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Respiratory Care Board of California
2026 Sunset Oversight Review

Board Response to Committees' Background Paper
March 27, 2026

All text is taken from the "BACKGROUND PAPER FOR The Respiratory Care Board of California Joint Sunset Review Oversight Hearing, March 24, 2026 published by the Senate Committee on Business, Professions, and Economic Development and Assembly Committee on Business and Professions" except where noted as "Board Response."

CURRENT SUNSET REVIEW ISSUES

The following are unresolved issues pertaining to the Board and other areas of concern that should be considered, along with background information for each issue. There are also recommendations Committee staff have made regarding particular issues or problem areas RCB needs to address. RCB and other interested parties have been provided with this Background Paper and RCB will respond to the issues presented and the recommendations of staff.

BOARD ADMINISTRATIVE AND BUDGET ISSUES

ISSUE #1: (FEES) The Board is recommending increasing the renewal ceiling fee and permanently eliminating the initial license fee.

Background: The authority for the Board's fees is established in BPC § 3775 and provides either a ceiling for the fee amount or an actual amount. This section also provides the Board with some flexibility, authorizing it to reduce the amount of any fee at its discretion.

As mentioned during the Board's previous Sunset review, the Board pays pro rata from its fund, most of the revenue for which comes from licensing and renewal fees. After two decades of not raising fees, the Board raised renewal fees over a four-year period from $230-$330 primarily due to increases in pro rata costs, hence threatening the stability of the fund. Following fee increases, the fund condition stabilized. The Board does not expect to increase fees in the foreseeable future as the Board's fund for FY 2022/23 and beyond is stable and the Board has no plans in the immediate future to raise expenditures. The statutory cap for renewal fees is set at $330.

However, as a proactive measure the Board is recommending a modest statutory increase to the renewal ceiling fee to establish a safeguard against potential future developments, including legislative or regulatory mandates, unanticipated fee increases imposed by other agencies, or potential expenses arising from significant enforcement actions or unforeseen litigation. The Board notes that having an increased statutory fee ceiling already in place allows a regulatory fee adjustment to be implemented in less than a year, if the Board experiences a financial burden, ensuring the Board remains financially stable.

In 2012, the Board eliminated charging applicants its initial license fee in order to reduce application processing times and increased the application fee from $200-$300. The Board is recommending to permanently eliminate the initial license fee to prevent any additional financial burden on applicants. The Board also proposes to repeal provisions in BPC § 3775, which prohibits the Board from maintaining a fund reserve balance that is greater than six months of the annual authorized expenditures of the Board in any FY. In the last four years the Board reports a fund reserve balance averaging over the six-month authorized limit. The Board states that the six-month reserve is no longer sufficient, and defers to BPC § 128.5 (b), which prohibits boards and bureaus from having a fund reserve greater than two-years operating budget in any FY. If the fund reserve equals or exceeds its operating budget in a FY, the board must reduce its licensing fees accordingly. For all other boards and bureaus under the DCA, excluding the Contractors State License Board, they abide by BPC § 128.5.

Staff Recommendation: The Board should inform the Committees on the necessity of increasing the renewal ceiling fee. The Board should update the Committees on whether it believes the reserve limit should be increased from six months to 24 months consistent with many other boards and bureaus under the DCA. The Committees may wish to amend the Act to ensure the Board is solvent and to allow the Board to eliminate burdensome fees by licensees and applicants.

Board Response: The Board's fee authority is established in BPC § 3775 and has historically provided sufficient flexibility to maintain fiscal stability. After nearly two decades without a fee increase, the Board implemented a phased adjustment to the renewal fee—from $230 to the current statutory maximum of $330—primarily due to rising costs outside of the Board's control. As a result of these increases, the Board's fund condition has stabilized, and at this time, the Board does not anticipate the need for additional fee increases in the foreseeable future.

However, the Board believes it is both prudent and necessary to recommend a modest increase to the statutory renewal fee ceiling as a proactive safeguard. This recommendation is not driven by an immediate need to raise fees, but rather to ensure the Board has the flexibility to respond to unforeseen fiscal pressures, such as increased pro rata assessments, new legislative or regulatory mandates, significant enforcement actions, or unexpected litigation costs. Having an increased statutory ceiling in place allows the Board to implement a regulatory fee adjustment in a timely manner should circumstances require, thereby avoiding potential fund insolvency and disruption to Board operations.

In addition, the Board supports permanently eliminating the initial license fee, which it discontinued in 2012 to streamline application processing and reduce barriers to entry for applicants. Maintaining the elimination of this fee aligns with the Board's commitment to reducing unnecessary financial burdens while continuing to ensure efficient licensure processes.

With respect to the fund reserve, the Board supports repealing the existing six-month reserve cap and aligning with the broader Department of Consumer Affairs framework under BPC § 128.5, which allows for a reserve of up to 24 months of operating expenditures. The current six-month limitation no longer reflects the fiscal realities of Board operations and does not provide sufficient cushion to address fluctuations in revenue or unexpected expenditures. Aligning with the 24-month reserve standard would provide the Board with greater financial stability and flexibility, while still maintaining appropriate safeguards, as BPC § 128.5 requires fee reductions if reserves approach or exceed the allowable threshold.

The Board respectfully requests that the Committees consider the following amendments to BPC § 3775:

The amount of fees provided in connection with licenses or approvals for the practice of respiratory care shall be as follows:

~~(c) The initial license fee for a respiratory care practitioner shall be no more than three hundred dollars ($300).~~

(d) ~~For any license term beginning on or after January 1, 1999, t~~ The renewal fee shall be ~~established at~~

~~two~~ three hundred thirty dollars ($~~2~~330). The board may increase the renewal fee, by regulation, to an amount not to exceed ~~three hundred thirty dollars ($330)~~ three hundred seventy five dollars ($375). ~~The board shall fix the renewal fee so that, together with the estimated amount from revenue, the reserve balance in the board's contingent fund shall be equal to approximately six months of annual authorized expenditures. If the estimated reserve balance in the board's contingent fund will be greater than six months, the board shall reduce the renewal fee. In no case shall the fee in any year be more than 10 percent greater than the amount of the fee in the preceding year.~~

In summary, the Board's proposals are intended to ensure long-term fiscal solvency, operational stability, and continued consumer protection, while minimizing unnecessary financial burdens on licensees and applicants.

ISSUE #2: (NATIONAL EXAMINATIONS AND BPC § 139) Should the Board be required to conduct occupational analysis for license types for which there are no California-specific examinations.

Background: To obtain a license from RCB, applicants are required to complete the Registered Respiratory Therapist (RRT) examinations, which include both the Therapist Multiple Choice (TMC) examination and the Clinical Stimulation Examination (CSE) administered by the National Board for Respiratory Care (NBRC).

The objective of a license examination is to determine whether applicants meet minimum competency requirements. Consequently, examination reviews and occupational analyses are conducted to assess whether the examination appropriately evaluates the candidates' skill levels in carrying out tasks routinely performed by the profession in a safe and competent manner. BPC § 139 requires the DCA and programs within the Department to develop a policy to evaluate examinations and conduct occupational analyses, and define circumstances under which review is appropriate, standards for review of state and national examinations, and standards for determining appropriate costs of reviews, among other examination policy considerations.

National examinations provide many advantages to regulatory programs and licensees alike. For example, licensing entities are not required to develop and administer the examinations, which provides considerable cost and workload savings to the program. For license candidates, advantages include that a national examination provides increased portability, greater assurance that their education will prepare them to pass the examination, and increased availability of test taking dates and locations. However, there is rationale for a California-specific examination in some circumstances that must be considered on a case-by-case basis. For example, there are professions where the law and ethical standards in California deviate sharply from other states, seismic considerations for engineering and architecture that must be evaluated in California, professions that do not require licensure in other states, and professions for which there is not a national examination.

A key component of BPC § 139 is the legislative findings of subdivision (a), which state in relevant part, "It is the intent of the Legislature that the policy developed by the department pursuant to subdivision (b) be used by the fiscal, policy, and sunset review committees of the Legislature in their annual reviews of these boards, programs, and bureaus." During the legislative process and sunset review oversight, each program within DCA has established whether its examination for licensure is California-specific, a national examination, or a combination of both. A program can also move to adopt a national examination on its own volition if it is not mandated to require a specific examination.

In the 2026 Sunset Review report to the Legislature the Board notes that they annually verify that the NBRC continues to meet the requirements related to occupational analyses and ongoing item analyses outlined in BPC § 139. Over the last four fiscal years the Board has not incurred any direct examination expenditures. BPC § 139(c) states, "Every regulatory board and bureau, as defined in Section 22, and every program and bureau administered by the department, the Osteopathic Medical Board of California, and the State Board of Chiropractic Examiners, shall submit to the director on or before December 1, 1999, and on or before December 1 of each subsequent year, its method for ensuring that every licensing examination administered

by or pursuant to contract with the board is subject to periodic evaluation." Given that programs are only required to provide a method for ensuring exams are periodically evaluated, and given that the Board relies on a national examination that it may not have the ability to change or update just for California applicants, it would be helpful to understand if the Board, as a program within DCA, is required to routinely evaluate a national examination that is not administered by or under contract with a DCA program under the provisions of BPC § 139. It would be helpful for the Committees to understand what steps the Board would take in the event that an OPES routine evaluation, which the Board pays for, found that some elements of the national examination is unable to measure aspects of respiratory care in California. Would California then require its own examination? Would patients and the public benefit from that?

Staff Recommendations: The Board should update the Committees on the status of OPES examination review, costs for this work, and any next steps the Board plans to take.

Board Response: The Board recognizes that, under B&P § 139 and the Department's examination policy developed by the Office of Professional Examination Services (OPES), programs are expected to ensure that licensing examinations are supported by a valid and current occupational analysis that reflects practice within California. The Board appreciates OPES' role in promoting consistent, high-quality examination standards and ensuring that licensure processes remain aligned with public protection. While the Respiratory Care Board of California has consistently relied on the national examination administered by the National Board for Respiratory Care—which is supported by national occupational analyses and rigorous psychometric validation—it is correct that the Board has not conducted a California-specific occupational analysis to independently validate alignment with state-specific practice.

Consistent with B&P § 139(c), the Board has fulfilled its obligation by maintaining and reporting a method for ensuring ongoing examination evaluation, including annual verification that the NBRC continues to perform occupational analyses and item validation. At the same time, OPES policy appropriately emphasizes the importance of periodically assessing whether national examinations continue to reflect California practice. B&P § 139(c) applies to examinations "administered by or pursuant to contract with the board," and while the NBRC contract is valuable in facilitating cooperation and access to examination data, the statute contemplates that such examinations be evaluated against California-specific information to confirm alignment with state practice and psychometric standards.

OPES also recognizes that cost is an important consideration, and both Policy OPES 22-01 and B&P § 139 thoughtfully account for the resource implications associated with occupational analyses and examination evaluations. B&P § 139(b)(5) directs the Department's policy to identify appropriate funding sources, and subdivision (c)(4) requires boards to annually report the estimated costs and staffing necessary to support these activities. This framework provides a balanced approach that supports both fiscal planning and ongoing evaluation.

If an OPES-informed evaluation were to include a California-specific occupational analysis and ultimately identify areas where the NBRC examinations could be strengthened in relation to California practice, the Board would work collaboratively with the Department and OPES to determine the most appropriate path forward. This could include evaluating whether continued reliance on the national examination remains sufficient, or whether supplemental measures, or if necessary, more tailored examination components should be considered.

