Item: 2025-2026 Sunset Report Review and Approval

Item Summary: Every four-five years, the Assembly Business and Professions Committee and the Senate Business, Professions, and Economic Development Committee hold joint sunset review oversight hearings to review the Board. The sunset review process provides an opportunity for the DCA, the Legislature, the Board, and interested parties and stakeholders to discuss the performance of the Board, and make recommendations for improvements.

Attached is a draft of the Board's 2025-2026 Sunset Review Report for your review and consideration.

Board Action:

1. President calls the agenda item and it is presented by or as directed by the President
2. If the Board is willing, make a motion to:
   - Approve the 2025-26 Sunset Report, as is (with updates) or edits; or
   - A motion to allow the Executive Committee to render final approval of the 2025-26 Sunset Report with edits.

   [Alternately, the Board may suggest to hold an additional meeting in November solely for the purpose of approving the Sunset Report.]
3. President may request if there is a second to the motion, if not already made.
4. Board member discussion/edits (if applicable).
5. Inquire for public comment / further Board discussion as applicable.
6. Repeat motion and vote: 1) aye, in favor, 2) no, not in favor, or 3) abstain

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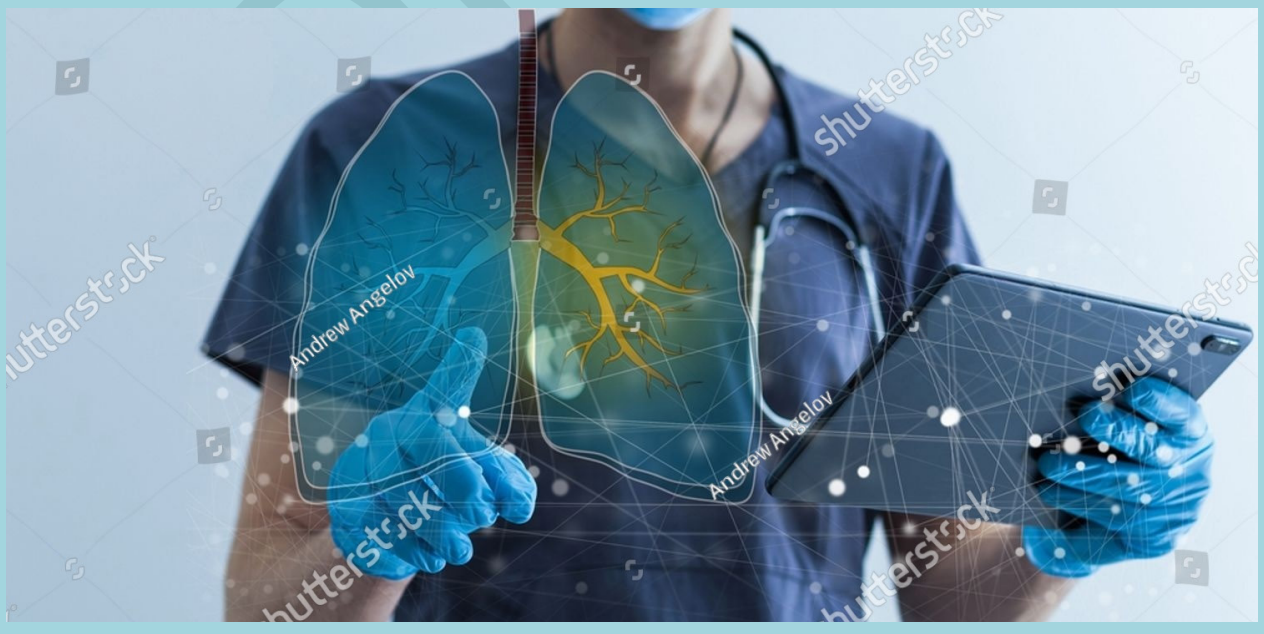

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Acronyms and Abbreviations

AARC	American Association for Respiratory Care
ADA	Americans with Disabilities Act
ALJ	Administrative Law Judge
APA	Administrative Procedure Act
B&PC	Business and Professions Code
CCR	California Code of Regulations
CDPH	California Department of Public Health
CE	Continuing Education
C&F	Cite and Fine
CoARC	Commission on Accreditation for Respiratory Care
CRT	Certified Respiratory Therapist
CSRC	California Society for Respiratory Care
DAG	Deputy Attorney General
DCA	Department of Consumer Affairs
DOJ	Department of Justice
NBRC	National Board for Respiratory Care
OAG	Office of the Attorney General
OAH	Office of Administrative Hearings
Board	Respiratory Care Board of California
RCP	Respiratory Care Practitioner
RCPA	Respiratory Care Practice Act
RRT	Registered Respiratory Therapist
SOI	Statement of Issues

Section 1
Background and Description of the Respiratory Care Board and Respiratory Care Practitioners

BACKGROUND AND DESCRIPTION OF THE RESPIRATORY CARE BOARD

The enabling statute to license Respiratory Care Practitioners (RCPs) was signed into law 43 years ago in 1982, thus establishing the Respiratory Care Examining Committee. In 1994, the name was changed to the Respiratory Care Board of California (Board).

The Board was the eighth “allied health” profession created within the jurisdiction of the Medical Board of California (MBC). Although created within the jurisdiction of the MBC, the Board had sole responsibility for the enforcement and administration of the Respiratory Care Practice Act (RCPA). At the time the Board was established, the MBC had a Division of Allied Health Professions (DAHP) designated to oversee several allied health committees. It was believed that this additional layer of oversight (in addition to the Department of Consumer Affairs [DCA]) was unnecessary and ineffective. Therefore, the DAHP subsequently dissolved on July 1, 1994.

The Board is comprised of a total of nine members, including four public members, four RCP members, and one physician and surgeon member. Each appointing authority— the governor, the Senate Rules Committee, and the speaker of the Assembly— appoints three members. This current framework helps prevent quorum issues and provides a balanced representation needed to effectuate the Board's mandate to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care (Business and Professions Code [B&PC] § 3701).

The Board is further mandated to ensure that protection of the public shall be the highest priority in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount (B&PC § 3710.1).

The Board's mission is to protect and serve consumers by licensing qualified respiratory care practitioners, enforcing the provisions of the RCPA, expanding the availability of respiratory care services, increasing public awareness of the profession, and supporting the development and education of RCPs.

The Board’s vision is that all California consumers are aware of the respiratory care profession and its licensing Board, and receive competent and qualified respiratory care.

