive salaries paid by hospitals.

Commenters note that suggesting only RCPs should perform suctioning raises concerns, including that the financial implications are considerable and cannot be overstated. Suctioning is often an "as-needed" procedure. Commenters state that requiring or mandating RCPs or RNs to exclusively provide stand-by suctioning support is not feasible, unrealistic, in some cases unattainable, unnecessary, costly to an education budget that is already experiencing a budget deficit and would divert resources from other critical educational and health services. This could lead to difficult decisions about staffing levels for other critical nursing services, as many districts simply cannot afford to allocate funds for additional specialized staff, further impacting the overall care that students receive, including those with complex health needs. Many schools do not even have a Registered Credentialed School Nurse on site due to budgets, so thinking care could be managed that way is unrealistic. Further, many districts may not have the resources to hire additional RCPs, particularly when they are already stretched thin in terms of staffing and budget. Comments state hiring enough RCPs to cover the suctioning needs of students across the state would strain already limited educational budgets. Commenter implores the RCB to review EDC §§ 49423.5 and 49422 to consider how public schools (noting they are vastly underfunded) will endure the cost of hiring an RCP to be on site for 6 hours (including during bus transportation to and from school) for stand-by-suctioning support, alone, for these students.

Commenters believe strongly that the current model, in which LVNs and trained staff can provide suctioning under proper supervision, is both safe and cost-effective. Commenters state that LVNs being unable to provide suctioning services places huge fiscal and personnel burdens on the 1,000 school districts statewide. It is unrealistic to require RCPs in the educational setting, when qualified, designated school personnel and LVNs are competent to meet the student’s complete medical needs. The commenters strongly urge the RCB to continue to allow students to be served in their schools for their necessary respiratory care services by LVNs and grandfather these services students in the educational setting.

Commenter also states that the RCB's analysis that provides there is no fiscal burden to the State is not just untrue, it is dangerous. The commenter provides that it is unrealistic to require RCPs in the educational setting to provide stand-by suctioning services, when trained unlicensed personnel and LVNs are allowed under the EDC to provide those provisions. Commenter adds that requiring additional staff burdens California's state budget to mandate to support these health care providers in the educational setting to a tune of millions of dollars.

Commenter states that allowing LVNs to provide tracheostomy care can significantly reduce healthcare costs. LVNs typically command lower salaries than RNs and utilizing their services for routing tracheostomy care would free RNs to handle more critical responsibilities. This cost-effective strategy can lead to reduced healthcare expenditures for facilities and patients alike, making care more accessible.

Commenter expresses that the change in wording from "basic respiratory tasks and services" raises significant concerns about the impact on student care and the financial implications for school districts. This decision could lead to a reliance on RNs for care that LVNs are fully capable of providing, resulting in increased costs for districts already facing budget constraints.

Comments from rural school districts provide that it would be a financial struggle to hire RCPs and that such an expectation is unrealistic. One comment specifically notes that the rural location, inclement winter weather, and competing wages with larger cities/districts, makes it difficult to maintain medical personnel. Commenter claims this regulation would cause a hardship for their district with the financial burden or would negatively impact their current staffing situation pulling already scarce resources from their existing programs and students.

RESPONSE TO ISSUE NO. 5

The RCB reviewed and considered the opposing comments and declines to make any amendments to the proposed text based thereon, for the same reasons detailed in Response to Issue Nos. 1 and 4 above.

The RCB notes that comments suggesting the proposed regulations require RCPs or RNs to exclusively provide suctioning support in K-12 schools misconstrues this regulatory action. As noted in Response to Issue No. 1 above, this regulatory proposal focuses on further defining, interpreting, and identifying basic respiratory tasks and services consistent with the RCB's experience and understanding of the practice of respiratory care in California for RCPs and does not address or alter the legislative authority regarding who is permitted to practice respiratory care.

As detailed in the Response to Issue No. 1 above, since 2020, the issue of LVNs practicing respiratory care has been discussed in numerous public meetings, including those held by the BVNPT. The RCB has also been actively engaged in legislative and regulatory efforts, including its Sunset Review, two legislative bills, and two regulatory proposals. Despite this ongoing public dialogue, K-12 schools only raised their concerns in September 2024 through a letter from the CSNO. Had these concerns been presented earlier, K-12 schools could have participated in these public discussions or requested legislative amendments in 2022 or 2024 to address their issues.

At this stage, amendments to the proposed regulatory action to accommodate the comments from K-12 schools would not align with current legislative intent, would delay compliance with

legislative and regulatory timelines, and is not the appropriate avenue to remedy their concerns. The RCB believes that it is the responsibility of K-12 school advocates to pursue a legislative remedy if so desired.

It is observed that although the amendments to B&P §2860 went into effect on January 1, 2023, there is no evidence that K-12 schools have reorganized their staffing or anticipated non-compliance with the law. This lack of preparation may stem from the belief that EDC §49423.5 provides authority for LVNs and unlicensed personnel, supervised by credentialed school nurses, to perform suctioning and similar tasks. If this interpretation holds, LVNs could operate as “unlicensed” personnel, addressing some, or all, of the fiscal impact concerns until a legislative remedy is secured.

Interested parties could choose to pursue a legislative amendment to clarify that EDC §49423.5 is not affected by B&P §2860. A "notwithstanding" clause could address the perceived conflict and ensure that K-12 schools can continue providing necessary suctioning services without additional financial burdens.

In addition, the fiscal impact concerns raised by K-12 school representatives are not caused by the proposed regulations, but they are instead a direct result of SB 1436. Among other actions, SB 1436 amended B&P §2860 clarifying that LVNs are not authorized to practice respiratory care. Subsequent statutory exemptions under SB 1451 did not include K-12 schools, but as discussed in Response to Issue No. 1 above, the RCB was not made aware of the concerns associated with K-12 schools until after the close of the 45-day comment period and the public hearing associated with this regulatory action. The RCB further notes that the fiscal concerns alleged by K-12 school representatives fail to account for alternative pathways to provide suctioning support under temporary legal frameworks, as discussed above.

COMMENTS FROM PEOPLE ADVOCATING FOR LVN SCOPE OF PRACTICE

ISSUE NO. 6 – Narrows LVN Scope of Practice (Submitted by commenters: L33, L34, L35, L36, L37, L38, L39, H44)

The RCB received comments in opposition, highlighting concerns about the proposed regulation’s impact on LVNs and their ability to perform respiratory care tasks, arguing that it would narrow their scope of practice and put patients at risk. Commenters note the BVNPT provides that preoxygenation or nasal suctioning; tracheal suctioning, cuff inflation/deflation, use or removal of an external speaking valve, or removal and replacement of the tracheostomy tube or inner cannula, and adjusting oxygen (O2) are tasks specifically included in their licensure training, and are part of the National Licensing Examination-PN (NCLEX-PN), which is the vocational nursing competency exam.[3]

Commenters state that LVNs are trained and licensed to perform respiratory care, including tracheostomy care, suctioning, and oxygen adjustment, and that these skills are essential for continuity of care, particularly in home health, long-term care, and pediatric settings. They argue that restricting LVNs’ roles would create workforce shortages, increase workloads for RNs and RCPs, and ultimately compromise patient outcomes. Commenters expresses concern that this

[3] A copy of the NCLEX-PN was submitted by BVNPT with a comment that was received after the close of the 45-day comment period. An identical comment was re-submitted without the attachments during the 15-day comment period, which is being considered herein.

proposed regulatory package omits certain tasks that are within the scope of practice of an LVN, specifically they do not represent assessment-related tasks. Commenter states, ”we certainly don’t want to erode current LVN scope of practice in regulations.”