Developing and maintaining a California-specific examination would carry notable fiscal and operational considerations. These would include the cost of conducting a statewide occupational analysis, examination development, psychometric validation, ongoing item analysis, and administration infrastructure. Unlike the current model, which results in no direct examination costs to the Board, these activities would require additional resources and could lead to increased licensing fees for applicants. Additionally, implementing a California-specific examination could affect licensure portability, which is an important consideration for workforce mobility.

From a policy perspective, the Board would carefully evaluate whether any identified gaps are uniquely California-specific—such as those tied to state statutes, regulations, or practice environments—or whether they could be effectively addressed through more targeted approaches. These may include jurisprudence or law-and-ethics components, regulatory training, or other supplemental measures that preserve the benefits of the national examination while ensuring alignment with California standards.

At this time, the Board is continuing to engage with OPES to better understand the scope and expectations of any California-specific occupational analysis under B&P § 139 as it applies to national examinations. The Board values this collaboration and remains committed to ensuring full alignment with Department policy while maintaining a licensing framework that is efficient, evidence-based, and firmly grounded in consumer protection.

ISSUE # 3: (EMERGING TECHNOLOGY) Is the Board prepared to address the impact of emerging technology, such as AI, on the delivery of services to respiratory care patients and the public?

Background: The rapid advancement of technology, and in particular, Artificial Intelligence (AI), has created opportunities to automate routine and common tasks that once needed humans to complete. As AI has incorporated increasingly complex algorithms that allow machine learning, the possibility of replacing less routine or mundane tasks has become an option. Consequently, proliferation of AI could lead to disruptions to industries that rely on analyzing data.

On September 6, 2023, the Governor issued Executive Order N-12-23, to address challenges and opportunities arising from the advancement of AI, which the order references as generative artificial intelligence (GenAI). Among the reasons for the state to take action, the EO states (in part):

> GenAI can enhance human potential and creativity but must be deployed and regulated carefully to mitigate and guard against a new generation of risks; and
>
> [T]he State of California is committed to accuracy, reliability, and ethical outcomes when adopting GenAI technology, engaging and supporting historically vulnerable and marginalized communities, and serving its residents, workers, and businesses in a transparent, engaged, and equitable way; and
>
> [T]he State of California seeks to realize the potential benefits of GenAI for the good of all California residents, through the development and deployment of GenAI tools that improve the equitable and timely delivery of services, while balancing the benefits and risks of these new technologies…

The Governor's Executive Order includes direction for various state entities, including, "Legal counsel for all State agencies, departments, and boards subject to my authority shall consider and periodically evaluate for any potential impact of GenAI on regulatory issues under the respective agency, department, or board's authority and recommend necessary updates, where appropriate, as a result of this evolving technology." The Board reports it has not received any complaints involving telehealth practice. There are no legal restrictions against using technology in healthcare delivery, provided that the services are rendered by licensed professionals in California. The standard of care remains consistent, whether care is provided in-person or via telehealth. RCPs are required to adhere to the same responsibilities and patient privacy protections, regardless of the mode of interaction.

Staff Recommendation: The Board should inform the Committees of whether it is equipped to investigate misuse of AI or other technology. The Board should discuss actions it has already taken, if any, to protect consumers, update regulations, and enable proper enforcement in cases using telehealth via AI, while simultaneously keeping up with changes in the safe delivery of services. Finally, the Board should inform the Committees of whether it needs legislative authority to address any concerns stemming from the use of AI.

Board Response: The Board recognizes the rapid advancement of technology, including AI, and its potential to impact the delivery of respiratory care services. Consistent with Executive Order N-12-23, the Board is mindful of both the opportunities and risks associated with emerging technologies and remains committed to ensuring that any use of such technologies aligns with its consumer protection mandate.

At this time, the Board has not received complaints specifically related to the misuse of AI or telehealth in respiratory care practice. The Board's existing statutory and regulatory framework already requires that all respiratory care services, regardless of whether they are delivered in-person or through technological means, must be provided by a licensed RCP and must meet the applicable standard of care. These requirements apply equally to services supported or augmented by AI.

The Board is equipped to investigate misuse of AI or other technologies under its current enforcement authority. Any instance in which technology is used in a manner that results in unlicensed practice, substandard care, or a violation of professional standards would be investigated and addressed through the Board's existing administrative and disciplinary processes. The focus remains on the conduct of the licensee and whether patient care meets established standards, regardless of the tools utilized.

To date, the Board has not identified the need for immediate regulatory changes specific to AI. However, the Board continues to monitor developments in this area, including the evolving use of AI in clinical decision-making, remote monitoring, and telehealth. Key considerations include maintaining appropriate standards of care, ensuring patient safety, protecting patient privacy, and clarifying the appropriate role of licensed professionals when utilizing technology.

At this time, the Board does not believe additional legislative authority is necessary, as its existing authority is sufficient to address potential misuse of AI within the practice of respiratory care. The Board will continue to evaluate this issue, in consultation with stakeholders and legal counsel, and will recommend updates if future developments indicate that additional statutory or regulatory tools are needed to protect California consumers.

BOARD LICENSING AND WORKFORCE ISSUES

ISSUE #4: (WORKFORCE LANDSCAPE) The Board recommends incorporating a baccalaureate degree provision into the Respiratory Care Practice Act. Would raising the minimal educational requirement for Respiratory Care Practitioners to a bachelor's degree create further barriers to entry into the profession? Would a bachelor's degree replace the current requirement for an associate degree?

Background: The California Respiratory Care Workforce Study (study) conducted by the University of California San Francisco in 2017 revealed significant deficits in consistent quality preceptor training and clinical internship availability for RCPs. In response, the Board developed several goals in its Strategic Plan 2017-2021 to improve its CE program and student clinical education outcomes. To address the Board's concern that requiring additional preceptor training may limit access, the Board pursued an alternative, specifically providing this training to RCPs as CE. In 2023 the Board adopted regulations that implemented significant changes to its CE requirements. The revised framework adds incentives to RCPs to participate in preceptor training and as a preceptor for clinical education students. The revised framework also incentivizes hospitals to provide the training, improving the quality of the training while developing leaders in the profession. The new CE requirements now include a minimum of 10 hours in leadership; a minimum of 15 hours directly related to the practice and up to five hours in courses or meetings indirectly related to the practice. The first group required to certify completion of CE under the new framework are those licenses which expired on December 31, 2025. The Board plans to incorporate a survey as part of its CE audit process to monitor the effectiveness of the revised requirements. The Board also plans to track the CE credit earned under the preceptor activities to monitor how licensees are using the option, the effectiveness and popularity of the method, and to determine if preceptorship options are beneficial to professional development.

Another component of the study was to determine the feasibility and impact of requiring new applicants to obtain a baccalaureate degree. Findings of the study underscored the need to develop and strengthen critical thinking, diagnostic and clinical reasoning skills in entry level respiratory therapy education. The study also highlighted the need for more time to cover the plethora of respiratory care courses that are currently condensed due to time constraints. To address these findings, the Board's Professional Qualifications Committee (PQC) conducted an examination of national trends in health- education, reviewed data on patient safety and workforce readiness, and sought broad input from educators, practitioners, employers, and other key stakeholders to determine if the current educational requirement for California licensure meets the burgeoning demands of respiratory care. After the extensive review, the PQC determined and recommended to the Board that raising the minimal educational standard to a bachelor's degree is warranted and will prepare RCPs to manage complex cardiac and pulmonary conditions improving patient outcomes and aligning California with national trends.

The Board reports that the advancement of technology, coupled with an aging population and a higher acuity of complex patient needs, requires RCP practitioners to display critical thinking, manage advanced ventilator systems, and provide critical diagnostic skills. According to the Board, the current requirement of an associate's degree no longer meets the expanse of those responsibilities. The Board maintains that the benefits of pursuing a bachelor's degree provide practitioners with an in-depth knowledge in respiratory pathophysiology, pharmacology and evidence base practice. Although the majority of the 21,400 active licensees in FY 2025-26 hold associates degree, 4,261 have self-reported they already hold a bachelor's degree or higher, signaling that some practitioners have chosen to pursue an advanced degree within the respiratory care profession. Nationally, there is no state that requires a bachelor's degree, although New York, Ohio and North Carolina are pursuing or considering legislation to require a bachelor's degree. There is national and statewide support at the stakeholder level for adopting a bachelor's degree as a minimum standard of education. The American Association for Respiratory Care advocates for a nationwide bachelor's degree requirement to create uniformity in education and licensing, improve licensure portability and ensure all RCPs deliver a high quality of care. In addition, The California Society for Respiratory Care strongly supports the adoption of a bachelor's degree.

As noted in the Board's 2026 Sunset Review report, this proposal will not affect current licensees and bridge degree completion programs will be available to practitioners if they choose to pursue a bachelor's degree. The bachelor's degree requirement will only apply to new licensees on or after January 1, 2033. To address any concerns with a decrease in new graduates that may occur during implementation the Board acknowledges that the existing workforce of 21,390 licensees already exceeds the projected 21,000 licensees needed by 2030 outlined in the Board's 2007 Workforce Study report. The Board notes the current workforce is strong enough to avoid any disruption in patient care during this transition to a higher minimum standard of education and plans to implement the following measures: support access to bachelor's programs for students who begin their education at the associate level; work collaboratively with educational institutions and employers to advocate for program availability including supporting online and hybrid models to increase accessibility; and advocate for employer-sponsored tuition assistance and scholarships to offset the financial burden to students.

However, there are only 18 Board approved respiratory care bachelor programs in the state. Two private schools, Carrington College, which offer both an associate and bachelor's degree in respiratory care at all six of their campuses; and Loma Linda University (LLU) which offers a two-year bachelor's degree in respiratory care with the completion of required prerequisites. According to LLU's website, tuition and fees for the two-year bachelor's program runs approximately $61,000. The website for Carrington College lists tuition and fees for the three-year Associates of Science in Respiratory Therapy program at approximately $63,000 and the online Bachelor's in Respiratory Therapy program which can be competed in approximately 16-19 months at a cost of approximately $30,000 just for tuition and fees.

Currently, there are 35 Board-approved programs that award an associate's degree in respiratory care, nearly half of which are offered at private institutions. Since the Board's last Sunset Review, which reported three Board approved bachelor programs, there are now 11 community college campuses offering both an associate

degree and a bachelor's degree in respiratory care. As one example, the Modesto Junior Community (MJC) college offers a two-year Associates of Science in Respiratory Care program designed to prepare students for entrance into the practice of Respiratory Care. Tuition costs are approximately $4,500 and include enrollment and materials fees, health clearance, uniforms, books, board exams, and licensure fees. Upon completion of the program graduates are eligible to take the National Board of Respiratory Care Therapist Multiple Choice Examination and the Clinical

Simulations Examination allowing them to practice respiratory care nationally. According to the U.S. Bureau of Labor Statistics, the 2024 median annual wage for respiratory therapists with an associate's degree is $80,450 per year with "employment of respiratory therapists projected to grow 12 percent from 2024-2034."

MJC offers an accelerated Bachelor of Science degree in Respiratory Care designed for working individuals which is offered online only. The total estimated cost for the 15-month online program is approximately $7,000. The program eligibility requirements include possession of an associate's degree; graduation from a CoARC accredited Respiratory Care program; possession of a Registered Respiratory Therapist credential; and completion of the 39 required CSU-GE Transfer Pattern units. There is a lottery for entry into the program. While the program offers four courses on advanced practice in respiratory care, the core of the curriculum is focused on promoting research, education, and leadership roles in respiratory care. There is no clinical component in the curriculum. While the affordability of the accelerated program is an attractive feature the lottery for entry may prove to be an impediment to accessibility for most.