In carrying out its mandate, the Board:

- Screens each application for licensure to ensure minimum education and competency standards are met and conducts a thorough background check on each applicant.
- Investigates complaints against licensees primarily as a result of updated criminal history reports (subsequent rap sheets) and mandatory reporting (licensees and employers are required to report violations).
- Aggressively monitors RCPs placed on probation.
- Exercises its authority to penalize or discipline applicants and licensees which may include: 1) issuing a citation and fine; 2) issuing a public reprimand; 3) placing the license on probation (which may include suspension); 4) denying an application for licensure; or 5) revoking a license.
- Addresses current issues related to the unlicensed and/or unqualified practice of respiratory care.
- Promotes public awareness of its mandate and function, as well as current issues affecting patient care.

The Board continually strives to enforce its mandate and mission in the most efficient manner, by exploring new and/or revising existing policies, programs, and processes. The Board also strives to increase the quality or availability of services, as well as regularly provide courteous and competent services to its stakeholders.

The Board regulates and issues licenses solely for RCPs. The RCPA is comprised of B&PC section 3700 et seq., and California Code of Regulations (CCR), title 16, division 13.6, article 1 et seq.

BACKGROUND AND DESCRIPTION OF RESPIRATORY CARE PRACTITIONERS

RCPs are one of three licensed healthcare professionals typically found at patients' bedsides, alongside physicians and nurses. RCPs work under the direction of a medical director and specialize in providing evaluation of, and treatment to, patients with breathing difficulties as a result of heart, lung, and other disorders, as well as providing diagnostic, educational, and rehabilitation services. RCPs are needed in virtually all health care settings.

On a daily basis, RCPs provide services to patients ranging from premature infants to older adults. RCPs provide treatments for patients who have breathing difficulties and care for those who are dependent upon life support and cannot breathe on their own. RCPs treat patients with acute and chronic diseases including chronic obstructive pulmonary disease (COPD), trauma victims, and surgery patients. RCPs most commonly work with patients affected by conditions such as:

Asthma	Bronchitis	Heart Attack
Cystic fibrosis	Emphysema	Stroke
Near-drowning	Lung cancer	Premature infants
Infants with birth defects	High-risk influenza	COVID-19

RCPs are key health care professionals that provide the needed treatments and services to these types of patients, as well as patients suffering from other ailments. RCPs are educated and trained in this very specialized area of medicine.

RCPs perform a number of diagnostic, treatment, and life support procedures, including:

- Employing life support mechanical ventilation for patients who cannot breathe adequately on their own.
- Administering medical gases and pharmacological agents for the purpose of inducing conscious or deep sedation.
- Administering extracorporeal life support (ECLS), including extracorporeal membrane oxygenation (ECMO).
- Inserting and maintaining arterial lines and umbilical arterial catheters (neonatal patients).
- Administering medications to help alleviate breathing problems and to help prevent respiratory infections.
- Monitoring equipment and assessing patient responses to therapy.
- Operating and maintaining various types of highly sophisticated equipment to administer oxygen or to assist with breathing.
- Obtaining blood specimens and analyzing them to determine levels of oxygen, carbon dioxide, and other gases.
- Maintaining a patient's artificial airway (i.e. tracheostomy or endotracheal tube).
- Performing diagnostic testing to determine the disease state of a patient's lungs and/or heart.

- Obtaining and analyzing sputum specimens.
- Analyzing chest X-rays.
- Interpreting data obtained from diagnostic tests.
- Assessing vital signs and other indicators of respiratory dysfunction.
- Performing stress tests and other studies of the cardiopulmonary system.
- Studying disorders of people with disruptive sleep patterns.
- Conducting rehabilitation activities.
- Conducting asthma education and smoking cessation programs.

Hospitals employ the majority of RCPs. However, there is a growing number of RCPs being employed in alternative facilities and locations. RCPs may be employed in any of these settings:

- Hospitals
- Emergency care departments
- Adult, pediatric, and neonatal intensive care units
- Critical care units
- Neonatal (infant) units
- Pediatric units
- Home care
- Subacute facilities
- Fixed-wing and helicopter critical care transport
- Critical ground transportation
- Physicians' offices
- Hyperbaric oxygen therapy facilities
- Pulmonary function, rehabilitation, cardiopulmonary, blood gas, and sleep laboratories

RESPIRATORY CARE BOARD MEMBERS

Ricardo Guzman, President

Ricardo Guzman, MA, RRT, RCP, serves as President of the Board, where he has been a professional member since his appointment by the Senate Pro Tempore in January 2019. He assumed the role of the Board's President on January 1, 2020. With more than four decades of experience in respiratory care, Mr. Guzman offers a unique perspective that combines hands-on clinical expertise with academic leadership. He is the Program Director and a professor for the Respiratory Care Program at Napa Valley College, and continues to provide bedside care as a practicing RCP in Napa County. His leadership reflects a strong commitment to consumer protection and ensuring safe, competent respiratory care across the state.

Raymond Hernandez, Vice President

Raymond Hernandez, MPH, RRT, NPS, FAARC, serves as Vice President of the Board and Chair of its Professional Qualifications Committee. He was appointed as a professional member by the Speaker of the Assembly in February 2020. A licensed RCP since 1986, Mr. Hernandez brings more than four decades of experience encompassing neonatal and pediatric care, academic leadership, and regulatory policy. From 1996 until 2020, he directed and taught in the Respiratory Care Program at Skyline College and later served as Dean of the Science, Math & Technology Division, continuing thereafter teaching and consulting for the respiratory and greater healthcare community. As Chair of the Professional Qualifications Committee, he has played a key role in guiding the Board's efforts to assess and enhance licensure standards to better protect patients and ensure the safe delivery of respiratory care services statewide.

Michael Terry, RCP Member

Michael Terry, BSRT, RCP, RRT, RPFT, CCRC, was appointed as a professional member of the Board by the Speaker of the Assembly in November 2020. With four decades of experience in pulmonary diagnostics, patient care, and clinical research, primarily through Loma Linda University Medical Center, he brings a wealth of expertise and leadership to the Board. Mr. Terry also contributes as adjunct faculty, mentoring new practitioners and engaging in scholarly research. As a member of the Professional Qualifications Committee, he has played an active role in evaluating respiratory care education requirements, including contributing to the 2024 statewide educational workforce survey. His work on the committee supports the Board’s mission to ensure that licensure standards remain aligned with public safety needs and the delivery of competent, high-quality care.

Abbie Rosenberg, RCP Member

Abbie Rosenberg, CAE, RRT, RCP, was appointed to the Board by the Governor in June 2024, as a professional member and currently serves as Chair of the Enforcement Committee. A lifelong advocate for patient safety and professional accountability, Ms. Rosenberg brings more than four decades of experience to the Board. She has been an RCP with Sutter Maternity and Surgery Center in Santa Cruz since 2000 and is the owner of Abbie & Company LLC, a healthcare consulting business. From 2000 to 2011, she also worked as an RCP at the Palo Alto Medical Foundation. Ms. Rosenberg is a life member of the California Society for Respiratory Care and a member of the American Association for Respiratory Care. In her role on the Board, she provides leadership on enforcement policy and disciplinary review, helping ensure accountability and consumer protection in respiratory care practice.