A commenter, on behalf of the BVNPT, reiterates concerns that this rulemaking would significantly narrow a long-practiced scope and create a critical workforce shortage, claiming it places tens of thousands of patients who depend on LVNs for care at risk. Commenter recognizes that this language [i.e., CCR §1399.365(b)(1)-(8)] is an improvement upon prior versions. However, commenter continues to have serious concerns that the language still narrows BVNPT’s long-standing interpretation of LVN practice scope and puts patients at risk. Preoxygenation or nasal suctioning; tracheal suctioning, cuff inflation/deflation, use or removal of an external speaking valve, or removal and replacement of the tracheostomy tube or inner cannula, and adjusting O2 are necessary LVN skills, common and essential tasks specifically included in their licensure training, and are part of the NCLEX-PN.

Commenter suggests amending the text consistent with the BVNPT’s recommendation by adding the following:

> (b) (9) Preoxygenation, or endotracheal or nasal suctioning.
> (10) Tracheal suctioning, cuff inflation/deflation, use or removal of an external speaking valve, or removal and replacement of the tracheostomy tube or inner cannula.
> (11) Adjusting oxygen as directed.

Additionally, commenters claim that according to Title 16, LVNs can practice basic assessment, which includes respiratory. Commenters provide that “according to the NCLEX test plan, reduction of risk potential, LVNs are trained to include client tube patency which include tracheostomies” and are “responsible for care plans for tracheostomy.” Commenters request that their scope of practice not be infringed upon, adding it is not safe in-patient care. Commenter notes that they have had clinical rotations in pediatrics and learned how essential it is to understand and know tracheostomy care. Commenter requests that the RCB adhere to recommendations on the BVNPT website.

Commenter further strongly disagrees with the proposed regulation, particularly regarding its potential impact on the scope of practice for LVNs. Commenter states that LVNs are trained professionals who have completed rigorous education and clinical training to provide quality patient care, including foundational knowledge in respiratory care. Commenter claims, this training prepares LVNs to perform essential tasks within their scope of practice safely and effectively. Commenter states it is vital to recognize that LVNs are already equipped with the necessary skills to support respiratory care, and any attempt to limit their role in this area undermines their qualifications and the comprehensive care they provide to their patients.

Commenter writes that for many years LVNs have been taught trach care and suctioning and it has been part of their scope of practice, most often in home care nursing. Commenter claims this change would decimate their ability to care for adults and children with trachs in the home and notes that home care is not funded at a level to provide shift care at RN or RCP rates of pay. Commenter states that the language needs to be modified and suggests to allow suctioning in home care by LVNs. Commenter notes that in long term care LVN’s can provide prompt attention to clients requiring suctioning leaving the RCP to more complex tasks. Commenter notes that to allow LVNs to suction in long term care after skill verification by an RCP, or even annual verification by an RCP reasonable.

Commenter, who is an RN and practicing since 1990, writes their experience has been in hospitals and long-term care. Commenter thinks trach care and suctioning is a shared scope of practice for RCPs, RNs, and LVNs. Commenter provides that the skill set of administering care to trach patients has been carried out successfully by LVNs and RNs in acute and long-term care for many decades. Commenter asks, if the RCP is not available and a patient requires urgent trach care, what will happen? Commenter states this potential change of practice can have negative outcomes for respiratory clients.

Comment was also received from an institution dedicated to training competent healthcare professionals. Commenter recognizes the vital role LVNs play in patient care and states their training includes essential respiratory care procedures, which are crucial for ensuring the well-being of patients with respiratory issues. Commenter states that removing these responsibilities could lead to several adverse effects:

1. Continuity of Care: LVNs are often involved in the ongoing management of patients with chronic respiratory conditions. Limiting their scope of practice may disrupt continuity, negatively impacting patient outcomes.
2. Increased Workload for RNs and RCPs: Should LVNs be restricted from performing respiratory tasks, the resulting increase in workload for RNs and RCPs may lead to burnout and a decline in the quality of care. This could also result in longer wait times for patients requiring respiratory interventions.
3. Patient Education and Support: LVNs play a crucial role in educating patients about their respiratory conditions and care regimens. Restricting their involvement may hinder effective patient education, leading to poorer self-management and increased hospital readmissions.
4. Emergency Preparedness: In acute care settings, LVNs frequently serve as first responders in emergencies. Their ability to perform basic respiratory care can be vital in stabilizing patients before further intervention. Limiting their scope may endanger patients during critical situations.
5. Holistic Patient Care: The collaborative nature of healthcare relies on the diverse skills of all team members. LVNs are trained to assess and monitor patients holistically. Excluding them from respiratory tasks undermines the integrated approach essential for optimal patient care.

RESPONSE TO ISSUE NO. 6

The RCB reviewed and considered the opposing comments and suggested amendment and declines to make any amendments to the proposed text based thereon, for the same reasons detailed in Response to Issue Nos. 1, 4, and 5 above. Further, as discussed in more detail below, the comments are based on the incorrect premise that the regulatory proposal limits the LVN scope of practice or would lead to workforce shortages, increased workloads for RNs and RCPs, or compromised patient outcomes.

As discussed in Response to Issue No. 4 above, the RCB asserts that LVNs have never been authorized to practice respiratory care, which necessitated legislative action. SB 1436 amended the VN Act, explicitly stating in B&P §2860(a) that LVNs have "no authority" to provide respiratory care services. However, B&P §2860(b) permits LVNs who have received appropriate training and demonstrate competence to perform certain basic respiratory tasks and services expressly identified by the RCB pursuant to B&P §3702.5(a).

The RCB is the only state agency statutorily authorized to define or interpret the practice of respiratory care in California (B&P §3702.5). The tasks identified in this regulatory proposal

represent basic respiratory tasks that do not require a respiratory assessment and require only manual, technical skills, or data collection, consistent with the RCB's experience and understanding of the practice of respiratory care in California.

Claims that these tasks are part of LVN licensure training are unsupported. No commenter has provided, and the RCB has not found, substantive evidence to substantiate the claim that respiratory care is part of every LVN training program. Furthermore, the required curriculum content under CCR §§ 2533 and 2534 do not include respiratory care or related tasks.

Even if some LVN programs offer limited training on respiratory care, such instruction does not extend the LVN scope of practice, particularly given that B&P §2860 was amended to specify that LVNs are not authorized to practice respiratory care. For example, training in minor surgeries would not grant LVNs authority to perform such procedures. As stated in the Response to Issue No. 1 above, the Board does not have the discretion to apply a definition of basic respiratory tasks and services different from what is commonly understood by the RCB's licensing population or inconsistent with the RCB's experience and understanding of the practice of respiratory care in California.

As detailed in the RCB's response to comments received during the 45-day comment period, pages 4, 5, and 6 of the ISOR, and Response to Issue No. 1 above, the tasks identified in proposed subdivision (c) of CCR §1399.365 require assessment, evaluation, or both, which depend on comprehensive respiratory education and training. Furthermore, numerous potential contraindications may arise that require extensive respiratory care expertise to mitigate effectively. For these reasons, the Board does not find it appropriate to include any of the tasks identified in proposed subdivision (c) of CCR §1399.365 as basic respiratory tasks and services.