While all the Board approved entry level respiratory care programs are accredited, the CoARC standards are designed in terms of the minimum content required, so some respiratory therapy programs may incorporate didactic content or clinical experiences that expose students to a variety of competency in different clinical settings. As reported in the study, the LLU entry-level bachelor's degree program is an outlier compared to other associate degree programs due to the emphasis on evidence-based medicine within the program. LLU is unique as the only program that requires coursework in research methods and statistics with the expectation that students engage in primary research with a faculty member and either co-author a peer-reviewed journal publication or present findings at a professional conference. The LLU program also has the distinction of having its own academic medical center and health care center, offering graduate-level health programs in medicine and pharmacy. This elevated distinction allows RCPs students to receive a higher level of supervised clinical experiences with an emphasis on a diversity of pathology, high acuity patients, a wide range of protocol-based therapies ensuring consistency in patient care, significant interactions with other clinical professionals and supervision within the clinical setting by experienced RTs who have trained to precept students. The study notes that all these conditions contribute to a level of evidence based clinical practice that may not be available within other Board approved programs.

The Board states that there are concerns with the quality and consistency of clinical education in the existing programs and that these leave many new graduates ill equipped to meet the responsibilities of the profession. As reported in the study, clinical placements are a major challenge with programs competing for the same clinical rotation availability and lack of accessibility to appropriate clinical settings impedes students' ability to experience the full range of clinical pathology, procedures and equipment used in respiratory care. Other clinical concerns raised in the study include inconsistencies in the quality of the clinical experience, lack of organization in the students' supervised experience, with students' training with any available staff member versus dedicated program faculty and variability of the number of clinical hours required by different programs. The study suggests standardization of clinical education for students would greatly benefit the respiratory care profession. As mentioned in the Board's previous Sunset Review, CoARC is working on new standards for clinical training. It would be helpful for the Committees to hear about the progress of implementing these new standards.

The current minimum education requirement of an associate's degree for licensure for respiratory care therapists requires competency in the modes of respiratory care and proficiency in providing bedside care, patient assessments, and technical skills. As noted in the study, 67% of respiratory care education program directors surveyed felt that the associate degree provided sufficient preparation for new graduates entering the workforce.

Some surveyed respiratory therapists report a lack of financial incentive to obtaining a bachelor's degree or found a requirement to obtain a higher degree in order to gain professional respect disturbing. One program director interviewed in the study supported efforts to increase the number of respiratory therapists with bachelor's degrees but maintained that a two-year associate degree in respiratory care prepares students adequately, much like the required associate's degree in registered nursing. As previously mentioned, the required educational degree can be obtained at any one of 11 California community colleges in a two-year period with costs of tuition and other related fees set at an affordable rate. Once graduated licensees can expect an above average annual median wage in a rapidly growing field and obtain gainful employment at a variety of acute and nonacute healthcare settings.

Staff Recommendation: The Board should update the Committees on the status of the CoARC new standards on clinical training. The Board should update the Committees on any impacts or effectiveness from the revamped CE requirements on the quality of clinical education standards.

The Board should advise the Committees of the impact to future licensees, applicants, the public, and reciprocity options if the Act is amended to require a bachelor's degree in order to become a part of the dynamic RCP profession. The Board should advise the Committees whether a bachelor's could be an option, rather than a requirement, in an individual's pursuit of livelihood as a practicing RCP.

Board Response: The CoARC implemented its 2022 Entry-into-Practice Standards, which significantly changed clinical training requirements by eliminating prescriptive minimum clinical hour requirements and transitioning to a competency-based framework. Under this model, programs must demonstrate that students achieve required clinical competencies through experiences of sufficient quality and duration, rather than meeting a set number of hours. As a result, clinical training hours are now determined at the program level, leading to increased variability across educational programs in both the number of hours and the types of clinical experiences provided.

The Board has received stakeholder input regarding both the quality of, and variation in, clinical education. Stakeholders have noted that these inconsistencies may contribute to deficits in the preparedness of some new graduates, leaving them inadequately equipped to meet the expectations and responsibilities of professional practice.

The Board is actively monitoring this shift. The Board's Professional Qualifications Committee (PQC) has identified variability in clinical preparation as a consumer protection concern, as it may impact consistency in entry-level competency. This issue will be incorporated into the Board's ongoing strategic planning efforts to ensure that respiratory care practitioners are adequately prepared to provide safe and effective care. The PQC will continue to evaluate these concerns and consider whether additional statutory or regulatory changes are warranted to address clinical training variability.

With respect to the Board's revised CE requirements, it is still too early to determine their effectiveness. The first group of licensees subject to the revised requirements renewed on December 31, 2025, and sufficient data has not yet been collected to evaluate measurable outcomes. The Board will continue to monitor trends in compliance, enforcement data, and any correlations with practice quality as additional renewal cycles are completed and can provide updates to the Committees as more information becomes available.

The Board supports advancing a bachelor's degree requirement to better align with the increasing complexity of respiratory care and evolving healthcare delivery models. This position is grounded in the Board's consumer protection mandate and its responsibility to ensure that all licensees enter practice with a consistent level of preparation. This position is further supported by employer demand and stakeholder input gathered through the Board's PQC.

The Board's evaluation of this issue has been informed by a multi-year effort led by its PQC, including surveys, focus groups, stakeholder engagement, research review, and input from employers and industry stakeholders (see PQC Timeline and PQC Research and Data).

Survey data submitted to the Board by respiratory care managers across California found that 75% of respondents support implementing a bachelor's degree as the minimum requirement for new hires, while 90% believe that increasing the educational standard will enhance patient outcomes, and 88% agree that it is necessary to align with other healthcare professions

Similarly, survey data submitted by the University of California health system reflects strong employer alignment, with 74% of management-level respondents supporting a transition to a bachelor's degree requirement, and 89% indicating that this change is necessary to align the profession with broader healthcare standards.

Qualitative feedback gathered through PQC-led focus groups and stakeholder engagement further supports this trend. Employers and clinical leaders consistently emphasized the need for stronger critical thinking, clinical reasoning, and communication skills among new graduates, particularly as respiratory care continues to evolve toward managing higher-acuity patients and more complex technologies.

With respect to compensation, while available data suggests that entry-level wages may not significantly differ between associate- and bachelor-prepared RCPs, stakeholders consistently reported that bachelor-prepared practitioners are more competitive for advancement opportunities. These include leadership, education, specialty care, and supervisory roles, which are associated with higher long-term earning potential.

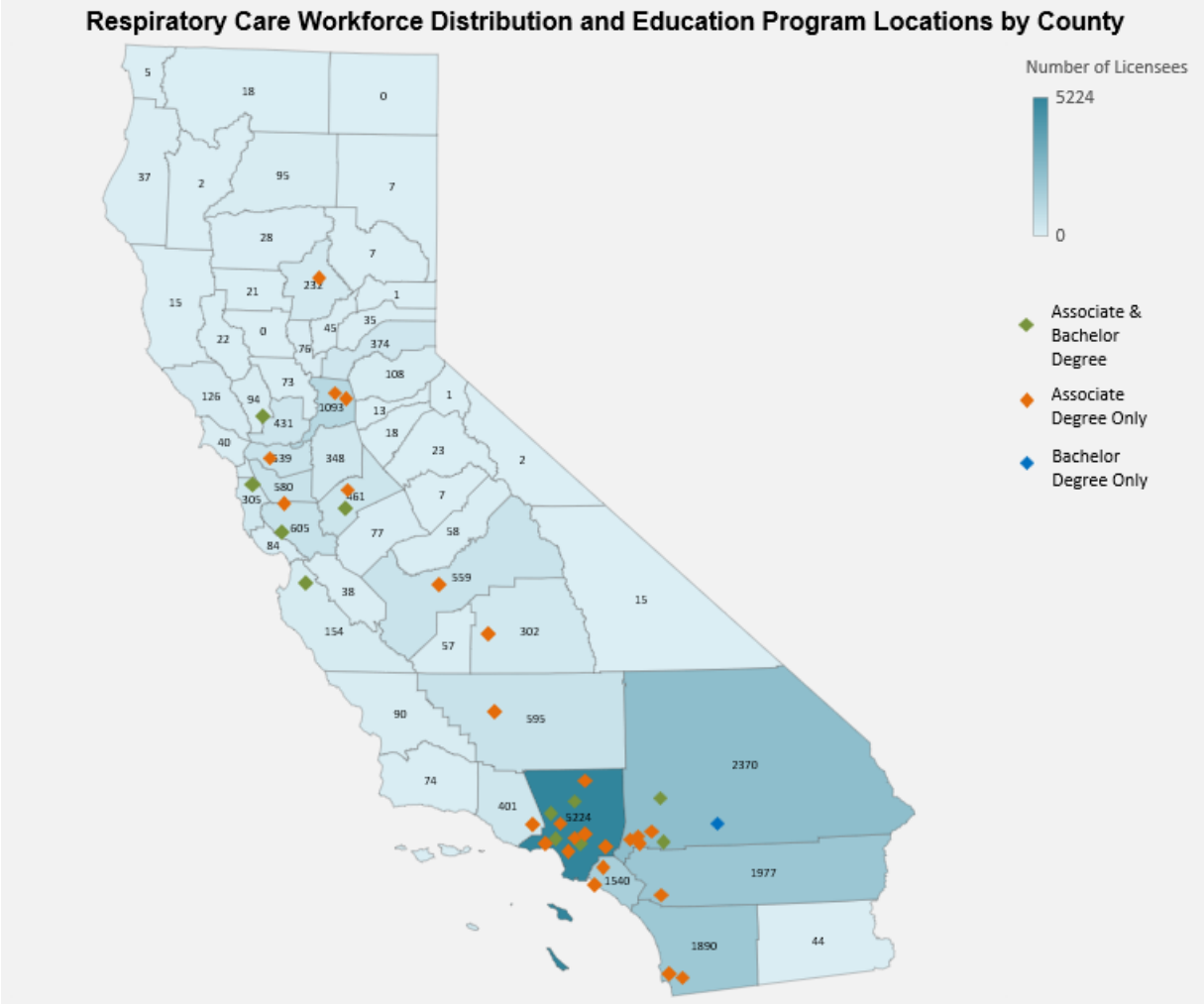
The Board received multiple letters of support from employers, educators, and professional organizations, all of which reinforce a consistent message: the expectations of the respiratory care workforce are evolving, and educational preparation must evolve accordingly.

While the Board acknowledges that the associate degree pathway has historically provided a viable entry point into the profession, the data collected through the PQC process demonstrates a clear, measurable, and consistent shift in employer expectations across healthcare systems. The Board views this trend as an important consideration in evaluating whether current minimum educational requirements continue to meet the needs of the healthcare system and adequately protect the public.

While employer demand supports advancing educational standards, the Board also carefully evaluated workforce distribution and access considerations to ensure this transition does not negatively impact underserved areas.