Dr. Preeti Mehta, Physician Member

Preeti Mehta, MD, serves as a physician member of the Board appointed by the Senate Rules Committee in February 2023. She is a board-certified physician with more than two decades of clinical experience and currently serves as Chair of the Department of Medicine at Scripps Memorial Hospital in La Jolla. In addition to her clinical leadership, Dr. Mehta is the current President of the San Diego County Medical Society and has been involved in regional medical organizations and public health initiatives. Her combined experience in patient care, hospital governance, and professional advocacy brings valuable insight to the Board's work in consumer protection, policy development, and regulatory oversight.

Manuel Magpapian, Public Member

Manuel Magpapian serves as a public member of the Board and a member of the Board's Outreach Committee. He was appointed by the Speaker of the Assembly in February 2025. Mr. Magpapian is a Senior Trial Attorney with Allstate Insurance, where he specializes in personal injury and insurance-related litigation. He brings legal expertise and a strong focus on consumer protection perspective to the Board's regulatory and outreach efforts. Through his work on the Outreach Committee, he supports education initiatives such as the Board's newsletter, website enhancements, and presentations to external organizations, all aimed at improving public awareness of the Board's mission and activities.

Cheryl Williams, Public Member

Cheryl Williams serves as a public member of the Board. Originally appointed by the Governor in April 2021, Mrs. Williams brings a well-rounded background in public service, community engagement, and nonprofit leadership. Her career spans roles in government, healthcare outreach, and the private sector, including legislative advocacy, nonprofit management, and insurance consulting. This diverse experience informs her work on the Board, where she offers valuable insight into consumer needs, equity in access to care, and effective community outreach. A long-time San Diego resident, Mrs. Williams is also an active member of Delta Sigma Theta Sorority and the San Diego Delta Foundation.

Table 1a. Current Board Member Roster

MEMBER NAME	APPOINTED	RE-APPOINTED	TERM EXPIRES	APPOINTING AUTHORITY	TYPE
Guzman, Ricardo	01/09/2019	07/05/2022	06/01/2026	Senate	Professional
Hernandez, Raymond	02/06/2020	05/26/2022	06/01/2025	Assembly	Professional
Magpapian, Manuel	02/20/2025	n/a	06/01/2026	Assembly	Public
Mehta, Preeti	02/17/2023	n/a	06/01/2027	Senate	Physician
Rosenberg, Abbie	06/06/2024	n/a	06/01/2027	Governor	Professional
Terry, Michael	11/12/2020	07/24/2023	06/01/2028	Assembly	Professional
Williams, Cheryl	06/01/2021	05/22/2025	06/01/2028	Governor	Public
Vacant	n/a	n/a	06/01/2027	Governor	Public
Vacant	n/a	n/a	06/01/2029	Senate	Public

Note: Vice President Hernandez is currently serving in a 1-year holdover period.

RESPIRATORY CARE BOARD COMMITTEES

The Board has established committees to enhance the efficacy, efficiency, and prompt dispatch of duties upon the Board. These committees include:

Executive Committee

Members of the Executive Committee include the Board's president and vice president. As elected officers, this Committee makes interim (between Board meetings) decisions as necessary. This Committee is responsible for making recommendations to the Board with respect to legislation impacting the Board's mandate. This Committee also provides guidance to administrative staff for the budgeting and organizational components of the Board and is responsible for directing the fulfillment of recommendations made by legislative oversight committees.

President: Ricardo Guzman, MA, RRT, RCP
Vice President: Raymond Hernandez, MPH, RRT, NPS, FAARC

Enforcement Committee

Members of the Enforcement Committee are responsible for the development and review of the Board-adopted policies, positions, and disciplinary guidelines. Although members of the Enforcement Committee do not typically review individual enforcement cases (if they do, they recuse themselves from any further proceedings), they are responsible for policy development of the enforcement program, pursuant to the provisions of the Administrative Procedure Act.

Chair: Abbie Rosenberg, CAE, RRT, RCP
Member: Vacant

Outreach Committee

Members of the Outreach Committee are responsible for the development of consumer outreach projects, including the Board's newsletter, website, e-government initiatives, and outside organization presentations. These members act as goodwill ambassadors and represent the Board at the invitation of outside organizations and programs.

Chair: Ricardo Guzman, MA, RRT, RCP
Member: Manuel Magpapian, Esq.

Professional Qualifications Committee

Members of the Professional Qualifications Committee are responsible for the review and development of regulations regarding educational and professional ethics course requirements for initial licensure and continuing education (CE) programs. Essentially, they monitor various education criteria and requirements for licensure, taking into consideration new developments in technology, managed care, and current activity in the health care industry.

Chair: Raymond Hernandez, MPH, RRT, NPS, FAARC
Member: Michael Terry, BSRT, RCP, RRT, RPFT, CCRC

RESPIRATORY CARE BOARD MEETINGS AND MEMBER ATTENDANCE

The Board meets at least two times per year and as mandated by B&PC § 101.7, holds at least one meeting per calendar year each in Northern and Southern California. The Board has not had any issues with establishing a quorum over the last four years.

Table 1b. Respiratory Care Board Meetings and Member Attendance

	Initial Appointment Date	M.D. Physician; P-Public; RCP-Professional	Appointing Authority: Governor; Senate; Assembly	10/20/2021 - WebEx	11/23/2021 - WebEx	3/24/2022 - WebEx	6/9/2022 - Temecula	10/28/2022 - Sacramento	3/9/2023 - WebEx	6/22/2023 - Temecula	10/24/2023 - WebEx	3/28/2024 - Sacramento	10/14/2024 - Sacramento	2/26/2025 - WebEx	3/13/2025 - Temecula	6/6/2025 - Sacramento	10/24/2025 - Sacramento
CURRENT MEMBERS																	
Guzman, Ricardo	Jan -19	RCP	S	X	X	X	X	X	X	X	X	X	X	X	X	X	-
Hernandez, Raymond	Feb - 20	RCP	A	A	X	X	X	X	X	X	X	X	X	X	X	X	-
Magpapian, Manuel	Feb - 25	P	A	-	-	-	-	-	-	-	-	-	-	-	X	X	-
Mehta, Preeti	Feb - 23	MD	S	-	-	-	-	-	X	X	X	X	X	X	X	X	-
Rosenberg, Abbie	Jun - 24	RCP	G	-	-	-	-	-	-	-	-	-	X	X	X	X	-
Terry, Michael	Nov - 20	RCP	A	X	X	X	X	X	X	X	X	X	X	X	X	X	-
Williams, Cheryl	Jun - 21	P	G	X	X	X	X	A	X	X	X	A	X	X	X	X	-
PAST MEMBERS																	
Early, MaryEllen	Apr - 13	P	G	X	X	X	X	X	X	X	X	X	-	-	-	-	-
Goldstein, Mark	Jun - 12	RCP	G	X	X	X	A	X	X	X	X	X	-	-	-	-	-
Kbushyan, Sam	Mar - 17	P	S	X	X	X	X	X	X	A	X	A	A	X	A	-	-
Lewis, Ronald	Jun -13	MD	S	X	X	X	X	X	-	-	-	-	-	-	-	-	-