Assertions that workforce shortages, increased workloads for RNs and RCPs, or compromised patient outcomes would result from this proposal are unsupported. The RCB is unaware of LVNs performing these services outside of skilled nursing facilities, home health, or community-based settings. Indeed, the unauthorized and unqualified practice of respiratory care by LVNs at skilled nursing and subacute facilities was a primary impetus for SB 1436. This is documented in the RCB's 2022 Sunset Oversight Review report (item 2 of the underlying data in the ISOR, beginning at page 87). LVNs at these facilities are not authorized to practice respiratory care beyond the tasks outlined in the proposed regulation. The RCB, in collaboration with other regulatory agencies, has undertaken enforcement actions by educating administrators and staff at skilled nursing facilities misusing LVNs for respiratory care and conducting follow-up visits to ensure compliance.

It is also important to note that regulations expanding LVN training and the respiratory services they may provide in home and community-based settings are forthcoming, with an expected implementation date of January 2028. For skilled nursing facilities, compliance with the law may necessitate hiring additional RCPs or RNs. However, LVNs continue to play a vital role in delivering a wide range of patient care services and will remain in high demand despite the nursing shortage. Laws are in place to prevent increased workloads for healthcare staff in ways that could compromise patient safety. Additionally, respiratory patients cared for at some skilled nursing facilities are reimbursed at significantly higher rates to offset the costs of employing more highly trained and qualified RCPs.

Lastly, the proposed regulation does not limit LVN classroom instruction, nor does LVN curriculum content influence the RCB's definition of basic respiratory tasks. It is critical to note

that respiratory care is not classified as a "skilled nursing service" for the purpose of determining patient-to-nurse ratios. The RCB affirms that the proposed regulatory language appropriately delineates basic respiratory tasks within its statutory authority, ensuring the safety and efficacy of respiratory care services.

ISSUE NO. 7 – Creates Confusion (Submitted by commenters: L33, L35)
The RCB received comments in opposition stating the proposed changes may cause confusion and inefficiency in patient care.

A commenter, on behalf of the BVNPT, commented that the proposed modified text creates confusion and inefficiency in patient care, as a nurse cares for the patient as a whole and considers all the anatomical systems. Commenter recommends adding a preamble with "safe harbor" language to clarify what is legally permissible under the respective practice acts of both boards. Commenter states they have concerns that without this language, it may be unclear to the regulated community what may be practiced lawfully in accordance with both boards' respective practice acts. Commenter recommends the following language, citing it is clearer:

> 1399.365. Basic Respiratory Tasks and Services.
> Pursuant to subdivision (a) of section 3702.5 of the B&P code, basic respiratory tasks and services as defined in subdivision (b), are considered tasks that do not require a respiratory assessment by a licensed respiratory care professional exclusively, and only require manual, technical skills, or patient data collection. Basic respiratory tasks and services shall not be considered the practice of respiratory care by the Board when performed by a licensed vocational nurse meeting the criteria in this section and B&P section 2860.

Commenter also notes that the use of the term "respiratory assessment" in the proposed rulemaking could create confusion even though it is specific to proposed CCR §1399.365, as all healing arts professionals perform assessments. Commenter also believes the final sentence is redundant. Commenter suggests refining the definition of "respiratory assessment" to involve analysis and judgment, rather than just documenting data, as follows:

> 1399.365. Basic Respiratory Tasks and Services.
> (a) For purposes of this section, "respiratory assessment" includes ~~means~~ making an analysis or judgment of a patient's breathing and making recommendations to a medical doctor 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.~~

Additionally, another commenter argues the proposed changes could create confusion in the healthcare system about the roles and responsibilities of LVNs versus RCPs. Commenter provides that instead of imposing restrictions, we should focus on enhancing collaboration among healthcare professionals to ensure that all patients receive the best possible care.

RESPONSE TO ISSUE NO. 7
The RCB reviewed and considered the opposing comments and suggested amendments and declines to make any amendments to the proposed text based thereon, for the same reasons detailed in Response to Issue Nos. 1, 4, 5, and 6 above. Further, the RCB disagrees with the

assertion that the language creates confusion, as it is precise and consistent with the terminology commonly used in the health care industry.

The "safe harbor" language suggested by BVNPT is both confusing and overly broad, potentially allowing anyone to perform basic respiratory tasks. Furthermore, this language conflicts with the intent of B&P §3702.5, which clearly defines respiratory care tasks and services consistent with the RCB's experience and understanding of the practice of respiratory care in California for licensed RCPs. Including safe harbor language for LVNs in this regulatory proposal would misplace such language, add confusion for licensed RCPs, and could jeopardize the regulation's approval.

To determine their scope of practice, the first reference an LVN would consult is the VN Act, where they would find B&P §2860, which states:

> **2860.**
> (a) This chapter confers no authority to practice medicine or surgery, to provide respiratory care services and treatment, or to undertake the prevention, treatment, or cure of disease, pain, injury, deformity, or mental or physical condition in violation of any provision of law.
> (b) Notwithstanding subdivision (a), a licensed vocational nurse who has received training and who demonstrates competency satisfactory to their employer may, when directed by a physician and surgeon, perform respiratory tasks and services expressly identified by the Respiratory Care Board of California pursuant to subdivision (a) of Section 3702.5.

After reviewing B&P §2860(b), which includes required training, LVNs would refer to the Act to find the specific list of respiratory care tasks and services outlined in the proposed regulatory text. This text clearly identifies tasks in accordance with B&P §3702.5(a).

Regarding the term "respiratory assessment," the RCB acknowledges BVNPT's concern about potential confusion. However, the RCB defined "assessment" after learning that BVNPT had been using the term to describe documenting observations and gathering data, which is beyond the scope of how "assessment" is typically defined and may have contributed to confusion among many LVNs regarding their scope of practice. The widely accepted understanding of the term "assessment" in the medical community, as defined in *Taber's Medical Dictionary*, is as follows:

> 1. An appraisal or evaluation of a patient's condition by a physician, nurse, or other health care provider, based on clinical and laboratory data, medical history, and the patient's account of symptoms.
> 2. The process by which a patient's condition is appraised or evaluated.

The RCB's proposed definition specifies that "assessment" involves analyzing and making judgments about a patient's condition, going beyond mere data collection. Defining the term "assessment" provides clarity and resolves confusion as to what "assessment" means in relation to CCR 1399.365. Additionally, the proposed definition provides important context for licensed RCPs, indicating that once assessments—defined as analysis and judgment—are being performed, the task exceeds basic respiratory care services, which are typically within the practiced scope of students or new licensees.

BVNPT's suggested revision of the definition of assessment not only disregards the need for this clarification but also alters the meaning entirely, as more than just a "patient's breathing" is analyzed and judged when performing assessments for the tasks outlined in the proposed text.

The RCB believes the proposed text provides essential clarity regarding the roles of LVNs and RCPs, promoting collaboration and ensuring the best possible care for patients. The 2022 amendments to B&P §2860, along with these proposed regulations, are designed to resolve longstanding misunderstandings and conflicts, while offering a clear distinction between basic, intermediate, and advanced respiratory care tasks for RCPs as outlined in B&P §3702.5.

ISSUE NO. 8 – Tasks Prohibited; Unnecessary Language (Submitted by commenter: L33)
The RCB received a comment on behalf of the BVNPT in opposition stating proposed CCR §1399.365(c) is unnecessary, and that it would be more appropriate to concentrate the regulation on what may be performed, and not call out what may not be performed. Commenter suggested striking subsection (c).