In response to questions raised during the Sunset Hearing regarding the potential impact of a bachelor's degree requirement on workforce availability in rural and underserved areas, the Board conducted a more detailed review of both workforce distribution and the location of existing educational programs. As reflected in the Board's licensure data and illustrated in the accompanying map of respiratory care workforce distribution and education program locations by county, the issue is not a statewide shortage of respiratory care practitioners, but rather a regional imbalance. Licensees are concentrated in urban areas, particularly in Los Angeles County and surrounding regions, while other parts of the state show lower practitioner-to-population ratios. As shown in the map, these differences are most pronounced in the San Joaquin Valley, Northern and Sierra regions, and certain rural interior counties, where licensee counts are comparatively lower and educational program availability is more limited.

For purposes of this analysis, the Board identified underserved regions to include the San Joaquin Valley (San Joaquin, Stanislaus, Merced, Madera, Fresno, Kings, Tulare, and Kern Counties), the Northern and Sierra regions (including Shasta, Tehama, Trinity, Humboldt, Del Norte, Siskiyou, Modoc, Lassen, and Plumas Counties), as well as additional rural interior counties such as Inyo, Mono, Mariposa, Calaveras, Tuolumne, Amador, and Alpine. As shown on the map, these regions consistently reflect lower license counts relative to population and geographic size. The Board also notes that this pattern is consistent with findings from the California Health Care Access and Information (HCAI) Workforce Report, which identifies similar regional disparities across multiple health care professions. The Board recognizes this as a broader statewide workforce distribution issue and believes it is important to address it proactively.



At the same time, the Board evaluated the availability of educational infrastructure in these regions. California's community college system includes 118 institutions statewide, approximately 25 of which are located within the regions identified above. Importantly, some of these institutions, including Modesto Junior College in Stanislaus County and Butte College in Butte County, already offer respiratory care programs. This demonstrates that program development in underserved regions is not theoretical, but already occurring in certain areas and capable of further expansion.

While private institutions may also contribute to increasing program availability, community colleges remain the most accessible and affordable option for many students, reflecting the Legislature's longstanding commitment to expanding access to higher education. For that reason, the Board's focus will remain on outreach to community colleges in underserved regions as part of its strategic planning efforts. This includes working with institutions that are already well-positioned to support program expansion and encouraging development in areas where workforce gaps are most pronounced.

Research across health professions has shown that individuals are more likely to practice in regions where they receive their education, further supporting the value of expanding educational opportunities in underserved areas. By strengthening and expanding programs in these regions, the Board believes there is a meaningful opportunity to improve workforce distribution over time while maintaining access to the profession.

In evaluating this change, the Board has carefully considered the potential impacts:

Future licensees and applicants: A bachelor's degree requirement would strengthen clinical judgment, critical thinking, and the ability to manage increasingly complex, technology-driven care. As respiratory care continues to evolve and patient needs grow more complex, practitioners are expected to exercise greater autonomy and clinical decision-making, making a higher baseline level of education essential.

Associate degree graduates already accumulate approximately 90–100 units upon graduation. While increasing the minimum educational requirements to a bachelor's degree may delay entry into the workforce by an estimated 6–12 months, the additional education provides increased clinical exposure, stronger development of critical thinking and communication skills, and improved competency in evidence-based practice.

The public: From a consumer protection standpoint, establishing a uniform bachelor's degree requirement promotes greater consistency in training and competency across all licensees. Patients receiving respiratory care are often among the most medically fragile, and ensuring a standardized, advanced level of education helps safeguard the quality and safety of care delivered.

Reciprocity: While the Board recognizes that this change may create challenges for out-of-state applicants from jurisdictions without similar requirements, it believes that aligning educational standards with the demands of modern practice is appropriate. To help mitigate potential barriers while maintaining standards, the Board could consider updating its existing education waiver criteria to allow credit for relevant work experience, where appropriate, as a means of recognizing demonstrated competency obtained through practice.

The Board does not support making a bachelor's degree merely an option. A dual-pathway approach—where some licensees enter with an associate degree and others with a bachelor's degree—would perpetuate variability in educational preparation and undermine the goal of establishing a clear, consistent minimum standard for safe practice. Furthermore, employers would be challenged to employ tiered license RCPs as staffing must be flexible to provide care at all practicing levels in a changing acuity environment. From a regulatory and consumer protection perspective, minimum qualifications must be uniform, transparent, and aligned with current practice demands.

Accordingly, the Board supports moving toward a single, standardized bachelor's degree requirement for entry into the profession and will continue working with stakeholders and the Committees to advance this effort in a thoughtful and measured manner that prioritizes patient safety while considering workforce impacts.

The Board respectfully requests that the Committees consider the following amendments to BPC § 3740:

(a) Except as otherwise provided in this chapter, all applicants for licensure under this chapter shall have completed an education program for respiratory care that is accredited by the Commission on Accreditation for Respiratory Care or its successor and, until December 31, 2032, been awarded a minimum of an associate degree from an institution or university accredited by a regional accreditation agency or association recognized by the United States Department of Education. Effective January 1, 2033, all applicants shall be required to have been awarded a bachelor's degree from such an institution or university.

(b) Notwithstanding subdivision (a), meeting the following qualifications shall be deemed equivalent to the required education:

(1) Enrollment in a baccalaureate degree program in an institution or university accredited by a regional accreditation agency or association recognized by the United States Department of Education.

(2) Completion of science, general academic, and respiratory therapy coursework commensurate with the requirements for an associate degree in subdivision (a) prior to January 1, 2033.

(3) This subdivision shall remain in effect only until January 1, 2033, and as of that date is repealed, unless a later enacted statute deletes or extends that date.

(c) An applicant whose application is based on a diploma issued to the applicant by a foreign respiratory therapy school or a certificate or license issued by another state, district, or territory of the United States that does not meet the requirements in subdivision (a) or

(d), shall enroll in an advanced standing and approved respiratory educational program for evaluation of his or her education and training and furnish documentary evidence, satisfactory to the board, that he or she satisfies all of the following requirements:

(1) Holds an associate degree or higher level degree equivalent to that required in subdivision (a) or (b) for the applicable date of application.

(2) Completion of a respiratory therapy educational program equivalent to that required in subdivision (a) or (b) for the applicable date of application.

(3) Possession of knowledge and skills to competently and safely practice respiratory care in accordance with national standards.

(d) Notwithstanding subdivision (c), an applicant whose application is based on education provided by a Canadian institution or university that does not meet the requirements in subdivision (a) or (b) shall furnish documentary evidence, satisfactory to the board, that he or she satisfies both of the following requirements:

(1) Holds a degree equivalent to that required in subdivision (a) or (b) for the applicable date of application.

(2) Completion of a respiratory therapy educational program recognized by the Canadian Board of Respiratory Care.

(e) A school shall give the director of a respiratory care program adequate release time to perform his or her administrative duties consistent with the established policies of the educational institution.

(f) Satisfactory evidence as to educational qualifications shall take the form of certified transcripts of the applicant's college record mailed directly to the board from the educational institution. However, the board may require an evaluation of educational credentials by an evaluation service approved by the board.

(g) At the board's discretion, it may waive its educational requirements if evidence is presented and the board deems it as meeting the current educational requirements that will ensure the safe and competent practice of respiratory care. This evidence may include, but is not limited to:

(1) Work experience.

(2) Good standing of licensure in another state.

(3) Previous good standing of licensure in the State of California.

(h) Nothing contained in this section shall prohibit the board from disapproving any respiratory therapy school, nor from denying the applicant if the instruction, including modalities and advancements in technology, received by the applicant or the courses were not equivalent to that required by the board.

While the Board recognizes that variability in clinical training is an important issue that may impact the consistency of hands-on experience across programs, addressing clinical hour variability alone does not resolve broader concerns related to entry-level competency. The purpose of advancing a bachelor's degree requirement is not to increase clinical hours, but to strengthen foundational knowledge, critical thinking, communication, and leadership skills necessary to safely manage increasingly complex patient care. These are distinct, but complementary issues, and both warrant continued evaluation.

This proposal aligns the Board's statutory authority with the evolving demands of respiratory care practice and ensures that minimum educational standards are consistent with the level of knowledge, skill, and clinical judgment required to protect the public. The Board looks forward to working with the Committees to further evaluate workforce impacts and refine the statutory language.

ISSUE #5: (ADVANCED PRACTICE RESPIRATORY THERAPIST) The profession and Board suggest creating an Advanced Practice Respiratory Therapist classification. What are the practical impacts of this proposal?

Background: The California Society for Respiratory Care (CSRC) is seeking to establish an Advanced Practice Respiratory Therapist (APRT) classification in California, and the Board supports this endeavor, citing a significant shortage of physicians in California, especially in pulmonary medicine, critical care, and underserved rural and urban areas as one driving factor. According to the Association of American Medical Colleges the physician shortage could be as high as 120,000 by 2030, with more than 70% of pulmonologists over the age of 55.

As noted in the Board's 2026 Sunset Review report, establishing the role will create a pathway for graduate-level trained RCPs to serve as physician extenders, delivering advanced assessments, ordering and interpreting diagnostic tests, prescribing medications, managing treatment plans, and supporting patients with complex needs.

Currently, the Ohio State University Master of Respiratory Therapy (MRT) is the only CoARC accredited advanced practice clinical master's degree for respiratory care in the nation. The MRT full- time program is five semesters, and the total cost is approximately $28,463 including tuition, fees and living expenses. Applicants must have graduated from a CoARC approved institution, have a bachelor's degree in respiratory care, at least one year of work experience as a Registered Respiratory Therapist (RRT) and be licensed to practice in the state of Ohio. The APRT curriculum consists of 47 credit hours in a five-course semester, and students are required to complete 1,000 hours of supervised practice by a licensed physician in a clinical specialty. The advanced courses are applied in inpatient and outpatient settings and students may indicate their interest in a specific area of practice such as adult/critical emergent care, pediatric or neonatal critical care, pediatrics, primary respiratory care, neuromuscular respiratory care and sleep disorders. The MRT program is designed to prepare APRTs as clinical specialists with an expanded scope of practice in a variety of settings. In 2021, the MRT program had its first graduating class of seven students and now currently has 14 APRT graduates working throughout the United States.

Enacting legislation for the APRT is in process in Ohio and North Carolina and the Veterans Administration Maryland Health Care System has created an APRT role within its system. In 2025, the Ohio Society for Respiratory Care sponsored House Bill (HB) 253 to create a regulatory framework for APRT licensure under the State Medical Board of Ohio. HB 253 specifies the services that an advanced practice respiratory therapist may perform under a physician's supervision, including administering, ordering, and prescribing drugs and medical devices. HB 253 passed the Ohio House and now moves to the Ohio Senate for further consideration.

The North Carolina Respiratory Care Board voted to introduce language into its existing respiratory therapy practice act that adds Advanced Practice Respiratory Care Practitioner (ARCP) much like the APRT to the state licensure law. The first APRT online educational program at the University of North Carolina (UNC) Charlotte is currently in the process of seeking CoARC accreditation. The UNC website states that the APRT program is designed to prepare RRTs to provide evidence-based, diagnostic and therapeutic clinical practice and disease management under the supervision of a licensed physician. In 2025, House Bill (HB) 71 the Respiratory Care Modernization Act supporting the ARCP licensure was introduced in the North Carolina General Assembly. HB 71 passed the North Carolina House and now moves to the North Carolina Senate for further consideration.

On a national level, the Board reports that the National Board for Respiratory Care (NBRC) has been working on developing an outcome assessment for APRT programs that can be used by accredited schools, licensure agencies, and employers. The Board further notes that the continued development of accredited academic APRT programs may also prompt the NBRC to create a credentialing examination for the advanced practice classification.