X - In Attendance
A - Absent
P - Partial Attendance

INTERNAL STRUCTURE AND OTHER SIGNIFICANT EVENTS/CHANGES

Staffing
Stephanie Nunez, the Board's longtime Executive Officer, retired in late 2024. Following her retirement, Assistant Executive Officer Christine Molina served as Interim Executive Officer beginning in December 2024 and was formally appointed as Executive Officer in February 2025. The Board currently employs 16 staff members, including the Executive Officer, 14 of whom were employed at the time of the Board's last Sunset Review.

Strategic Planning
In 2023, the Board undertook a comprehensive strategic planning process and adopted a four-year Strategic Plan focusing on three key areas: Administration, Licensing, and Enforcement. The next Strategic Plan will be developed after the conclusion of the 2025–26 Sunset Review to incorporate any resulting legislative recommendations.

Administrative Procedure Manual (attached)
In 2025, the Board updated its Administrative Procedure Manual established to assist new Board Members in familiarizing themselves with the Board, its mandate, and its overall processes and operations.

BEYOND THE ASSOCIATE DEGREE: RETHINKING RESPIRATORY CARE EDUCATION

The Board's Professional Qualifications Committee (PQC) was charged with evaluating whether California's current educational requirements for licensure continue to meet the demands of modern respiratory care. Acting under the Board's strategic direction, the PQC undertook a careful and sustained review of this question. Over the course of several years, the committee examined national trends in health-care education, reviewed data on patient safety and workforce readiness, and sought broad input from educators, practitioners, employers, and other key stakeholders. Its objective was to determine whether the associate degree presently required for licensure provides a sufficient foundation for today's increasingly complex clinical environment. After completing this thorough analysis, the committee concluded that raising the minimum educational standard to a bachelor's degree is both warranted and achievable, and it has formally recommended that the Board pursue this change.

The rationale for this recommendation reflects the goals and priorities articulated in the Board's strategic plans. From 2017 through 2021, the Board emphasized maintaining the ongoing competency of licensed RCPs and directed exploration of whether a bachelor's degree should become the new minimum requirement, including potential amendments to the RCPA. Building on that foundation, the 2023–2027 strategic plan reaffirmed the importance of reviewing and updating educational standards to strengthen patient safety, ensure consistency of preparation across training programs, and align the profession with contemporary clinical expectations. The PQC's work represents the natural continuation of these objectives, transforming long-standing strategic intent into a concrete, evidence-based proposal for elevating the educational threshold for licensure.

To inform its recommendation, the PQC conducted an extensive series of activities from 2021 through 2025. These included the Board's study sessions examining the evolution of respiratory care and educational structures; focus groups gathering input from educators, clinicians, employers, and policy stakeholders; and surveys aimed at capturing the perspectives of licensees and program directors across California. The data collected from these efforts provided key insights into the current gaps in education and the readiness of new graduates.

Findings indicated that respiratory care has become increasingly complex, incorporating advanced modalities such as extracorporeal membrane oxygenation (ECMO), conscious sedation, and mechanical ventilation management. These advances demand higher levels of clinical reasoning, decision-making, and communication than those traditionally covered within associate degree programs. The American Association for Respiratory Care (AARC) has identified 153 of 202 core competencies as essential prior to entering the profession, further demonstrating the inadequacy of existing associate-level curricula.

Stakeholder feedback overwhelmingly supported the transition to a bachelor's degree requirement. Employers, academic institutions, and professional organizations agreed that this shift would lead to improved patient outcomes, better integration of evidence-based medicine, and enhanced retention of RCPs within the profession.

While some concerns were raised about workforce impact and access, data showed that many associate programs already require over 90 credit units, approaching the workload of a bachelor's degree. This presents a feasible starting point for the transition. Survey data collected in 2024 revealed that 45% of licensees supported a bachelor's degree requirement by 2030, with many favoring a phased implementation. Respondents also emphasized the need for more clinical experience and structured orientation. A separate 2025 survey of program directors revealed wide variation in curriculum design (units, and laboratory and clinical experience hours), underscoring the need for statewide standards. Some programs had already reduced unit requirements due to institutional policies, highlighting the importance of protecting educational quality.

Additional support was documented through formal letters from the California Society for Respiratory Care's (CSRC's) Managers Association and Professional Advancement Committee, as well as the University of California Health Care Collaborative. These letters affirmed the necessity of raising educational standards and advocated for a phased approach that would not negatively impact current licensees.

Based on the extensive evidence gathered, the PQC presented, and the Board adopted, a recommendation to increase the minimum education for RCP licensure to a bachelor's degree. This change is expected to bolster public protection, align the profession with other allied health fields, and open the door for future classification and reimbursement changes under Medicare and Medicaid. The committee also recognized the importance of a strategic and equitable implementation process. Recommendations include a target implementation date of 2033, with continued stakeholder engagement to guide the transition.

"Stakeholder feedback overwhelmingly supported the transition to a bachelor's degree requirement. Employers, academic institutions, and professional organizations agreed that this shift would lead to improved patient outcomes, better integration of evidence-based medicine, and enhanced retention of RCPs within the profession."

The PQC believes this change is critical to meeting the demands of modern respiratory care and ensuring that California's respiratory workforce remains prepared, competent, and positioned for continued growth in an increasingly complex healthcare environment. As a means of maintaining transparency and keeping stakeholders informed, the PQC has established a dedicated webpage that functions as a centralized, continuously updated resource of its progress. The webpage provides access to committee presentations, research outcomes, stakeholder input, and opportunities for public engagement. All related research and data are available through this resource.

This issue will be addressed in greater detail in Section 10, New Issues, beginning on page 84.