RESPONSE TO ISSUE NO. 8
The RCB reviewed and considered the opposing comment, suggesting the removal of subsection (c) of CCR §1399.365, and declines to make any amendments to the proposed text based thereon, for the same reasons detailed in Response to Issue Nos. 1 and 7 above. Moreover, the intent and purpose of this regulatory action is to clearly define the boundaries of basic respiratory tasks and services. By explicitly identifying tasks that may not be performed, proposed subsection (c) of CCR §1399.365 plays a critical role in safeguarding public safety and upholding the integrity of the healthcare profession.

While the commenter advocates for a focus on what may be performed, it is equally important to outline prohibited tasks to eliminate ambiguity in tasks that may cross over in some services and ensure full compliance with established standards of practice. Defining these boundaries helps prevent misunderstandings and protects both patients and healthcare providers from potential harm or legal and professional consequences.

In conclusion, proposed subsection (c) of CCR § EDC §49423.5 is necessary for providing clear guidance on prohibited tasks, offering clarity for practitioners and regulatory bodies alike, and maintaining a robust regulatory framework that protects the public and the profession.

ISSUE NO. 9 – Limited LVN Settings (Submitted by commenters: L33, and H44)
The RCB received comments in opposition, advocating for broadening the scope of practice for LVNs to provide respiratory care in all settings. Commenters argue that restricting certain tasks to one profession, while allowing exceptions in specific settings as mandated by B&P §3765(j) [SB 1451, statutes of 2024], is counterproductive and could worsen healthcare access in California. Additionally, they suggest amending the regulatory text to clarify that basic respiratory tasks should be authorized by the RCB without limitations to specific healthcare settings, reflecting the legislative intent to allow overlapping roles among healthcare professionals in organized healthcare systems.

Specifically, a commenter, on behalf of BVNPT, provides it would better serve California consumers to provide well trained LVNs in all possible settings, which is why the commenter supports the patient-specific training requirements authorized in SB 1436 (Stats. 2022, ch. 624).

Commenter states that they believe it is counterproductive to restrict LVNs from performing the tasks found in CCR §1399.365(c) and then creating exceptions in specified employment settings. In California, the need for respiratory care is expected to grow in the coming years, with the after-effects of long-COVID, exposure to wildfires, rise in asthma and allergies, and the aging of the population. Commenter claims these restrictions will only exacerbate problems with healthcare access for consumers by further restricting these health care services to one profession when these services have historically been provided by numerous other professions who have received training and education in these areas, and when such services are provided by both professions under the supervision of other licensed healthcare professionals (doctors and nurses). It is similar to the myriad of legislative attempts to establish priorities for expediting licensure for specific groups. Commenter states that eventually, if one exception exists, others will follow if public policy dictates the need, e.g., schools, retirement communities, state department facilities.

Another commenter, on behalf of a home and community-based service provider, requested that a second amendment be added to the beginning of the proposed regulatory text, preferably before section (a), as follows:

> *In accordance with Business & Professions (B & P) Code Section 3702.5., basic respiratory tasks and services, as defined in this section, shall be authorized by the Board without limitation to specified healthcare employment settings.*

Commenter cited B&P §3702.5, added by SB 1003 (2018) and stated that it gave the RCB express authority to define basic respiratory tasks and services, as well as intermediate and advanced tasks, services, and procedures. Commenter points out that both the legislation and the code section were silent on the healthcare employment settings for which this section applied. Commenter adds that while the code section was silent on the healthcare employment settings for which this section applied, existing law "states the intent of the Legislature to provide clear legal authority in the Act for functions and procedures which have common acceptance and usage. The Legislature also recognizes the existence of overlapping functions between physicians and surgeons, registered nurses, physical therapists, respiratory care practitioners, and other licensed health care personnel, and (the intent) to permit additional sharing of functions within organized health care systems."

RESPONSE TO ISSUE NO. 9

The RCB reviewed and considered the opposing comments and suggested amendment and declines to make any amendments to the proposed text based thereon for the same reasons detailed in the Response to Issue Nos. 1, 4, and 8 above and Response to Issue No. 13 below.

The RCB also notes that the commenters may be confusing the proposed regulatory proposal aimed to make B&P §3702.5 specific, with future regulatory proposals that will make B&P §3765(j) specific (SB 1451, statutes of 2024).

ISSUE NO. 10 - Other States LVN Scope of Practice (Submitted by commenter: L33)

The RCB received a comment providing that other states, including Texas, New York, South Carolina, Illinois, Washington, Kentucky, Oklahoma, New Mexico, Nevada and Ohio include the following tasks in their LVN/LPN scope of practices: tracheostomy care; suctioning (nasopharyngeal, endotracheal); pulse oximetry; incentive spirometer; nebulizer treatment.

RESPONSE TO ISSUE NO. 10

The RCB reviewed and considered the opposing comment and declines to make any amendments to the proposed text based thereon, for the same reasons detailed in Response to Issue Nos. 1, 4, and 6 above. The Board notes that the claim that the tasks identified by the commenter are within the scope of practice for LVNs in ten states is unsupported. The commenter did not provide any references, citations, or evidence to substantiate this claim, leaving the basis for it unclear. A quick but thorough review of the laws and regulations in each of these states revealed no mention of these tasks, except for Texas and New York. While some states have provisions for the limited delegation of tasks, they do not specify the tasks in question. However, there is mention of delegating unspecified tasks in home and community-based settings that aligns with the RCB's plan under SB 1451, which will lead to future regulatory proposals. Advisory opinions and frequently asked questions were also reviewed where applicable.

Further, since the commenter did not address the other thirty-nine (39) states excluding California, the RCB interprets this as an indication that in the majority of states there is no authority for LVNs to practice respiratory care, or that such practices are prohibited for vocational/practical nurses.

Lastly, the RCB recognizes that other states may have different scope of practices for various health care practitioners. However, those states rely on different authority and the issues in California respiratory care practice, including the scope of practice issue between RCB and BVNPT, are unique, as detailed in pages 1 and 2 of the ISOR and the RCB's *2022 Sunset Oversight Review* report (item 2 of the underlying data in the ISOR, beginning at page 87). As discussed in Response to Issue No. 1, with this rulemaking, the RCB is focused on further defining, interpreting, or identifying basic respiratory tasks and services, not to determine who may provide them. The RCB finds those tasks listed in proposed subdivision (c) of CCR §1399.365 are beyond basic respiratory tasks and services based on the RCB's experience and understanding of the practice of respiratory care in California for the Board's licensing population.

ISSUE NO. 11 - Cost Effectiveness (Submitted by commenter: L33)

The RCB received a comment in opposition, stating that LVNs cannot replace the specialized expertise of RCPs. However, it was noted that LVNs can care for patients with general or stable respiratory needs, allowing RCPs to focus on providing specialized care for individuals with complex or severe respiratory conditions. The proposed additional changes are viewed as an efficient way to meet the need for healing arts professionals to address patient care needs throughout the state.

RESPONSE TO ISSUE NO. 11

The RCB reviewed and considered the opposing comment and declines to make any amendments to the proposed text based thereon for the same reasons detailed in the Responses to Issue Nos. 1, 4, and 6 above.

The RCB also emphasizes that respiratory care encompasses a full range of tasks and services, from basic to advanced. This proposed rulemaking is focused on further defining, interpreting, and identifying basic respiratory tasks consistent with the RCB's experience and understanding of the practice of respiratory care in California for licensed RCPs, as authorized by B&P §3702.5(a), not to determine who can provide such services.