While access to care issues remain significant for millions of patients throughout the state, it would be helpful for the Committees to understand the practical impacts of this proposal and whether it may be premature, given that there is currently only one program in the nation that provides the type of additional education and curriculum that would be envisioned as necessary for advanced practice. It would be helpful for the

Committees to learn about discussions with other healthcare providers, healthcare facilities, and payors about the opportunities that may exist for RCPs to take on additional practice authority. The creation of a new category of licensed or regulated professional is subject to Government Code provisions that require a plan and numerous data sets to better allow the Legislature to evaluate the impacts of a licensure proposal on members of the profession, the public, and government agencies. The profession and Board may wish to work with the Committees to develop a formal plan and respond to the Sunrise Questionnaire worksheet the Committees utilize.

Staff Recommendation: The Board should update the Committees on the discussions it has had with stakeholders and the feasibility of creating this new category of licensed RCP with new practice authority.

Board Response: The Board has continued discussions with the CSRC regarding the potential development of an APRT category and appreciates being included early in these conversations, as the Board would ultimately be responsible for administering and regulating this license category should it be established.

In doing so, the Board recognizes the widely acknowledged shortage of physicians and supports the development of the APRT role as a physician extender to help improve access to care while maintaining patient safety. This role would be distinct from bachelor's-prepared respiratory care practitioners, similar to the distinction between bachelor's-prepared registered nurses (BSRNs) and nurse practitioners (NPs), with the APRT representing an advanced practice role with additional education, training, and clinical responsibilities. The Board will provide updates to the Committees as this work progresses.

ISSUE #6: (RECIPROCITY) What are the client and consumer impacts of interstate compacts and what would it mean for California to join interstate licensure compacts for RCP practitioners?

Background: An interstate licensing compact represents a legally binding agreement between multiple states to facilitate cross-state practice for licensed professionals without requiring them to obtain full licensure in each participating state. To participate in such a compact, a state must adopt model statutory language provided by a compact organization. Typically, a practitioner must already hold a license in their home state before seeking authorization to practice in a compact member state.

Compacts are often viewed as a means by which licensees can gain additional portability and practice in other states, reducing administrative burdens of becoming licensed in multiple states. Compacts have particularly been touted as beneficial to military spouses; however recently enacted federal legislation allows clearer portability for service members and their spouses to be able to use their professional licenses and certificates issued in one state when they relocate to another state due to military orders.

The American Association for Respiratory Care (AARC) is partnering with the Council of State Governments (CSG) and the Department of Defense (DoD) to create the new Respiratory Care Interstate Compact (RCIC) designed to provide an additional licensing pathway and reduce the barriers to license portability for licensed respiratory therapists. The model legislation of the compact was finalized in 2024 allowing states to begin enacting the language through their legislative process. RCIC has four member states with an activation threshold of seven states. The RCIC allows licensed respiratory therapists who hold a credential from the NBRC that would otherwise qualify them for state licensure in the member state they are seeking compact privilege, and an active license in their member home state, to practice in other member states without becoming licensed in that state. The licensee must not have any adverse actions against their license within the previous two years, pay any applicable fees and meet any jurisprudence requirements, if applicable, in the compact member state they are seeking a compact privilege.

California currently does not participate in any health professional licensing compact. Compacts have proven to be problematic and challenging for California licensees and regulatory programs alike, in terms of compact governance, enforcement options, parity in licensure qualifications, and other aspects of compact pathways. When a state joins a compact, it is subject to the rules of the compact and the bylaws established by a compact

governing body. While a member state may have a vote or voice in the governance of a compact and may have some say in the development and amendment of bylaws, that is not the case for all licensing compacts. Many licensing priorities in California may not be reflected in compacts, such as the ability for individuals in California to become licensed using an individual taxpayer identification number, rather than only a social security number. Compact rules and specifications cannot be amended by a single member state, and updates are not always subject to the transparent and open discussions held in the Legislature or by California regulatory programs subject to the Bagley-Keene Act. Some compacts group categories of licensees together who may be licensed by a separate licensing entity, and there are often several key differences between the rules and processes of a Compact and the practice acts administered by a California program.

Staff Recommendation: It would be helpful to know if the Board finds any benefits or impacts in joining RCIC and what joining the compact would mean for Board operations and California consumer protections.

Board Response: The Board is aware of the RCIC and continues to monitor its development and potential implications for California. While the Board has not formally considered participation, it has evaluated the potential impacts of interstate licensure compacts on California's regulatory framework.

The Board recognizes that interstate compacts may offer workforce mobility benefits. However, beyond this, the Board has not identified significant additional advantages, particularly given that California currently maintains a sufficient number of licensees and has established state-specific requirements, such as continuing education and ethics coursework, designed to support California's consumer protection standards.

As the regulator of the largest population of RCPs in the nation, the Board would need to carefully evaluate any proposal to ensure that participation does not compromise California's public protection standards or limit its enforcement authority. Participation in a compact would require the Board to adopt a multi-state framework for licensure, data sharing, and enforcement coordination, resulting in operational and administrative impacts, including system modifications, staff training, and ongoing coordination with the compact commission and other member states.

Of particular concern is ensuring equivalency in law and ethics standards, minimum licensure requirements, and continuing education criteria, especially where other states' requirements may be less stringent than California's. Participation in a compact would require some reliance on other states' standards and disciplinary actions, which may not align with California's more rigorous framework.

At this time, the Board has not taken a formal position on joining the RCIC. The Board will continue to monitor the development of the compact, including its implementation in other states, and evaluate whether participation would provide meaningful benefits beyond workforce mobility while maintaining California's strong consumer protection standards.

The Board looks forward to working with the Committees to further evaluate this issue as additional information becomes available.

BOARD ENFORCEMENT ISSUES

ISSUE #7: (BASIC SERVICES) The Board has worked for years and taken proactive steps to ensure that Licensed Vocational Nurses (LVNs) who provide basic respiratory care services to certain patients are not deemed as engaging in the unlicensed practice of respiratory care. Despite statutory clarifications and robust discussions between the Board of Vocational Nursing and Psychiatric Technicians (BVNPT) and Board, as well as regulatory efforts at the Board level, BVNPT continues to provide guidance that creates confusion and compliance issues for licensees, health facilities, schools, and medical equipment providers alike. Is further clarification necessary?

Background: In the1960s, home health care was first included in the Medicare, Medicaid, and Old Age Assistance Act. Due to assumptions by those establishing guidelines for this that family members would be subsidizing home health care needs, coverage for home health care was mandated only for medically necessary, intermittent care for those acutely ill patients who had been released from the hospital. By the 1990s, however, changes within varying levels of government allowed for initial expansion of home health services until the Balanced Budget Act of 1997 drastically slashed Medicare home benefits, and as a result, the number of patient visits were reduced, and 3000 home care agencies shut down. In response, the California Legislature enacted legislation AB 68 (Migden, Chapter 242, Statutes of 2001) that created Health and Safety Code §1743 to address the shortage of providers in home care and community-based settings, with the intent to uphold the "same strong consumer protections."

The first California respiratory care practitioner license was issued in 1985 with the mandate to protect the public from the unqualified and unlicensed practice of respiratory care. The Act was amended in to add BPC § 3710.1 providing that "protection of the public shall be the highest priority" for the Board and "whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

As changes were taking place in home care and new home and community-based settings were emerging in the 1990s, the licensure of RCPs was in its infancy. During this transition, home and community-based health care continued to evolve, likely without a focus on RCPs and the respiratory care scope of practice, as well as their expertise in managing all things cardiopulmonary. Many facilities began using LVNs to deliver respiratory care, in addition to skilled nursing services.

For over 20 years, the Board and BVNPT have differed in their view of whether LVNs are legally authorized to provide certain respiratory services, including mechanical ventilator care, and have long discussed the difference in education and training between LVNs and RCPs. BVNPT maintains that because LVNs learn about the respiratory system, they are trained and educated to provide respiratory services, regardless of the fact that the LVN practice act does not confer any authority for the LVN "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" pursuant to BPC § 2860 (a). At one point, BVNPT issued guidance to its licensees saying that according to that board, they were authorized to adjust ventilator settings and do various related respiratory tasks, despite not having any statutory or regulatory authority to support that administrative guidance. The Board has remained concerned about the patient safety implications of this messaging, noting that BVNPT has failed to revoke the policy even though there is no accompanying legal justification for it. The Board notes that LVNs performing services beyond the basic care they are authorized to engage in has led to adverse incidents resulting in death or serious harm that the Board is made aware of via requirements to take enforcement action for unlicensed practice.

There appear to be a few primary factors that have led to confusion, particularly for home and community-based patients:

1. A misunderstanding by the industry that respiratory care is a skilled nursing service. At some point after the establishment of many home and community-based facilities in the 1990s, some regulators and many in the industry erroneously interpreted "skilled nursing services" to include respiratory care tasks and services identified in BPC §§ 3702 and 3702.5, despite the mandated nursing-patient ratios excluding RCPs and respiratory care services from being counted toward meeting those ratios

2. Nurse-to-patient ratios established years ago may have led to the evolution of the definition of "skilled nursing services" to include respiratory care tasks and services erroneously. Because RCPs providing respiratory care services are not counted toward this ratio, and there is no reimbursement for respiratory

services in home and community-based settings and it is convenient for some providers to claim respiratory care is included in nursing services in order to meet the nurse-to-patient ratio in the most fiscally prudent manner. This interpretation has likely led to unauthorized health care providers like LVNs performing tasks they are not fully trained, educated or competency-tested to perform.

3. The lack of reimbursement OR reimbursement requirements and enforcement thereof, that requires RCPs or other qualified health care personnel be the actual providers of respiratory tasks and services. While establishing or increasing a reimbursement amount for the service may be necessary, not using qualified providers for services and instead having providers with less or no education, training, and competency testing perform certain tasks above and outside their scope of practice does not entirely solve the issue.

California reimbursement law does not completely omit respiratory care in home and community- based settings, but it does treat it unevenly. Medi-Cal expressly recognizes RCP services as a covered benefit, and California Code of Regulations (CCR), Title 22, § 51507.3 establishes reimbursement rules for RCPs. However, the home health agency provisions in Title 22 do not expressly include respiratory therapy as a separate home health service category. 22 CCR §58013 defines “Home Health Care Services” to include skilled nursing, home health aide, physical therapy (PT), occupational therapy (OT), speech therapy and audiology, and medical social services, but it does not list respiratory therapy. Likewise, 22 CCR §51523 sets reimbursement rates for home health agency visits for nursing, aides, PT, OT, speech therapy, and medical social services, without a separate respiratory therapy line item.

For patients where family members are the sole health care providers and/or do not utilize a home health agency, RCPs employed at Home Medical Device Retail (HMDR) facilities serve as a key bridge between the patient and the doctor in addressing problems. For these HMDR Facilities, the reimbursement structure is generally tied to durable medical equipment rather than separately payable clinical support services. California’s HMDR program was established through legislation in 2000 (AB 1496, Olberg, Chapter 837, Statutes of 2000) and is now administered by the California Department of Public Health. HMDR facilities supply prescription medical devices and durable medical equipment for use in the home, and CDPH also licenses exemptees for certain facilities. Medi-Cal’s durable medical equipment rules (CCR, Title 22, § 51521) outline reimbursement for durable medical equipment, under which services such as installation, setup, and instruction in the use of equipment are included in the equipment reimbursement and are not separately reimbursed. As a result, although RCPs may provide important home-based respiratory support, California’s reimbursement framework does not clearly create a distinct payment pathway for those setup, education, and follow-up functions when they are tied to home respiratory equipment. For patients where family members are the sole health care providers and/or do not utilize a home health agency, RCPs employed at HMDR facilities serve as a key bridge between the patient and the doctor in addressing problems.