LEGISLATIVE CHANGES AFFECTING THE BOARD SINCE 2021

(All sections are from the Business and Professions Code [B&PC] unless otherwise noted)

SB 1436 (Roth), Chapter 624, Statutes of 2022

- Sections 3710 and 3716 were amended to extend the Board's Sunset date to January 1, 2027.
- Section 3758 was amended to expand the definition of suspension or termination for cause to include any leave or resignation from employment for specified reasons that would additionally include suspected acts, and to require an owner, director, partner, or manager of a registry or agency that places one or more practitioners at any facility to practice respiratory care to report those specified suspected or actual acts to the Board.
- Section 3758.6 was amended to add "leave" and "resignation" to align with section 3758 as noted above.
- Section 3760.5 was added to require the Board to share all complaints and information related to investigations involving a person licensed under the Vocational Nursing Practice Act with the Board of Vocational Nursing and Psychiatric Technicians.
- Section 3765 was amended to allow an exemption for the temporary performance, by other health care personnel, students, or groups, of respiratory care services, as identified and authorized by the Board, in the event of an epidemic, pandemic, public disaster, or emergency.
- Section 3765 was also amended to allow LVNs who have received training satisfactory to their employer, and when directed by a physician and surgeon, to perform basic respiratory tasks and services that do not require a respiratory assessment and only require manual, technical skills, or data collection. Also, allows LVNs employed by a home health agency to perform respiratory tasks and services identified by the Board, if the LVN complies with the following:

  a) Before January 1, 2025, the licensed vocational nurse has completed patient-specific training satisfactory to their employer.

  b) On or after January 1, 2025, the licensed vocational nurse has completed patient-specific training by the employer in accordance with guidelines that shall be promulgated by the Board no later than January 1, 2025, in collaboration with the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

SB 1451 (Ashby) Chapter 481, Statutes of 2024

- Section 3765 (i) was amended to extend the licensed vocational nurses training requirement dates to from January 1, 2025, to January 1, 2028.
- Section 3765 was also amended to provide additional exemptions allowing LVNs with appropriate training to perform respiratory tasks and services identified by the Board in home and community-based settings, as specified.

SB 389 (Ochoa Bogh) Chapter xxx, Statutes of 2025

- Section 3765(l) was added to authorize LVNs to perform suctioning and basic respiratory care tasks in a school setting, under the supervision of a credentialed school nurse.

REGULATORY CHANGES AFFECTING THE BOARD SINCE 2021

(All sections are from the California Code of Regulations [CCR] unless otherwise noted)

Effective July 1, 2022

- Section 1399.329 was amended to make clear the expeditious and special handling of applications for licensure or renewal for military personnel and spouses of, domestic partners of, and those in legal union with, military personnel. These amendments also clarify what type of evidence can be presented to demonstrate discharge from active duty.
- Section 1399.374 which incorporates the Board's Disciplinary Guidelines by reference, was amended to reflect changes to the Board's laws related to the respiratory care scope of practice being further defined, to incorporate a new cause for discipline for providing false statements to a Board investigator or probation monitor, as well as to update enforcement processes.

Effective October 1, 2023

- Section 1399.349 was amended to provide a clearer understanding that the education and training required to become a licensed RCP does not qualify for CE credit.
- Section 1399.350 was amended to establish new CE framework to balance several competing priorities: the need to develop leadership among licensees to take over management roles, the need for licensees to maintain and grow their clinical practice skills, and the Board's desire to encourage licensee participation in the Board's meetings and the meetings of specific industry associations.
- Section 1399.350.5 was amended to provide that credit for completion of a Law and Professional Ethics Course shall count as credit in the "RCP leadership" category of CE rather than for "non-clinical practice" CE.
- Section 1399.351 was amended to provide a current and accurate list of credentials/ examinations and certifications the Board accepts for continuing education credit and to accurately list the names of the corresponding examinations and certification courses.
- Section 1399.352(a) was amended to provide additional references and language that better describes acceptable CE courses.
- Sections 1399.352 (a)(1) – (a)(5) was amended to provide better organization and structure of courses "indirectly" related to respiratory care and accepted for credit under section 1399.350(a)(3) by adding language and removing courses the Board no longer recognized as "indirectly" related to the practice.
- Section 1399.352(h) was amended to provide a distinction in approved providers by the method of delivery of CE courses and identify providers who are approved to provide courses in any format, including the addition of five organizations not previously recognized by the Board.
- Section 1399.352(i) was amended to identify providers approved to only offer courses in a live interactive format.
- Section 1399.352.5 was amended to clarify that CE hours are accepted based on the number set by approved entities.

REGULATORY CHANGES (continued)

- Section 1399.352.6 was added to define the requirements of a preceptor program.
- Section 1399.352.7 was amended to provide readers with a clearer understanding of the Law and Professional Ethics Course provider's obligations. This section also ratifies practices that have become standards since the course was first offered.
- Section 1399.381 was amended to add a new fine of $5,000 for violation of Business and Professions Code section 3750(q), providing false statements or information on any form provided by the Board or to any person representing the Board during an investigation, probation monitoring compliance check, or any other enforcement-related action when the individual knew or should have known the statements or information was false.

Effective October 1, 2025

- Section 1399.365 was added to define basic respiratory care tasks and services.

NATIONAL (AND STATE) ASSOCIATION PARTICIPATION

The Board maintains membership in the American Association for Respiratory Care (AARC), the Council on Licensure, Enforcement, and Regulation (CLEAR), and the Federation of Associations of Regulatory Boards (FARB). While these memberships do not confer voting privileges, they provide the Board with valuable resources and best practices related to enforcement, licensure, examinations, and issues unique to the respiratory care profession.

In addition, all RCP Board members are individual members of the AARC and its state affiliate, the California Society for Respiratory Care (CSRC). Several members also choose to attend the AARC's Annual Conference or Summer Forum to stay current on national trends, emerging practices, and developments within the profession, as well as CSRC's Annual Conference and regional meetings.

NATIONAL EXAM PARTICIPATION

The Board currently utilizes the National Board for Respiratory Care's (NBRC's) Registered Respiratory Therapist (RRT) examinations, which include both the Therapist Multiple-Choice (TMC) Examination and the Clinical Simulation Examination (CSE), as the basis for licensure. These examinations are developed, scored, and analyzed by the NBRC. Each year, the Board verifies that the NBRC continues to meet the requirements established in B&PC § 139 regarding occupational analyses and ongoing item analyses.

The RRT examinations were specifically designed to objectively assess the essential knowledge, skills, and abilities expected of advanced respiratory therapists and to establish uniform national standards for measuring such competencies. The TMC Examination evaluates the foundational knowledge and skills required of entry-level respiratory therapists and also serves as the qualifying examination for the Clinical Simulation Examination. Candidates who successfully complete both the TMC and the CSE earn the Registered Respiratory Therapist (RRT) credential, which signifies advanced professional competence and readiness for independent clinical practice.