ISSUE NO. 12 - Scope of Practice Process/Healthcare Advancements (Submitted by commenter: L35)

The RCB received a comment in opposition, providing that changes in scope of practice often arise from shifts in healthcare needs, technological advancements, or efforts to improve patient safety and care efficiency. However, these changes typically involve thorough stakeholder engagement, including input from nursing associations, to address concerns about training, safety, and the quality of care. The commenter states that it is the nursing board's responsibility to address scope of practice questions when they arise, not another profession's board.

RESPONSE TO ISSUE NO. 12

The RCB reviewed and considered the opposing comments and declines to make any amendments to the proposed text based thereon for the same reasons detailed in the Response to Issue Nos. 1, 4, and 6 above.

COMMENTS FROM PEOPLE REPRESENTING HOME AND COMMUNITY-BASED CARE

ISSUE NO. 13 – Staffing and Recruiting Challenges (Submitted by commenter: H40)

The RCB received a comment in opposition, from an employee of a home health agency, citing these regulations will create staffing and recruiting challenges. Commenter states the healthcare industry is currently facing significant staffing shortages, particularly among nursing and allied health professions. By restricting LVNs from performing basic respiratory services without additional certification, this regulation will further strain the healthcare workforce. LVNs already provide critical patient care and could help relieve the growing pressure on RCPs. Restricting LVNs' roles in this way places an undue burden on RCPs, who are also in short supply, and will hinder the ability of healthcare facilities-particularly those in rural or underserved areas-to meet patient care demands.

RESPONSE TO ISSUE NO. 13

The RCB reviewed and considered the opposing comment and declines to make any amendments to the proposed text based thereon for the same reasons detailed in the Response to Issue Nos. 1, 4, and 6 above.

Moreover, B&P §3765(i) provides an exception for home health agencies as follows:

> 3765.
> This act does not prohibit any of the following activities:
> …
> (i) The performance, by a vocational nurse licensed by the Board of Vocational Nursing and Psychiatric Technicians of the State of California who is employed by a home health agency licensed by the State Department of Public Health, of respiratory tasks and services identified by the board, if the licensed vocational nurse complies with the following:
>
> (1) Before January 1, 2028, the licensed vocational nurse has completed patient-specific training satisfactory to their employer.
>
> (2) On or after January 1, 2028, the licensed vocational nurse has completed patient-specific training by the employer in accordance with guidelines that shall be promulgated

by the board no later than January 1, 2028, in collaboration with the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

Commenter may be confused given the numerous changes made in three recent legislative bills. The RCB expects to promulgate several additional regulatory packages in the next three years to interpret or make specific amendments carried in SB 1003 (statutes of 2018) SB 1436 (statutes of 2022) and SB 1451 (statutes of 2024) as follows:

1. **Identify Basic Respiratory Tasks and Services** (SB 1003) To interpret or make specific B&P §3702.5(b)
2. **Identify Home Care Respiratory Tasks and Services** (SB 1436 and SB 1451) To interpret or make specific B&P §3765(i)
3. **Establish Home Care Respiratory Patient-Specific Training Guidelines** (by the employer) (SB 1436) To interpret or make specific B&P §3765(i)(2).
4. **Identify Home and Community-Based Settings-Respiratory Tasks and** Services (SB 1451) To interpret or make specific B&P §3765(j).
5. **Establish Home and Community-Based Settings: Patient-Specific Employer Training Guidelines and Competency Training Guidelines** (SB 1451) To interpret or make specific B&P §3765(j)(1)(B) and §3765(j)(1)(C).

ISSUE NO. 14 – Financial Implications (Submitted by commenters: H40, H42, H43, H44)
The RCB received comments in opposition from home and community-based employers and organizations, citing significant financial implications of these regulations. Higher costs are attributed to: 1) the lack of financial reimbursement for RCPs in the home, 2) higher wages employers would be forced to pay for RCPs and RNs, and 3) forcing patients to be institutionalized, either from the inability to hire RCPs/RNs due to shortages or financial limitations, which costs significantly more than patients being cared for in the home.

Specifically, one commenter with a Home Health Agency (HHA) expressed concern with the exclusion of RCPs from home health services in that RCPs are often not covered under home health services, despite the essential care they provide for patients requiring respiratory support. Commenter notes many home health agencies are already grappling with staff shortages, and further restricting LVNs' ability to perform basic respiratory tasks would strain these agencies even more. This lack of flexibility and limited availability of home-based respiratory care could force patients into institutional settings, where the cost of care is significantly higher than home health care, especially for state members on Medi-Cal. If patients are unable to receive adequate care in the home, this will result in higher state expenditures due to the increased demand for institutional healthcare services, further burdening California's healthcare system.

Commenter also states by limiting LVNs' ability to provide basic respiratory care, the state is missing out on significant cost-saving opportunities. Utilizing LVNs to perform routine tasks allows higher-paid RCPs and RNs to focus on more complex procedures. RN services are associated to a higher reimbursement rate in home health. This approach would reduce the need for additional RCPs, streamline care delivery, and mitigate the rising costs associated with extended hospital stays or overtime. Allowing LVNs to perform these tasks without unnecessary restrictions could lead to better allocation of resources, reducing overall healthcare costs for both public and private sectors.

A commenter on behalf of another HHA states that they provide private duty nursing (PDN) services to over 21,000 patients via 21 offices and nearly 18,000 caregivers and that a majority of their workforce in the state is composed of LVNs. They state that they join with other groups, including the California Association for Health Services at Home (CAHSAH), in strongly opposing the RCB's proposal to limit the scope of practice for LVNs.

Commenter states that at their office in Roseville, they have 48 patients on census where 18 of these patients have a tracheostomy and are mostly staffed by LVNs. Because there are fewer RNs in homecare and a limited availability of RCPs in homecare, deviation from the current established scope will affect PDN families throughout the state and dramatically worsen the healthcare workforce crisis.

Commenter states that if an LVN's scope removes the ability to manage respiratory care, to keep patients at home, everyone would need an LVN and an RCP at the same time, increasing costs, complicating the delivery and coordination of care, and more. They provide an example citing respiratory nursing tasks such as suctioning may be necessary six to eight times an hour and point out that an RCP cannot provide most of the necessary skilled care that their PDN patients need including administering feedings and meds through an enteral tube, providing urinary catheter care, or providing other standard skilled nursing tasks. Commenter provides that they work collaboratively with RCPs in homecare, but they are not in the home for an 8-hour shift, providing total care to a patient as an LVN does. They also assure that all PDN caregivers are trained in these skills, and that competency is annually revalidated.

Commenter states that the proposed regulations will have significant financial consequences, including increased costs of recruiting and training new staff, and the potential displacement of LVNs. The regulations could lead to increased use of institutional care (where RCPs may be more likely to work) and higher costs for the state and families.

Some commenters strongly disagreed with the statements made in the "Business Impact" and "Economic Impact Assessment" regarding the impact on access to care and businesses as alleged in the ISOR. Specifically, commenters questioned the "no or minimal impact" statements in the "Business Impact" and "Economic Impact Assessment" sections of this regulation package, as follows: The RCB has determined that this regulatory proposal will not have any impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California.

Commenter cites wages and provides that the Employment Development Department (EDD) BLS tracks and publishes data on salaries, projected labor workforce shortfall, and the industry/employers for each profession. In the first quarter of 2024, the BLS determined that the wages for LVNs and RCPs compare as follows:

	Hourly Median	Hourly Wage by Percentile		
		25th	Median	75th
RCP	$51.05	$40.60	$50.13	$60.31
Licensed Vocational Nurse	$37.93	$32.27	$37.45	$40.69

Commenter states if LVNs are prohibited from performing certain respiratory tasks, for which they have been determined competent, the increased costs to businesses, the sustainability of businesses who cannot afford to pay these increased costs, and the number of healthcare

related businesses that will close is extremely high, thus reducing access to essential healthcare services. Overall, RCPs command a higher salary than LVNs.