The Board and BVNPT began to work collaboratively again in 2019 and issued a joint statement clarifying RCP and LVN roles relating to patient care, particularly for patients reliant on mechanical ventilators. In 2022, SB 1436 (Roth, Chapter 624, Statutes of 2022), amended the Vocational Nursing Practice Act to reiterate that LVNs do not possess independent authority to perform respiratory care services or treatments that are not specifically identified by the Board. SB 1436 authorized LVNs with appropriate training, to perform only those basic respiratory tasks expressly identified by the Board. The Board-authorized tasks must be manual or technical in nature or involve data collection and must not require any form of respiratory assessment. This was intended to ensure that LVN involvement in respiratory care is restricted to narrowly defined, non-clinical activities that do not overlap with the specialized judgement and skills of RCPs.

The bill recognized the unique care needs in home settings and provided clarifications to ensure LVNs performing certain tasks pursuant to employer training would not be considered the practice of respiratory care, ensuring that the LVN would not face unlicensed activity enforcement under narrow circumstances. By the time SB 1436 took effect, the Board had presented the topic and issue at numerous public board meetings and the language in the bill had been considered at numerous public Legislative hearings.

Since the passage of SB 1436, the Board became aware of other licensed home and community-based facilities and patients not covered in the exemptions outlined by that bill. Settings with only one or a few patients requiring respiratory services make it unfeasible to hire a full-time RCP and the Board sought to find balance to ensure patients would not be re-institutionalized or lose access to daily living services. In response to stakeholder concerns, the Board conducted extensive research to identify additional types of facilities, like small facilities outside of acute care facilities and independent providers who provide for transport and/or overseeing care of patients during daily activities, such as an outing, attending school, or providing a few hours of relief for parents' in-home care.

SB 1451 (Ashby, Chapter 480, Statutes of 2024) further amended the Act to add new exemptions for LVNs working in additional community-based settings to clarify that those individuals would not be considered to be practicing respiratory care and subject to Board oversight. SB 1451 provided that LVNs employed by exempt home health agencies or working in designated home and community based exempt settings may perform additional respiratory tasks, beyond basic level, if they have received appropriate task and patient specific employer training and obtained valid competency certification for each respiratory task from a board-recognized organization. According to the Board, as of November 2025, the Department of Public Health's Cal Health Find database lists approximately 4,343 Home Health Agencies, 335 Adult Day Health Care Centers, 215 Congregate Living Health Facilities, 987 Intermediate Care Facilities, of which only 55 have more than six beds, and 26 Pediatric Day Health and Respite Care Facilities. In addition, data from the California Department of Social Services' Community Care Licensing Division indicate that there are 364 Small Family Homes licensed statewide, each serving six or fewer children with special health care needs. Reliable data is not available for nurse providers working in residential homes and private duty nurses providing community-based support. In total these combined facility types represent more than 5,900 licensed programs statewide that provide or support respiratory care services in home health and home community-based settings. This data represents the facilities, programs and individuals specifically included in the statutory exemptions of BPC §§ 3765 (i) and (j).

In March 2024, the Board initiated the first of several new regulatory packages to define Board- approved basic respiratory tasks and services that LVNs may lawfully perform, in accordance with requirements for the Board to undertake this work. The regulatory language, discussed extensively at public meetings, explicitly listed the tasks that could be considered "basic", while also clarifying the limits of LVN practice. The Office of Administrative Law approved the regulation defining basic respiratory tasks and services that may be performed by LVNs to require manual, technical skills, or data collection without conducting a respiratory assessment. The regulation became effective on October 1, 2025.

To support the implementation of the basic respiratory tasks and services regulations the Board mailed a formal notice in August 2025 to approximately 1,200 licensed subacute and skilled nursing facilities. The notice explained the potential impact of the new requirements and included a comprehensive self- audit tool to help facilities assess compliance, along with a detailed Frequently Asked Questions document. The Board also notified the California Department of Public Health's Facility Inspection Division and the Department of Health Care Services' Subacute Contracting Unit to ensure interagency awareness and coordination. As an additional measure of transparency, the Board developed a dedicated website as a centralized resource, providing information and guidance for RCPs, LVNs, facility administrators, and patients on the new regulation and its implications.

While the basic respiratory tasks and services regulation provided clarity for licensed health care facilities, it erroneously did not include the additional exempt settings as added by SB 1451. This oversight prompted questions and concerns regarding the level of care permitted in home health and community-based settings where LVNs have historically provided respiratory care beyond respiratory care services. To address these concerns, on January 12, 2026, the OAL approved an emergency amendment that clarified that the LVNs performing respiratory care services identified by the Board while working in the specified home and community based exempt settings are not engaging in respiratory care.

The Board continued to receive questions from stakeholders specifically related to how its regulatory definition of basic respiratory services impacts suctioning-related tasks involving oral, nasal and tracheostomy-related care. According to the Board, the questions generally related to tasks that were typically viewed as basic nursing or caregiving functions and were not intended to be regulated as respiratory care services by Board. To address this concern, on January 23, 2026, the Board held a Professional Qualifications Committee (PQC) meeting to discuss stakeholder feedback, examine how certain suctioning tasks are described and categorized under CCR, Title 16, §1399.365 and consider whether additional clarification is necessary. As discussed during the PQC meeting, the Board's regulatory concerns were focused on suctioning that involves entry into the airway and carries associated respiratory risks, such as bronchospasm, hypoxemia, mucosal trauma, or hemodynamic instability. The Board states that the regulation was structured to address suctioning procedures that rise to the level of respiratory care because they involve airway entry and require clinical respiratory assessment.

Specifically, §1399.365 (c)(5) identifies nasal suctioning as a task that is not considered a basic respiratory task. In practice, nasal suctioning ranges from very superficial suctioning of the nostril openings or upper nasal cavity to deeper suctioning that approaches the pharynx including the nasopharynx. The PQC has determined that superficial nasal suctioning, within the nasal cavity only, is commonly treated as a basic nursing or caregiver task and does not involve airway entry, and therefore, does not rise to the level of requiring a clinical respiratory assessment. Nasal suctioning becomes a respiratory task when it enters the pharynx or airway therefore requiring a clinical respiratory assessment.

Additionally, §1399.365 (c)(7) identifies tracheal suctioning as a task that is not considered a basic respiratory task. Stakeholders have requested clarification regarding how this provision applies in clinical settings involving patients with tracheotomies and questioned whether suctioning that remains confined to the interior of a tracheostomy tube, where the depth is fixed and the suction catheter does not extend beyond the distal end of the tube, should be treated differently from suctioning that enters the patient's airway beyond the tube. The PQC has determined that suctioning that remains confined to the interior of the tracheostomy tube and does not pass beyond the distal end of the tube is commonly treated as a basic nursing or caregiver task and does not involve airway entry, and therefore, does not rise to the level of requiring a clinical respiratory assessment.

The regulation does not address oral suctioning. Currently, oral suctioning is permissible when it is limited to the visible oral cavity and does not enter the airway or the oropharynx. The PQC acknowledged that stakeholders often request clarification regarding how suctioning beyond the visible oral cavity should be treated for purposes of identifying basic respiratory tasks. For clarification purposes, the PQC has determined that oral suctioning becomes a respiratory task when it enters beyond the oral cavity into the oropharynx or airway therefore requiring a clinical respiratory assessment.

The Board states that any clarification discussed by the PQC is intended to limit airway-entry suctioning and clinical respiratory assessment to appropriately licensed professionals. The Board reports that the PQC will provide an update to the Board at its next scheduled board meeting that will include a summary of the committee's discussion and any recommended next steps, including whether to pursue rulemaking to address potential amendments to the regulation. The Board has updated the Frequently Asked Questions on the Board's website to reflect the guidance provided by the PQC establishing when nasal, oral and tracheostomy suctioning tasks rise to the level of requiring a clinical respiratory assessment. The Board has also provided updated guidance on suctioning activities to the BVNPT and other relevant stakeholders.

At the March 2025, Board meeting initial conceptual regulatory language was presented for three proposed sections to CCR Title 16, §§§1399.361, 1399.362 and 1399.363, implementing the statutory framework created by SB 1451. The Board was provided with detailed feedback from board members and stakeholders to help refine the draft language. The clarified task lists aligned the terminology with national respiratory care standards, and separated the rulemaking package into three coordinated components:

- 1399.361 - Define the scope of respiratory care tasks and services LVNs may perform in home health and community-based settings.

- 1399.362 - Establish training guidelines (to be developed in collaboration with the BVNPT) including certification requirements, for LVNs practicing under the new exemptions
- 1399.363 - Set forth guidelines for Demonstrated Limited-Competency Certification issued by the California Society for Respiratory Care, California Association of Medical Suppliers or another organization identified by the Board.

This framework was designed to ensure that any expansion of LVN performance of respiratory care is coupled with consistent training, supervision, and competency safeguards as required per statute. At the November 2025, board meeting the regulatory language clarifying the scope of respiratory tasks that LVNs may perform in exempt settings was approved. The rulemaking process is anticipated to be completed by January 2027. The Board reports that board staff have initiated coordination with training providers and will continue working closely with the BVNPT and other stakeholders to refine the regulatory language establishing corresponding training standards. The final regulatory package is expected to be completed and adopted by or prior to the existing January 1, 2028, implementation date, barring any unforeseen obstacles.

In addition to health-related settings, school nurses and school districts have also sought clarification to ensure that the longstanding practice of students who rely on the support services of a LVN while they are at school continue. Last year, SB 389 (Ochoa-Bogh, Chapter 582, Statutes of 2025) clarified the limited circumstances under which a LVN can perform specified basic respiratory tasks and services like suctioning for a student in a school under the supervision of a credentialed school nurse. Now, the Education Code (§49423.5) specifically allows students with exceptional needs who require specialized physical health care services during the regular school day to be assisted, for basic respiratory services, by a LVN under the supervision of a credentialed school nurse. Specialized physical health care services include catheterization, gastric tube feeding, suctioning, or other services that require medically related training.
One school district has weighed in requesting to statutorily authorize other non-LVN school personnel to be able to provide the basic respiratory services and tasks that LVNs can provide under school nurse supervision, however it is unclear how patients and the public would be protected by this new authority. Currently, qualified designated school personnel are not authorized to provide services beyond those that are routine for the student, services that pose little potential harm for the student, services that are performed with predictable outcomes as defined in the individualized education program of the student, and services that do not require a nursing assessment, interpretation, or decision making by the designated school personnel. (Education Code §49423.5)

It would be helpful for the Committees to understand whether additional changes to the Act are necessary to ensure continuity of safe patient care. It would be helpful for the Committees to understand if the definition of basic respiratory services should be codified in the Act or how the Act can support facility and licensee compliance while promoting patient safety and well-being.

Staff Recommendation: The Board should update the Committees on outstanding issues and whether additional statutory changes need to be made to reflect the robust and ongoing public stakeholder discussions that have taken place in the past two years.

Board Response: The work the Board has undertaken regarding the unauthorized practice of respiratory care by LVNs has been guided by a single principle: protecting respiratory patients.