Beginning in January 2027, the NBRC will launch a redesigned examination pathway aimed at simplifying the process for individuals entering the respiratory care field, while preserving the profession's high standards. The updated approach will merge existing examinations to lessen obstacles for recent graduates and broaden access. In addition, the NBRC will embed clinical judgment testing within an expanded multiple-choice structure, providing a more comprehensive measure of knowledge, critical thinking, and practice readiness.

Section 2
Fiscal Issues and Staffing

FUND CONDITION

Following several fee increases between 2017 and 2020, the Board's fund is showing stable recovery with a projected 6.1 months in reserve in fiscal year 2025–26. The Board has not made any loans to the General Fund in the last 25 years. Loans made prior to that date were repaid in fiscal year 2000–01.

Table 2a. Fund Condition

	FY 21/22 ACTUAL	FY 22/23 ACTUAL	FY 23/24 ACTUAL	FY 24/25 ACTUAL	FY 25/26 PROJECTED	FY 26/27 PROJECTED
Beginning Balance	$1,361	$1,676	$2,144	$2,407	$2,572	$2,250
Adjusted Beginning Bal.	$95	$51	$79	-	-	-
Revenues & Transfers	$3,838	$4,024	$4,055	$4,099	$4,063	$4,023
Total Resources	$5,294	$5,751	$6,278	$6,506	$6,635	$6,273
Budget Authority	$4,011	$4,098	$4,223	$4,250	$4,190	$4,316
Expenditures	$3,387	$3,530	$3,797	$3,900	$4,190	$4,316
COVID Transfer to GF (AB84)	$139	n/a	n/a	n/a	n/a	n/a
Supplemental Pension	$76	$76	$76	$54	$54	-
CS 4.12 Vacancy Reduction and CS 4.05 OE&E Reduction	n/a	n/a	n/a	n/a	($149)	($149)
General Fund Pro Rata[1]	$239	$268	$235	$239	$290	$290
Reimbursements	($223)	($267)	($237)	($259)	-	-
Fund Balance	$1,676	$2,144	$2,407	$2,572	$2,250	$1,816
Months in Reserve	5.6	6.6	7.3	7.0	6.1	4.8

DOLLARS IN THOUSANDS

[1] General Fund pro rata is payment to central service and general fund agencies (e.g., Department of Finance, State Controller's Office, Department of Human Resources, and the Legislature) for budgeting, accounting, auditing, payroll, and other services. However, the services provided by these agencies benefit not only general fund programs, but also programs supported by special funds and federal funds. Consequently, the Department of Finance uses the pro rata cost allocation and recovery process to recover a fair share of indirect costs from special funds (pro rata). The amounts recovered are transferred to the General Fund.

HISTORY OF FEE CHANGES

The authority for the Board's fees is established in B&PC § 3775 and provides either a ceiling for the fee amount or an actual amount. This section also provides the Board some flexibility by authorizing it to reduce the amount of any fee at its discretion. All fees are current in the Board's regulations at CCR §1399.395.

During its 2016 Sunset Review, the Board noted concerns with costs associated with BreEZe, the new licensing and enforcement database. These expenditures coupled with rising pro rata and personnel costs outside the Board's control, resulted in a spiral-down trajectory of the Board's fund condition. After nearly 20 years of reengineering processes to avoid fee increases, the Board was forced to raise its renewal and renewal-related fees to the statutory maximum to maintain a fund balance equal to approximately six months.

In 1998 the Board's renewal fee was established at $230; however, the Board did not implement the renewal fee increase until January 2002. Also in 1998, the Board gained the authority to increase its renewal fee up to $330. The Board worked steadfast and reengineered its processes to avoid another fee increase for years. In fact, it was costs outside of the Board's control that prompted it to increase its renewal fee nearly 20 years after receiving authority to do so. Since its last Sunset Review, the Board has not increased any fees. The following summary outlines the most recent renewal fee adjustments, each applied in increments of 10% or less, in accordance with B&PC § 3775(d):

Effective 7/1/17:	Renewal fee raised to $250 (was $230) Delinquent fee raised to $250 (was $230) Delinquent fee > 2 years was raised to $500 (was $460)
Effective 7/1/18	Renewal fee raised to $275 Delinquent fee raised to $275 Delinquent fee > 2 years was raised to $550
Effective 7/1/19	Renewal fee was raised to $300 Delinquent fee was raised to $300 Delinquent fee > 2 years was raised to $600
Effective 7/1/20	Renewal fee was raised to $330 Delinquent fee was raised to $330 Delinquent fee > 2 years was raised to $660

It should be noted that, for more than two decades, licensees have expressed concern about the renewal fee amount. The Board's members and staff remain mindful of these concerns and continue to pursue cost-saving measures while carefully evaluating any action that could increase expenses. While no immediate shortfall is anticipated, the Board believes it would be prudent to consider raising the statutory renewal fee ceiling. Doing so would provide a safeguard against unexpected future expenses and help ensure the Board's long-term financial stability.

This issue will be addressed in greater detail in Section 10, New Issues, beginning on page 84.

The Board is a special fund agency deriving 100% of its funds from fees collected for services. Since the inception of the Board, the license renewal cycle has always been scheduled on a biennial basis, based upon the licensee's birth month.

EXPENDITURES BY PROGRAM COMPONENT

Reviewing expenditures by program you will find that the majority of expenditures are attributed to the Board's Enforcement Program followed by Administration, DCA pro rata, and then Licensing/Examination.

Table 2b. Expenditures by Program Component

PROGRAM AREA	FY 2021–22		FY 2022–23		FY 2023–24		FY 2024–25		Average %
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	
Enforcement	$1,101	$724	$1,153	$726	$1,184	$912	$1,196	$822	53.5%
Licensing/Exam	$335	$92	$433	$99	$448	$106	$464	$96	14.2%
Administration	$437	$91	$466	$95	$481	$101	$650	$72	16.4%
DCA Pro Rata	-	$608	-	$558	-	$565	-	$600	15.9%
TOTALS	$1,873	$1,515	$2,052	$1,478	$2,113	$1,684	$2,310	$1,590	
Budget Expenditure	$3,387		$3,530		$3,797		$3,900		

- Dollars listed in thousands.

BREEZE COSTS

Table 2c shows the Board's BreEZe system costs for fiscal years 2021–22 through 2024–25. These costs have steadily declined since the Board implemented use of the system in 2013 and appear to have plateaued over the past two fiscal years.