Commenter references the BLS projections on the number of individuals in each occupation category that will be needed by 2030 and states that it is painfully evident that the healthcare delivery system is struggling to hire and retain licensed staff, with fierce competition between all segments of healthcare. Commenter states the RCB is seeking to restrict the respiratory care tasks and services performed by LVNs, even if that LVN has been determined to be competent by their employer and holds a certificate of competency from an RCB-approved organization. Commenter provides a chart that including the projected need for LVNs and RCPs. They question how the RCB will "grow" the RCP workforce to not only meet current needs but mitigate the dramatic reduction in the respiratory tasks that LVNs are proposed to be prohibited, and fill RCP positions for which there is no workforce supply.

Occupational Projections [Outlook/Demand] 2020 - 2030

	Estimated	Projected	% Change	Total Job Openings
RCP	16,600	20,700	24.7%	12,790
LVNs	72,400	83,500	15.3%	69,910

Commenter notes RCPs command a much higher salary than LVNs, which would require employers to pay significantly more for the same tasks and services. Hospitals/general acute care hospitals employ the largest number of RCPs with 66.7% of RCPs working in that setting, and hospitals may be able to pay RCPs a higher salary. Only 3.2% of RCPs work for home health agencies. There are far fewer RCPs than LVNs, and we are concerned that providers will be unable to pay higher salaries and wages or have sufficient numbers of RCPs to fill positions, when publicly funded reimbursement rates are not increasing.

Some commenters requested the RCB temporarily withdraw or delay this package and conduct a more thorough analysis, of the business and economic impact of these proposed regulations, including joining with stakeholders, and consider how the proposed package promotes or reduces access to life sustaining care for the patients, residents, and clients they serve.

RESPONSE TO ISSUE NO. 14

The RCB reviewed and considered the opposing comments and declines to make any amendments to the proposed text based thereon for the same reasons detailed in the Response to Issue Nos. 1, 4, 6, and 13 above.

Pointedly, the fiscal impact concerns raised by home health agencies do not exist or are not the result of this proposed rulemaking. Home health agencies were provided an exemption in SB 1436 at B&P §3765(i). There is still a misunderstanding with some home health agencies that mistakenly believe this regulatory proposal is identifying the home care tasks found in B&P §3765(i) and §3765(j)(2)(D).

With respect to community-based settings, any increased cost to businesses is not caused by the proposed regulations but are instead a direct result of SB 1436 (statutes of 2022), which clarified that LVNs are not authorized to practice respiratory care. However, SB 1451 was enacted in 2024, specifically to address concerns raised by patients and employers in home and community-based settings by providing additional exemptions as found at B&P §3765(j)(2).

Although the amendments to B&P §2860 went into effect on January 1, 2023, there is no evidence that community-based facilities have reorganized staffing or expelled respiratory patients to institutions. And for those facility-types, identified in B&P §3765(j)(2), no such action is recommended with the exception if the employer has concerns around personnel's competency or liability.

The RCB has been engaged in legislative and regulatory efforts for several years to align laws with the safe practice of respiratory care in California. The current transition is complex and is expected to take until January 1, 2028, to fully implement. During this transition, the RCB has no plans to impose disciplinary measures or administrative sanctions contrary to the intended and final legislative and regulatory plan, with the exception of cases where gross negligence, gross incompetence, or inadequate training, as determined by a reasonable person, causes patient harm or death. It is incumbent upon LVNs and facilities to consult with their legal counsel to determine any liability issues.

ISSUE NO. 15 – Task Certification for LVNs (Submitted by commenters: H40, H43)
The RCB received comments in opposition from home and community-based employers and organizations, citing that the training and certification as referred to in B&P §2860(b) is duplicative and unnecessary. Comments also refer to future regulations that are separate from these regulations. Comments in more detail include the following:

- LVNs bring significant experience and skills to patient care, and many are already proficient in performing basic respiratory tasks. Their core training includes competencies in medication administration, patient assessment, and technical skills, making them well suited to handle these responsibilities safely and efficiently. Requiring additional certification for tasks that LVNs are already capable of performing under physician supervision not only undermines their expertise but also contributes to unnecessary regulatory and financial burdens on healthcare providers.
- The proposed regulation requires additional training and certification for LVNs to perform basic respiratory tasks, despite the fact that many LVNs already possess the necessary skills through their core nursing education and practical experience. These duplicative training requirements place undue financial and time burdens on LVNs and healthcare employers, further discouraging participation. This redundancy also contributes to workforce burnout and undermines the attractiveness of the LVN role in the healthcare field, exacerbating existing staffing challenges.
- The list of approved basic respiratory tasks and services contained in proposed regulations package is not all-inclusive of the tasks and services that may be safely performed by an LVN, and is far too limiting. These omitted tasks and services do not constitute assessment and constitute data collection, manual or technical skills or data collection. Commenter believes that LVNs should be able to perform many more tasks than are proposed in the package and state that if an LVN has a current license in good standing, has been determined to be competent by their employer, holds a certificate of competency from an RCB-approved organization, and the tasks do not require an assessment, the LVN should be able to perform those tasks. Commenter provides that the requirement that an LVN must have a certificate of competency in specific tasks is new and is one that commenter "wholeheartedly support."
- Citing B&P §3765(j), commenter states LVNs are permitted to perform respiratory services identified by the board if the LVN holds a current license, has received patient specific training satisfactory to their employer, current and valid certification of competency for each respiratory task to be performed from the California Association of

Medical Product Suppliers, the California Society for Respiratory Care, or another organization identified by the board. Commenter states that this statutory subsection does not refer to limiting respiratory tasks and services performed by LVNs to those defined as "basic respiratory tasks and services".

- If an LVN obtains certification of competency for specific respiratory tasks from an approved organization, it would appear that the LVN would not be limited to performing only basic tasks and services. However, the proposed regulations do not address this omission.
- Commenter requests that the proposed regulations package for "Basic Respiratory Tasks and Services" be amended to provide for additional tasks beyond the "basic tasks and services" for which the LVN has been determined competent by their employer and holds a valid certificate, as long as the specific task does not violate the LVN scope of practice. The delivery of health care has undergone tremendous change and will continue to change as new technologies and community standards of practice evolve and these proposed regulations are very restrictive which will have detrimental effects on access to care.

RESPONSE TO ISSUE NO. 15

The RCB reviewed and considered the opposing comments and declines to make any amendments to the proposed text based thereon for the same reasons detailed in the Response to Issue Nos. 1, 4, 6, 13, and 14 above. Further, the training requirements that will be imposed on LVNs performing basic respiratory care tasks are codified in law at B&P §2860(b), so the RCB does not have authority to unilaterally remove those requirements. Moreover, the training requirements referred to in the comments are not part of this regulatory package.

ISSUE NO. 16 – Basic Tasks Narrowly Defined (Submitted by commenter: H40)

The RCB received a comment in opposition on behalf of a home health agency citing the regulation in not flexible in its design. Commenter states the regulation narrowly defines a list of seven basic respiratory tasks that LVNs may perform. Healthcare environments, however, are dynamic, with rapidly evolving patient needs. This rigid task list hampers the ability of healthcare teams to adapt in real time, particularly in fast-paced or high-demand settings, such as skilled nursing facilities (SNFs) and direct one on one patient care, such as home health. Flexibility is crucial to improving patient outcomes, and limiting LVNs to this narrow scope reduces the effectiveness of care delivery, especially during emergencies when time is of the essence.