Respiratory care often involves medically fragile individuals who rely on oxygen therapy, ventilatory support, and other life-sustaining treatments. These services require clinical assessment, ongoing monitoring, and the ability to respond rapidly to changes in a patient's condition. Ensuring that these responsibilities remain with appropriately trained and licensed professionals is a critical component of consumer protection.

In this context, respiratory care education and training for licensed RCPs and LVNs differ significantly in both scope and depth. RCP programs are specifically designed to prepare practitioners to assess, treat, and manage cardiopulmonary conditions, including advanced airway management, mechanical ventilation,

and interpretation of diagnostic data. These programs include extensive didactic instruction in respiratory physiology, pathophysiology, pharmacology, and evidence-based practice, as well as substantial clinical training dedicated to respiratory care across a range of patient populations and acuity levels.

By comparison, LVN programs are not designed to provide comprehensive training in respiratory care and include only limited respiratory-related content. A review of California programs confirms that respiratory instruction within LVN programs is minimal and not comparable in scope to respiratory care programs.

For example, at Butte College, the LVN program includes a single 3-unit course covering cardiovascular and respiratory nursing, which introduces the nursing process related to adult clients with respiratory and cardiovascular disorders and provides a general overview of pathophysiology and medical treatment. In contrast, the respiratory care program consists of a full sequence of dedicated coursework, including instruction in cardiopulmonary anatomy and physiology, blood gas analysis, ventilatory dynamics, respiratory pharmacology, and mechanical ventilation, along with extensive laboratory and clinical training focused exclusively on respiratory care.

At Hartnell College, the LVN program totals approximately 67 units and is structured around general nursing theory and clinical practice across multiple body systems and patient populations. By comparison, the respiratory care program requires approximately 89 units and includes specialized coursework such as cardiopulmonary anatomy and physiology, respiratory therapeutics, diagnostic studies, pharmacology, and supervised clinical experience specifically focused on respiratory care.

Similarly, at Gurnick Academy of Medical Arts, LVN students receive instruction in general nursing topics, including basic physiology, pharmacology, and limited respiratory-related skills such as oxygenation within broader coursework. In contrast, the respiratory therapy program includes a dedicated sequence of courses focused entirely on respiratory care, including airway management, aerosol therapy, arterial blood gas analysis, patient assessment, mechanical ventilation, and clinical practicum experience in hospital settings.

These differences are not simply a matter of total units, but of specialization. LVN programs introduce respiratory concepts within a broader nursing framework, while respiratory care programs provide in-depth, focused education and clinical training dedicated to cardiopulmonary assessment, treatment, and management. As a result, LVN training does not include the level of focused education, clinical training, or competency validation required to independently assess, manage, or make clinical decisions regarding respiratory care.

At the same time, the Board recognized that in practice, certain limited respiratory-related tasks were occurring and that there was significant confusion regarding what activities constitute the practice of respiratory care. The Board's efforts have therefore focused on establishing clear guardrails so that providers, employers, and regulators understand what tasks require a licensed RCP and what limited activities may be performed by LVNs under narrowly defined circumstances.

This framework is particularly important across care settings. In home and community-based settings, patients often choose to remain in their homes to maintain independence and participate in daily activities. The statutory framework appropriately recognizes this reality by allowing limited, well-defined exemptions supported by training and competency safeguards.

By contrast, patients receiving care in licensed health care facilities—such as skilled nursing or subacute settings—are in environments specifically designed to provide a higher level of clinical oversight. In those settings, there is a reasonable expectation that respiratory care services will be delivered by licensed professionals with the training and expertise to perform clinical assessments and manage complex respiratory conditions.

Through prior legislation and rulemaking, including SB 1436 (2022), SB 1451 (2024), and the Board's adoption of CCR § 1399.365, significant progress has been made in clarifying the boundaries of LVN involvement in respiratory-related tasks. However, despite these efforts, confusion persists among stakeholders, in part due to inconsistent interpretation and application across settings.

Accordingly, the Board believes that targeted statutory refinements are still necessary to improve clarity, support compliance, and ensure consistent application of the law while maintaining patient safety.

To address remaining gaps identified through stakeholder engagement, the Board is proposing limited amendments that would:

Streamline and consolidate existing exempt settings into a clearer, more cohesive structure;
Align training and competency requirements across all exempt settings; and
Add a limited number of additional home and community-based settings where similar patient care circumstances exist.

These refinements are based on feedback the Board has received during implementation of recent legislation and ongoing stakeholder discussions. Some of the changes are intended to clarify or better align existing facility categories so the law is applied consistently. Others reflect care settings where similar services are already being provided but were not previously included in statute.

Amendments to existing exempt settings:

- Removing the six beds or fewer requirement for congregate living health facilities licensed by the State Department of Public Health, and small family homes licensed by the State Department of Social Services.
- Amending the six beds or fewer requirement for intermediate care facilities licensed by the State Department of Public Health to 15 beds or fewer.

Addition of the following exempt settings:

- As an employee of a hospice agency or hospice facility licensed by the State Department of Public Health.
- At a residential care facility for persons with special health needs or at a residential care facility for the chronically ill licensed by the State Department of Social Services.
- At a group home for children with special health care needs licensed by the State Department of Social Services.
- At a medical foster home for veterans approved by the United States Department of Veterans Affairs.
- At an adult residential facility licensed by the State Department of Social Services.
- At a group home licensed by the State Department of Social Services.
- At an enhanced behavioral supports home licensed by the State Department of Social Services.
- At a community crisis home licensed by the State Department of Social Services.
- At a residential care facility for the elderly licensed by the State Department of Social Services.
- At an adult day program licensed by the State Department of Social Services.
- At a therapeutic day services facility licensed by the State Department of Social Services.
- As part of services provided through a Family Home Agency, as defined in Section 4689.1 of the Welfare and Institutions Code.
- As part of Supported Living Services provided pursuant to Section 4689 of the Welfare and Institutions Code.

The Board respectfully requests that the Committees consider the following amendments to BPC § 3765 (i) and (j):

(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~~ provider in the settings listed in paragraph (3), of respiratory tasks and services identified by the board, if the licensed vocational nurse complies with the following:

(1) Before January 1, ~~2028~~ 2029, the licensed vocational nurse has completed patient-specific training satisfactory to their employer and prior to the provision of patient care.

(2) On or after January 1, ~~2028~~ 2029, the licensed vocational nurse has completed ~~patient-specific training by the employer~~ both of the following, 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.

~~(j) The performance of respiratory care services identified by the board by a licensed vocational nurse who satisfies the requirements in paragraph (1) in the settings listed in paragraph (2).~~

~~(1)~~ (A) ~~The licensed vocational nurse is licensed pursuant to Chapter 6.5 (commencing with Section 2840).~~ Task-specific training on each respiratory task or service the licensed vocational nurse will perform. This training may be provided by the employer directly or through the California Association of Medical Product Suppliers (CAMPS), the California Society for Respiratory Care (CSRC), or another organization identified by the board.

(B) ~~The licensed vocational nurse has completed p~~Patient-specific training ~~satisfactory to their~~ provided by the employer.

~~(C) The licensed vocational nurse holds a 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.~~

(~~2~~ 3) A licensed vocational nurse may perform the respiratory care services identified by the board pursuant to this subdivision in the following settings:

(A) At a congregate living health facility, intermediate care facility designated as 15 beds or fewer, adult day health care center, pediatric day health and respite care facility, hospice agency, hospice facility, or home health agency, licensed by the State Department of Public Health ~~that is designated as six beds or fewer~~.

(B) ~~At an intermediate care facility licensed by the State Department of Public Health that is designated as six beds or fewer.~~

~~(C) At an adult day health care center licensed by the State Department of Public Health.~~

~~(D) As an employee of a home health agency licensed by the State Department of Public Health or an individual nurse provider working in a residential home.~~

~~(E) At a pediatric day health and respite care facility licensed by the State Department of Public Health.~~

~~(F)~~ At a small family home, adult residential facility, adult residential facility for persons with special health care needs, group home, group home for children with special health care needs, enhanced behavioral supports home, community crisis home, residential care facility for the elderly, residential care facility for the chronically ill, adult day program, or therapeutic day services facility, licensed by the State Department of Social Services ~~that is designated as six beds or fewer~~.

(C) At a medical foster home approved by the United States Department of Veterans Affairs.

(~~G~~ D) As a private duty nurse as part of daily transportation and activities outside a patient's residence or family respite for home- and community-based patients.

(E) As an individual nurse provider working in a residential home.

(F) As part of services provided through a Family Home Agency, as defined in Section 4689.1 of the Welfare and Institutions Code.

(G) As part of Supported Living Services provided pursuant to Section 4689 of the Welfare and Institutions Code.

~~(3) This subdivision is operative on January 1, 2028.~~

(4) “Employer,” for purposes of this section, means any person, agency, facility, organization, or entity responsible for assigning, directing, or coordinating the care provided by the licensed vocational nurse, including, where applicable, a family member or legal guardian authorized under the patient’s plan of care to perform that function.

~~(k) The performance of pulmonary function testing by persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.~~

(~~l~~j) The performance of suctioning and other basic respiratory tasks and services by a vocational nurse licensed by the Board of Vocational Nursing and Psychiatric Technicians of the State of California under the supervision of a credentialed school nurse in accordance with Sections 49423.5 and 49426.5 of the Education Code.

These proposed refinements are intended to maintain the existing statutory structure while improving clarity, consistency, and compliance across settings where respiratory-related tasks are performed.

The Board looks forward to working with the Committees to refine these statutory changes and ensure that the framework continues to support both patient safety and access to care.

The Board is also aware of SB 1226 (Ochoa Bogh, 2025–2026), which proposes changes to the provision of basic respiratory services in school settings, including modifying the current role of licensed vocational nurses and authorizing certain qualified individuals to perform specified respiratory-related tasks. While this issue is distinct, it raises similar considerations related to scope of practice, training, and patient safety.

The Board is committed to continue working collaboratively with stakeholders and the Committees to help identify a balanced approach that meets student needs while maintaining appropriate safeguards.

ISSUE #8: (ENFORCEMENT) Formal disciplinary action for even egregious violations of the law takes a very long time. Should the Board be granted authority to authorize automatic suspension and license revocation for specified felony convictions?

Background: The Board currently has disciplinary authority in statute pursuant to BPC §§ 3750 – 3755. This disciplinary authority allows the Board to establish general grounds for suspensions, revocation or probation of a license for unprofessional conduct, guilty pleas, guilty verdicts or no contest pleas that result in a conviction, crimes involving bodily injury or attempted bodily injury, sexual misconduct or attempted sexual misconduct whether with or without a patient and to establish mandatory license revocation for sexual misconduct with patients or certain offenses.

According to the Board, the current process of pursuing disciplinary action against RCPs requires case by case adjudication, even in the most serious cases. These lengthy administrative steps include filing an accusation, initiating an investigation, holding a hearing, awaiting a proposed decision and the Board’s final action. As a result, licensees convicted of serious or violent felony offenses may continue to practice while their administrative case proceeds. The most egregious cases require formal discipline action are referred to the Office of the Attorney General (OAG) and while the Board may seek suspension during the criminal proceedings through the Penal Code § 23 process, that authority ends when the case concludes. Once the conviction is final, the Board must pursue a separate interim suspension, which requires additional time and procedural steps.