Table 2c. BreEZe Costs

FY 21-22	FY 22–23	FY 23-24	FY 24–25
$96,000	$76,000	$71,000	$71,000

Table 2d. Fee Schedule and Revenue

FEE	Current Fee Amount	Statutory Limit	Revenue FY 21/22	%	FY 22/23	%	FY 23/24	%	FY 24/25	%
Duplicate License	$25	$75	$4	0.1%	$5	0.1%	$5	0.1%	$4	0.1%
Endorsement Fee	$25	$100	$28	0.7%	$23	0.6%	$18	0.4%	$14	0.3%
Examination Fee	$190 - $390	actual cost	$0	0%	$0	0%	$0	0%	$0	0%
Re-Examination Fee	$150	actual cost	$0	0%	$0	0%	$0	0%	$0	0%
Application Fee	$300	$300	$328	8.5%	$368	9.1%	$358	8.8%	$375	9%
Application Fee (OOS)	$300	$300	$124	3.2%	$112	2.7%	$82	2%	$68	1.7%
Application Fee (Foreign)	$300	$350	$0	0%	$0	0%	$0	0%	$0	0%
Biennial Renewal Fee	$330	$330	$3,230	84.3%	$3,304	82%	$3,353	82.7%	$3,394	82.8%
Delinquent Fee (< 2yrs)	$330	$330	$67	1.7%	$79	1.9%	$62	1.5%	$64	1.6%
Delinquent Fee (> 2yrs)	$660	$660	$16	0.4%	$6	0.1%	$7	0.2%	$6	0.2%
Cite and Fine	varies	$15,000	$23	0.6%	$54	1.3%	$45	1.1%	$27	0.6%
Enf. Review Fee	varies	actual cost	$8	0.2%	$14	0.3%	$9	0.2%	$8	0.2%
Reinstatement Fee	$300	$300	$0	0%	$1	0.2%	$1	0.2%	$1	0.1%
Miscellaneous	-	-	$10	0.2%	$58	1.4%	$116	2.8%	$138	3.4%
TOTAL REVENUE			$3,838		$4,024		$4,055		$4,099	

BUDGET CHANGE PROPOSALS

The Board has not submitted any budget change proposals during this reporting period, nor does it intend to in the foreseeable future.

STAFFING AND TRAINING

The Board has been fortunate in retaining a highly-skilled and experienced workforce over the last 25 years. Turnover is extremely rare, with only a handful of employees leaving to pursue other promotional opportunities or for retirements. At the time of the Board's last Sunset Review in 2022, the Board had 18 staff members. Since that time, two have retired; though one has returned as a retired annuitant. Currently, the Board has 16 staff members, 14 of whom were employed during the Board's last Sunset Review. Organizational charts for the last four fiscal years can be found on pages 96-99.

Workforce and Succession Plan 2025–2030

In Spring 2020, the Board identified the expected upcoming retirements in its workforce, as a threat facing the Board. In response, the Board approved a Workforce and Succession Plan for 2021–2024 at its March 2021 Board Meeting.

However, the Board's ability to deliver services remains at risk, as 44% of its permanent workforce is projected to retire within the next five years, a figure that increases to 56% when intermittent employees are taken into account. With the departure of experienced employees who possess a wealth of institutional knowledge and perform vital roles, it is important for the Board to outline opportunities where it can enhance its infrastructure and be proactive in developing workforce planning guidance. Accordingly, the Board considered and [insert action taken] an updated Succession Plan for 2025–2030 at it October 2025 Board Meeting.

Staff Training

Over the last four fiscal years, the Board has spent approximately $1,000 on training and education. Costs are associated with courses taken outside of DCA such as the Certified Professional Collector Program, a course our probation monitors take to maintain certification in collecting specimens for drug testing. However, staff have also participated in numerous courses, free of (direct) charge, offered through the DCA. A list of training completed since fiscal year 2021–22 is provided in Table 2e.

In May and June of 2025, the Board's staff participated in job-shadowing at the University of California Davis Medical Center, observing licensed RCPs in a variety of clinical settings. This immersive experience offered valuable, real-world perspective on the scope of practice, clinical responsibilities, interdisciplinary collaboration, and day-to-day challenges faced by RCPs. By witnessing the complexity and critical nature of their work, The Board's staff gained meaningful insight that will directly inform future policy development, support the refinement of licensing and enforcement standards, and enhance the Board's ability to make informed, profession-specific decisions. This initiative also strengthened the Board's connection to the practitioners it regulates, helping to ensure that regulatory efforts align with the evolving needs of both the profession and the respiratory care consumers it is charged with protecting.

Table 2e. Staff Training

Course	*# of staff*
FY 2021-22	
Information Security Awareness Fundamentals	13
Beyond the Pandemic: The Hybrid Workforce	2
Board President's Training	1
Certified Professional Collector	2
Defensive Driver Training	1
FY 2022-23	
Information Security Awareness Fundamentals	15
Sexual Harassment Prevention Training	10
Defensive Driver Training	2
Microsoft Teams ("Getting Started")	1
Microsoft Teams ("Tips, Tricks & What's New")	1
Project Management Essentials	1
Improve Your Leadership Through Better Decision-Making	1
Communicate With Better Reception	2
Improve Work-Life Balance	2
Conducting Effective Meetings	1
Completed Staff Work	1
Critical Thinking	1
Communicate Effectively	1
Useful Habits to Stay Productive	1
How to Create a Learning Assignment	1

Course	*# of staff*
FY 2023-24	
Information Security Awareness Fundamentals	18
Defensive Driver Training	1
Certified Professional Collector	2
Grant Funding Series: Why Seek Grant Funding	1
EEO: Upward Mobility Program for Leaders	1
Developing a Records Retention Schedule	1
FY 2024-25	
Information Security Awareness Fundamentals	18
Sexual Harassment Prevention	9
Workplace Violence Prevention Training	18
Surviving an Active Shooter Situation	5
Certified Professional Collector	2
What does DEI Mean?	1
Building Great Teams - Leadership Panel	1
CEC Credit: Building Great Teams - Leadership Panel	1
Cal-Card Training	1
Planning Your Retirement	1
Responsible AI for Public Professionals	12

Section 3
Licensing Program

LICENSEE POPULATION

Since the Board issued its first license in 1985, it has issued over 49,000 licenses. As of June 30, 2025, the Board had 21,390 active and current licensees, 2,799 delinquent licensees, and 891 current but inactive licensees. Of these licensees, 1,536 live out of the state or country. An additional 1,474 licenses have been placed in retirement status as of June 30, 2025.

Table 3a. Licensee Population

		FY 21/22	FY 22/23	FY 23/24	FY 24/25
Respiratory Care Practitioner	Active	20,467	20,845	21,268	21,390
	Delinquent	2,819	2,849	2,804	2,799
	Inactive	802	848	883	891
	Out-of-State	1,653	1,743	1,697	1,529
	Out-of-Country	9	9	9	7
	Retired	1,218	1,296	1,389	1,474

APPLICATION PROCESSING TIMES

The Board strives to process applications for licensure as quickly as possible. Over the last four fiscal years, the average cycle time to process a complete application from date of receipt to date of licensure was 8 days. The average cycle time for incomplete applications was 57 days.