RESPONSE TO ISSUE NO. 16

The RCB reviewed and considered the opposing comment and declines to make any amendments to the proposed text based thereon for the same reasons detailed in the Response to Issue Nos. 1, 4, 6, and 13 above.

ISSUE NO. 17 – Rural and Underserved Communities (Submitted by commenter: H40)

The RCB received a comment in opposition from a home health agency citing concerns with vulnerable populations. Commenter states rural and underserved communities will be disproportionately affected by this regulation. These areas already face challenges in recruiting healthcare professionals, and further restricting the role of LVNs will worsen the situation. Limiting access to respiratory care in these communities will delay treatment, increase hospitalizations, and contribute to poorer health outcomes, especially for vulnerable populations. These restrictions will also exacerbate healthcare disparities, limiting the ability of underserved communities to access timely and appropriate care.

RESPONSE TO ISSUE NO. 17

The RCB reviewed and considered the opposing comment and declines to make any amendments to the proposed text based thereon for the same reasons detailed in the Response to Issue Nos. 1, 4, 6, 13, and 14 above.

ISSUE NO. 18 – Dissolving the Pool of LVNs for Home Care (Submitted by commenter: H41)

The RCB received a comment in opposition on behalf of a home health agency providing that despite low reimbursement for LVNs, they have been successful for decades without any incidents involving LVNs performing airway suctioning and claim the regulatory proposal will threaten the already inadequate nursing pool and fail to meet the demand. Commenter is alarmed and believes it is gravely misguided to think that RNs and RCPs can meet the demand for families who have relied upon LVNs for years. Commenter also raises concerns that In-home Support Services' (IHSS') providers (provided via Department of Social Services (DSS)) egregiously practice out of their scope, including suctioning.

RESPONSE TO ISSUE NO. 18

The RCB reviewed and considered the opposing comment and declines to make any amendments to the proposed text based thereon for the same reasons detailed in the Response to Issue Nos. 1, 4, 6, 13, and 14 above. In addition, RCB staff were recently alerted about the unlicensed practice of respiratory care being facilitated by DSS and the matter is currently under investigation.

ISSUE NO. 19 – Unlicensed Personnel vs. LVN Confusing (Submitted by commenter: H43)

The RCB received a comment in opposition on behalf of a community-based organization expressing concern and confusion due to the inconsistent use of terms. The commenter noted the term "limited and basic respiratory care or respiratory care related services" is used to describe the scope of services provided by unlicensed personnel and the term "basic respiratory tasks and services" used proposed for LVNs.

RESPONSE TO ISSUE NO. 19

The RCB reviewed and considered the opposing comment and rejects in part and accepts in part the comment. The RCB declines to make any amendments to the current regulatory action based thereon, for the same reasons detailed in Response to Issue Nos. 1, 4, 6, and 7 above. Notably, the RCB lacks discretion to modify the term "basic respiratory tasks and services" as used in this proposed regulatory action since the term comes from B&P §3702.5.

However, the Board accepts in part the opposing comment with respect to future rulemaking.

Review of the RCB's regulations found CCR §1399.360(a), which addresses scope of practice for unlicensed personnel, uses the term "limited and basic respiratory care or respiratory care related services." CCR §1399.360 became operative in 2007 and an amendment to the "Note" of the regulations was made in 2012.

B&P §3702.5, the basis of this regulatory proposal, went into effect in 2019. Subdivision (a) of B&P §3702.5 uses the term "basic respiratory tasks and services." As a result, this proposed regulatory action similarly uses the term "basic respiratory tasks and services" and gives deference to the legislator by declining to amend the language.

Given the similar, but different, terminology used in CCR §1399.360 and proposed CCR §1399.365, the RCB agrees with commenter that the language of CCR §1399.360 can be more

precise. To reduce possible confusion, the RCB commits to amending the language of §1399.360 in a future regulatory proposal to increase clarity by striking "limited and basic respiratory care."

ISSUE NO. 20 – Basic Respiratory Tasks and Services Limited to LVNs (Submitted by commenter: H44)

The RCB received a comment in opposition on behalf of a home and community-based organization, expressing concerns that the proposed regulation restricts the performance of basic respiratory tasks and services solely to LVNs. They argue that these tasks have historically been performed by various trained healthcare professionals under appropriate supervision and training. They request an amendment to the regulations to clarify that other properly trained healthcare personnel, consistent with their scope of practice and statutory requirements, should also be allowed to perform these tasks. They provide that this amendment is suggested to ensure continuity of care and regulatory clarity, particularly as scope-of-practice debates evolve in California. They also note the recent passage of SB 1451, which has influenced future regulatory changes for different healthcare providers and emphasizes the importance of including all qualified healthcare workers to address workforce shortages and ensure access to care.

RESPONSE TO ISSUE NO. 20

The RCB reviewed and considered opposing comments and declines to make any amendments to the proposed text based thereon for the same reasons detailed in Response to Issue Nos. 1, 4, and 6 above.

Additionally, the RCB's mandate provided in B&P §3701 is "to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care." The ability of other healthcare personnel to legally practice respiratory care is subject to the laws that govern their practice.

COMMENTERS CROSS REFERENCE

COMMENTER S1: Troy Brown, Ed.D, County Superintendent of Schools
San Joaquin County Office of Education
Letter dated October 16, 2024 (E-mail from B. Brunni)
Issues: 1, 2, 3, and 5

COMMENTER S2: Yooni Kim BSN, RN
[Typed names in signature block: Kelley Gordon BSN, CSN, RN, Madi Schumann BSN, CSN, RN, Preet Kaur BSN, RN]
WPUSD School Nurses
E-mail dated October 31, 2024
Issues: 3, and 5

COMMENTER S3: Christina Mashore, BSN, RN, PHN, CMSRN
District Nurse, Liberty Union High School District
E-mail dated October 16, 2024
Issues: 1 2, 3, and 5

COMMENTER S4: Danna dePuglia, LVN, BS HSC
Pollock Pines Elementary School District
Fax received October 17, 2024
Issues: 1, 2, and 5

COMMENTER S5: David Tate, District Nurse
Rio Bravo-Greeley Union School District
E-mail dated October 16, 2024
Issues: 1, 2, 3, and 5

COMMENTER S6**:** Elizabeth Semmelmann, RN, BSN, PHN, SNSC, District Nurse
Santa Rita Union School District
E-mail and letter dated: October 16, 2024
Issues: 1, 2, 3 and 5

COMMENTER S7: Hollie Tamez, MSN, RN, PHN, SNSC District School Nurse
Hemet Unified School District
E-mail and letter dated October 23, 2024
Issues: 1, 2, 3

COMMENTER S8: Jessica Chadwell, RN, BSN, PHN, School Nurse
Springs Charter Schools
E-mail dated October 18, 2024
Issues: 1, 2, 3, and 5

COMMENTER S9: Joyce Rara, MSN, BSN, RN, PHN, CSN
E-mail dated October 18, 2024
Issues: 1, 2, 3, and 5

COMMENTER S10: Margaret Tyson, LVN
Sonora High School
E-mail dated October 24, 2024
Issues: 1, 2, 3, and 5

COMMENTER S11: Leslie Hansen, Director Pupil Services
Anaheim Elementary School District
E-mail received October 22, 2024
Issues: 1, 2, 3, and 5