The Board reports that their overall goal for all cases to be completed from the date the complaint is filed to final adjudication is 540 days or 18 months. In FY 2021-22 through FY 2024-25, the Board notes the adjudication process for cases was completed in an average of 444 days well under its target processing goals. The only exception is for cases that are referred to the OAG and are out of the Board’s control. The Board acknowledges that the OAG has made significant progress in reducing processing times and is largely

responsible for the marked improvements enabling the Board to largely meet its target goals over the last four years. As noted in the Board's 2026 Sunset Review report, 76% of cases in which formal discipline of a license or denial of an application pursued through the OAG were closed in one year.

As previously stated, licensees may still practice during the administrative process, putting vulnerable patients at risk. Allowing licensees convicted of serious felony offenses to continue practicing during extended administrative proceedings undermines public trust and jeopardizes patient safety.

To bridge this gap in enforcement, the Board is recommending a legislative proposal modeled after the Medical Board of California statue which would authorize automatic license suspension upon felony conviction for specified offenses and automatic license revocation for licensees convicted of specified felony offenses involving sexual misconduct or serious violence. The Board states this proposal balances protecting patients with an enforceable mechanism while maintaining due process for licensees through limited hearings on procedural issues.

Staff Recommendation: The Committees may wish to amend the disciplinary authority in the Act to ensure that specified felony offenses are swiftly adjudicated.

Board Response: The Board agrees that additional statutory authority is warranted to allow for timely action in cases involving the most egregious criminal conduct.

As outlined, the current enforcement process requires full administrative adjudication before final discipline can be imposed, even after a qualifying felony conviction. In practice, this creates a delay between conviction and Board action during which a licensee may potentially continue to practice. Existing tools, such as interim suspension orders and Penal Code § 23 suspensions, are limited and do not fully address this gap once a conviction has been entered and becomes final.

Since its last Sunset Review, the Board has handled four cases involving convictions for serious and violent felony offenses, including possession of child pornography, murder of a minor, rape of a minor, and possession of a controlled substance for sale while armed with a loaded firearm. In each of these cases, the outcome ultimately resulted in revocation or surrender of the license. However, the Board was required to pursue full administrative discipline in every instance. The Office of the Attorney General costs for these four cases exceeded $40,000, not including the costs associated with pursuing the initial Penal Code § 23 suspension process, which are not recoverable.

The Board currently has two additional cases which it must now initiate the full disciplinary process despite the finality of the egregious convictions. Under the proposed statutory authority, the Board would be able to act immediately to revoke these licenses.

While the Board is grateful that the number of these cases is low, the nature of the underlying conduct is exceptionally serious. These are not borderline or technical violations, they involve conduct that presents a clear and immediate risk to public safety. The current process requires significant time and resources to reach outcomes that are ultimately consistent across cases: revocation or surrender.

To address this issue, the Board is proposing a targeted statutory amendment modeled after Business and Professions Code § 2232.5 (Medical Board). The proposal is limited to specified felony convictions involving serious misconduct, such as sexual offenses or acts of violence, where the underlying conduct is directly relevant to public protection.

The proposal would authorize automatic suspension upon conviction, followed by automatic revocation once the conviction becomes final. It is not intended to apply broadly, but rather to a defined set of offenses where the conviction itself establishes a clear risk to patient safety.

The Board's intent is to close a narrow but significant timing gap while maintaining appropriate due process. Any hearing would be limited to confirming that the statutory criteria for automatic action have been met.

The Board respectfully requests that the Committees consider adding BPC § 3752.8 as follows:

(a) The board shall suspend a license under the following conditions:

(1) Notwithstanding any other provision of this chapter, the board or its designee shall automatically suspend a license following a conviction of a felony by a licensee, where the conviction involves a violation of one or more of the statutes identified in subdivision (b), whether in course of the licensee's practice as a respiratory care practitioner or otherwise.

(2) The suspension shall remain in effect until the time for appeal has elapsed, if no appeal has been taken, or until the judgment of conviction has been affirmed on appeal, or has otherwise become final, and until further order of the board.

(3) The board or its designee may decline to impose or may set aside the suspension when it appears to be in the best interest of justice to do so, with due regard being given to maintaining the integrity of, and confidence in, the profession.

(b) The offenses subject to this section include the following:

(1) A violation of Section 726.

(2) An offense described in subdivisions (c) or (d) of Section 290 of the Penal Code.

(3) A serious felony, as defined in Section 1192.7 of the Penal Code.

(c) The board shall revoke a license under the following conditions:

(1) Following the conviction of a felony as described in subdivision (b), the board or its designee shall automatically revoke a license at such time as the time for appeal has elapsed with no appeal having been taken, or the judgment of conviction has been affirmed on appeal, or the judgment of conviction has otherwise become final.

(2) If the related conviction of the licensee is overturned on appeal, no revocation order shall be issued as to that conviction, and any suspension order issued pursuant to the above shall be rescinded, unless any such order is based on a stipulated settlement. Nothing in this subdivision shall prohibit the board from pursuing disciplinary action based on any cause other than the overturned conviction, including, but not limited to, the underlying conduct alleged in the criminal case.

(d) A licensee subject to suspension or revocation under this section may request a hearing as follows:

(1) The licensee may request a hearing within 30 days of the automatic suspension order described in subdivision (a) and the automatic revocation order described in subdivision (c). The proceeding shall be conducted in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

(2) The Legislature finds and declares that the conviction of any felony identified in subdivision (b) is substantially related to the qualifications, functions, or duties of a respiratory care practitioner. An administrative law judge shall not permit or give any weight to expert testimony regarding whether the conviction is substantially related to the practice of respiratory care. The only purpose of an administrative hearing shall be to determine whether the discipline imposed shall be a suspension, revocation, or other action under the circumstances of the case.

(e) Nothing in this section shall limit the board's authority to pursue disciplinary action under any other provision of this chapter, including, but not limited to, Sections 3750, 3750.5, and 3755, based on conduct or violations separate from the conviction addressed in this section.

This approach aligns the Board with other healing arts boards and ensures the Board can act without unnecessary delay in cases where patient safety is clearly at risk. The Board looks forward to working with the Committees to further refine the scope of qualifying offenses and statutory language.

ISSUE #9: (BACKGROUND CHECKS) The Federal Bureau of Investigation is working to implement a "rap back" service which would provide enhanced background check services to licensing boards. Are statutory updates necessary?

Background: The Federal Bureau of Investigation (FBI) is working to implement federal "rap back" service for federal criminal history information relating to California license applicants and licenses. The service is the federal equivalent of the California Department of Justice's subsequent arrest and disposition notification for applicants and licensees. To enroll in that federal service, state fingerprinting authorization statutes must meet specific federal criteria per Public Law 92-544 and FBI guidance: The statute must exist as a result of a legislative enactment; It must require the fingerprinting of applicants who are to be subjected to a national criminal history background check; It must, expressly or by implication, authorize the use of FBI records for the screening of applicants; It must identify the specific category of licensees falling within its purview, thereby avoiding overbreadth; It must not be against public policy; and it may not authorize the receipt of criminal history record information by a private entity.

Through SB 160 (Committee on Budget and Fiscal Review), Chapter 113, Statutes of 2025, the Legislature made the necessary statutory changes for the Medical Board of California, Osteopathic Medical Board of California, Board of Psychology, Board of Behavioral Sciences, and other DCA programs to meet these criteria. The Board is requesting statutory authority to participate in this service ensuring that existing fingerprint authorization statutes meet specific federal criteria.

Through indirect notification, the Board learned of several incidents throughout the years that involved licensees and serious criminal activity and arrests that occurred in other states. These cases highlighted the serious risks that are associated when the Board is not formally informed of serious criminal activity that involves their licensees. Without a formal federal notification process in place, the Board is unaware of any licensee's criminal activity and unable to take immediate action to prevent individuals from continuing to provide care to vulnerable patients. Updating the statutes, to align with federal requirements, will enable the Board to receive timely and reliable federal criminal history information allowing them to take the necessary steps to protect the public.

Staff Recommendation: The Board should continue to collaborate with the Committees during the upcoming sunset review cycle on a bill that will grant the RCB explicit statutory authorization to utilize FBI background check services.

Board Response: The Board agrees that statutory updates are necessary to authorize participation in the Federal Bureau of Investigation's "rap back" service.

The Board's current background check framework relies primarily on California Department of Justice subsequent arrest notifications. While effective within California, this system does not capture criminal activity occurring outside the state. As a result, the Board may not receive timely notice of serious out-of-state arrests or convictions involving licensees.

Participation in the FBI's rap back service would address this gap by providing timely, nationwide notification of criminal activity involving licensees. This is particularly important given the mobility of the healthcare workforce and the nature of respiratory care practice, which often involves vulnerable patient populations.

The Board notes that other DCA healing arts boards have already received statutory authority to participate in this service. Aligning the Respiratory Care Practice Act with those existing frameworks promotes consistency across boards and ensures that respiratory care practitioners are subject to comparable oversight.
To meet federal requirements under Public Law 92-544 and enable participation in the rap back service, the Board supports a narrowly tailored statutory amendment to expressly authorize the use of federal criminal history information.

The Board respectfully requests that the Committees consider adding BPC § 3733, as follows:

(a) The Board shall require an applicant for a respiratory care practitioner license, as defined in Business and Professions Code sections 3730, to undergo a fingerprint-based state and national criminal history background check, pursuant to Section 144.

(b) The Board shall submit to the Department of Justice fingerprint images and related information for individuals specified in subdivision (a) who are subject to a state and national criminal history background check, pursuant to subdivision (u) of Section 11105 of the Penal Code. The Department of Justice shall provide a state and federal level response pursuant to subdivision (p) of Section 11105 of the Penal Code.

This proposal is intended to align the Board with federal requirements, ensuring the Board receives timely and reliable criminal history information necessary to protect the public.

The Board is committed to working with the Committees during the sunset review process to finalize appropriate statutory language and implement this authority.

TECHNICAL CHANGES

ISSUE #10: (TECHNICAL CHANGES MAY IMPROVE EFFECTIVENESS OF THE ACT AND BOARD OPERATIONS.) There are amendments to the Respiratory Care Practice Act that are technical in nature but may improve Board operations and the enforcement of the Act.

Background: There are instances in the Respiratory Care Act where technical clarifications may improve Board operations and application of the statutes governing the Board's work.

Staff Recommendation: The Committees may wish to amend the Act to include technical clarifications.

Board Response: The Board is unaware of any technical changes proposed, but is pleased to work with the Committees' in this endeavor.

CONTINUED REGULATION OF RESPIRATORY CARE THERAPISTS BY THE RESPIRATORY CARE BOARD OF CALIFORNIA

ISSUE # 11 (CONTINUED REGULATION BY RESPIRATORY CARE BOARD OF CALIFORNIA.) Should the licensing and regulation of RCPs be continued and be regulated by the current Board membership?

Background: Patients and the public are best protected by strong regulatory boards with oversight of licensed professions. The Board has shown a strong commitment toward efficiency and effectiveness, responding to practice and operational issues in a proactive, forward-thinking manner.

Staff Recommendation: The licensing and regulation of respiratory care practitioners by the Respiratory Care Board of California should be reviewed again on a future date to be determined.

Board Response: The Board's highest priority is consumer protection, which it advances through effective application review, timely and thorough investigations, and the consistent, meaningful enforcement of the law. The RCB is also committed to delivering efficient, responsive service and upholding high standards of customer service within state government.

The Board extends its sincere appreciation to the Senate Committee on Business, Professions and Economic Development and the Assembly Committee on Business and Professions, as well as their staff, for their thorough review of the Board and for identifying recommendations that support enhanced efficiency and strengthen consumer protection.