COMMENTER S12: Rebecca O'Brien, EdD, Director, Special Education
Morgan Hill Unified School District
E-mail dated October 20, 2024
E-mail states "Please see attached letter outlining my concerns with proposed changes" Letter attached is from Dawn Anderson and Sheri Coburn of the CSNO addressed to Stephanie Nunez and dated October 16, 2024. This letter was never received by Stephanie Nunez from CSNO. Infer sender did not update signature block.
Issues: 1, 2, 3, and 5

COMMENTER S13: Susan Han, MSN, RN, FNP, Credentialed School Nurse
Hart MS Mohr Elementary School
E-mail dated: October 16, 2024
Issues: 1, 2, 3, and 5

COMMENTER S14: Stephanie Valenzuela, LVN
Fullerton Joint Union High School District
E-mail dated October 24, 2024
Issues: 1, 2, 3, and 5

COMMENTER S15: Trinh Nguyen
E-mail dated October 16, 2024
E-mail contains no text and attaches letter from Dawn Anderson and Sheri Coburn of the CSNO addressed to Stephanie Nunez and dated October 16, 2024. This letter was never received by Stephanie Nunez from CSNO. Infer sender did not update signature block.
Issues: 1, 2, 3, and 5

COMMENTER S16: Tara Vanderpool, RN
Camino Union School District
Fax received October 17, 2024
Issues: 1, 2, and 3

COMMENTER S17: Ynette Johnson, MSN, MPN, RN, NCSN, PHN
Fullerton Joint Union High School District
E-mail and letter dated October 23, 2024
Issues: 1, 2, and 5

COMMENTER S18: Kitty McNeil, RN MSN PHN CSN, District Nurse
Fallbrook Union Elementary School District
E-mail and letter dated October 16, 2024
Issues: 1 and 3

COMMENTER S19: Susana Vieira, MSN, RN, CSN
Special Education Department – Nurse Coordinator
Jurupa Unified School District
E-mail and letter dated October 16, 2024
Issues: 3 and 5

COMMENTER S20: Nisa Shinagawa, Administrator of Health Services
Stockton Unified School District
E-mail and letter dated October 21, 2024
Issues: 4 and 5

COMMENTER S21: Dawna L. Paul, Program Coordinator
Stockton Unified School District
E-mail and letter dated October 21, 2024
Issues: 4 and 5

COMMENTER S22: Michelle Harrison MSN, PHN, RN, District School Nurse
Buena Vista & Los Amigos
E-mail dated October 29, 2024
Issues: 1, 2, 3, and 5

COMMENTER S23: Danielle Madrigal, MSN, RN, PHN, RCSN
Letter dated October 30, 2024
Issues: 1, 2, 3, 4 and 5

COMMENTER S24: Michelle Kowsari, MSN, RN, PHN
Stockton Unified School District
Letter dated October 31, 2024
Issues: 4 and 5

COMMENTER S25: Rosemarie Dowell, MSN, RN, PHN, CSN
Palo Alto Unified School District
E-mail dated October 28, 2024
Issues: 1, 2, 3, and 5

COMMENTER S26: Grace E. Van Doren, MSN, RN, PHN, RCSN
CSNO Central Coast Section President
San Luis Coastal Unified School District
Hard copy letter received October 28, 2024
Issues: 1, 2, 3, and 5

COMMENTER S27: Katie Rodriguez, RN, PHN, RCSN
Letter dated October 25, 2024
Issues: 2, 3, and 5

COMMENTER S28: Marci McLean-Crawford, MSN-NI, M.Ed, BS.Kin, RN, PHN, RCSN, CPT, CLE
HBUHSD/Fountain Valley High School B4L '93
E-mail dated October 31, 2024
Issues: 4 and 5

COMMENTER S29: Janene Armas, RN, PHN, RCSN
Letter dated October 25, 2024
Issues: 2, 3, and 4

COMMENTER S30: Jennifer Newsom BSN, RN
HBUHSD Float School Nurse
E-mail dated October 31, 2024
Issues: 2, 4, and 5

COMMENTER S31: GROUP COMMENT (GC-Coburn)
Letter dated 10/24/2024/E-mail (Rachel Scicluna) dated 10/30/2024

Sheri Coburn, EdD, MS, RN, PHN, RCSN,
Executive Director Consultant, Deputy Legislative Director,
CSNO

Erika K. Hoffman, Deputy Legislative Director,
State and Federal Programs
California School Boards Association

Toni Triguiero, Med, Legislative Consultant
California Teachers Association

Brianna Burns, Director, Policy & Advocacy
California County Superintendents

Serette Kaminski, Legislative Advocate
Association of California School Administrators

Jeffrey A. Vaca, Chief Governmental Relations Officer
Office of the Riverside County Superintendent of Schools

Issues: 1, 2, 3, 4, and 5

COMMENTER S32: Kelly Shepherd, MSN, RN National Board Certified School Nurse
Santa Clara County Office of Education
"On behalf of SCCOE School Nurses: Theresa Bovey, Grace Szymanska-Matsuiewi, Amelia Owen-Casillas, Barbara Biafore, Christine Headley, Debbie Yoon, Gianne Pineda, Gloria Graham, Josephine Okafor, Kimiko Curtis, Michelle Murray, Suzanne Williams, Elva Spindel"
Letter dated October 31, 2024
Issues: 1, 2, 3, 4, and 5

COMMENTER L33: Aleta Carpenter, Chair
Legislative and Regulations Committee
Board of Vocational Nursing and Psychiatric Technicians (BVNPT)
Letter dated 10/29/2024/Email (Elaine Yamaguchi) dated 10/30/2024
Issues: 6, 7, 8, 9, 10, and 11

COMMENTER L34: Cindy Montiel
E-mail dated October 29, 2024
Issue: 6

COMMENTER L35: Cheryl Arnold, BSN, RN
Corporate Director of Nursing
Institute of Technology
E-mail and letter dated October 18, 2024
Issues: 6, 7, and 12

COMMENTER L36: Norma Hidalgo-Silva
Hartnell College Email dated October 29, 2024
Issue: 6

COMMENTER L37: Nancy Schur Beymer, RN
LVN Faculty, Hartnell College
Email dated October 28, 2024
Issue: 6

COMMENTER L38: Linda Cortese, RN
Hartnell College Email dated October 31, 2024
Issue: 6

COMMENTER L39: Heidi Stiemsma, MSN, RN
Director of Nursing and Health Sciences
Copper Mountain College
Heidi Steines, MSN, BSN, RN, Assistant Director, Full Time Faculty and Theresa McCarthy, BSN, RN, Full Time Faculty names were included in signature block
E-mail dated October 28, 2024
Issue: 6

COMMENTER H40: Colby Kostur, Regional Vice President
Team Select Home Care
Typed names added to signature block:
Carla Persson RN, Regional Clinical Vice President
Melissa Malone CRT
Email with letter attached dated October 23, 2024
Issues: 13, 14, 15, 16 and 17

COMMENTER H41: Drew Brusaschetti
Altus Health, Inc. OBA Brightstar Care of Roseville
Letter dated October 24, 2024/Email dated October 25, 2024
Issue: 18

COMMENTER H42: Catherine E. Morrison, MPH
Director, State Government Affairs
Maxim Healthcare Services
Letter dated October 31, 2024
Issue: 14

COMMENTER H43: Michael Lyman, President
Pediatric Day Health Center Coalition
Letter dated October 28, 2024
Issues: 14, 15, and 19

COMMENTER H44: Gloria Peterson, Executive Director
CA Association of Medical Product Suppliers
Letter dated October 31, 2024
Issues: 6, 9, 14, and 20