Table 3b. Licensing Performance Targets

	Target Processing Times	FY 21-22 Average Processing Times	FY 22–23 Average Processing Times	FY 23-24 Average Processing Times	FY 24–25 Average Processing Times
Complete Applications	60 days	10	16	4	1
Incomplete Applications	365 days	64	66	55	41

Table 3c below illustrates the number of pending applications at the end of each fiscal year is significant in comparison to the total number of applications received (i.e., 538 pending compared to 1,464 received in fiscal year 2024–25). This is a direct correlation with the graduation cycles of respiratory care programs. The largest graduating classes begin submitting applications mid-May through July. Therefore, a count of "pending applications" anywhere from May through August will be significantly higher than at any other time of the year.

INITIAL LICENSURE AND RENEWALS

The Board currently issues over 1,200 new licenses and renews over 10,000 licenses each fiscal year.

Table 3c. Licensing Data by Type

	Application Type	Received (opened)	Approved	Closed *	Initial and Renewed Licenses Issued	Pending Apps at Close of FY	Cycle Times (in days)	
							Complete Apps	Incomplete Apps
FY 21/22	License/Exam	1,601	1,240	165	1,240	659	10	64
	Renewal	10,924	9,832	856	9,832	N/A	-	-
FY 22/23	License/Exam	1,695	1,347	148	1,347	636	16	66
	Renewal	10,901	10,031	768	10,031	N/A	-	-
FY 23/24	License/Exam	1,487	1,369	108	1,369	476	4	55
	Renewal	11,206	10,126	802	10,126	N/A	-	-
FY 24/25	License/Exam	1,464	1,232	108	1,232	538	1	41
	Renewal	11,397	10,295	1,034	10,295	N/A	-	-

* Closed includes initial license applications that are withdrawn, abandoned, and denied, and open renewal applications that update from delinquent to canceled.

Table 3d. License Denials				
	FY 21/22	FY 22/23	FY 23/24	FY 24/25
License Applications Denied (no hearing requested)	0	2	0	1
Statements of Issue Filed	0	1	0	0
Average Days to File SOI (from request for hearing to SOI filed)	-	31	-	-
Statements of Issue Declined	0	0	0	0
Statements of Issue Withdrawn	0	0	0	0
Statements of Issue Dismissed (licensed granted)	0	0	0	0
Licenses Denied (after hearing requested)	0	0	0	0
License Issued with Probation / Probationary Licensed Issued	0	1	0	0
Average Days to Complete (from SOI filing to outcome)	-	123	-	-

Between fiscal years 2021–22 and 2024–25, the Board denied four applications for initial licensure, regardless of whether the applicant requested a hearing. Each denial was based on criminal history, with one case also involving disciplinary action taken in another state, as detailed below:

BROWN-JONES
Initial Denial Date: 11/30/22; No Hearing Requested

Application denied under B&PC § 3750(d), 3750(m), 3750.5(a), (b), and (d), 3752, and CCR § 1399.370(c)(1) and (c)(3).

On May 7, 2016, applicant was arrested for violating Arizona Revised Statute (ARS) § 28-1381(a)(2), driving with a blood alcohol content of .08% or higher. On August 1, 2016, applicant was convicted for violating ARS § 28-1381(a)(1), driving under the influence of alcohol.

On September 9, 2022, applicant entered into a Consent Agreement and Disciplinary Order for Probation with the Arizona State Board of Respiratory Care after testing positive for cocaine on a preemployment drug screen.

VALDEZ
Initial Denial Date: 12/28/22; SOI Filed: 2/27/23; Probation, 5 Years, effective 6/9/23

Application denied under B&PC § 3750(d), 3752, 3752.5, 3760(a) and (c), 3761(a), and CCR § 1399.370(c)(1).

On March 27, 2022, applicant was arrested for violating Penal Code (PC) § 273.5(a), inflicting corporal injury on a spouse/cohabitant, a felony. On December 9, 2022, applicant was convicted of violating PC § 273.5(a), a felony.

On May 17, 2022, applicant was issued an Administrative Citation in the amount of $950.00 for violations of B&PC § 3760(a) and (c), and 3761(a).

WHITING
Initial Denial Date: 4/6/23; No Hearing Requested

Application denied under B&PC § 3750(d), 3750.5(b), 3752, and CCR § 1399.370(c)(1) and (c)(3).

On September 11, 2018, applicant was charged with violating Vehicle Code (VC) § 23152(a), driving under the influence of alcohol and 23152(b), driving with a blood alcohol content of .08% or higher. On January 25, 2019, applicant was convicted of violating VC § 23103(a), reckless driving.

On February 18, 2022, applicant was arrested for violating VC § 23152(a) and 23152(b). On February 22, 2023, applicant was convicted of violating VC § 23152(b).

NUNEZ
Initial Denial Date: 12/19/24; **No Hearing Requested**

Application denied under B&PC § 3750(d), 3750.5(b) and (d), 3752, and CCR § 1399.370(a) and (c)(3).

On July 5, 2021, applicant was arrested for violating PC § 647(f), public intoxication. On November 22, 2021, applicant was convicted of violating PC § 647(f).

On June 10, 2022, applicant was arrested for violating VC § 23152(a), 23152(b), and 20002(a), hit and run. On September 11, 2023, applicant was convicted of violating VC § 23152(a), a felony.

On August 4, 2024, applicant was arrested for violating PC § 647(f).

APPLICATION BACKGROUND VERIFICATION/FINGERPRINTS

As part of the application for licensure process, the Board requires the following documentation (as applicable):

- Department of Justice background check.
- Federal Bureau of Investigation background check.
- Official education transcript(s).
- Verification of successful completion of the licensing examinations.
- Verification of successful completion of a Board-approved Law and Professional Ethics course
- Out-of-state licensure history, if applicable.
- National Practitioner Data Bank history for applicants whose residence or education may be outside California.

All required documentation must be submitted directly to the Board by the issuing source. Materials provided by the applicant are generally not accepted.

Since its inception, the Board has required all applicants to be fingerprinted to determine any criminal history. The Board notifies the Department of Justice (DOJ) when it is no longer interested in receiving follow-up information once a license is cancelled, retired, surrendered, revoked, or when an application is denied or abandoned. The Board remains current and up to date in notifying the DOJ of all records that are no longer within its jurisdiction.

The Board's application also includes background questions for the rare occasion in which an event is not captured by other means. The Board takes a tough stance against any type of perjury, and discourages applicants from concealing any information. An incident that may result in a strong warning letter if revealed will nearly always result in the denial of a license if perjury is committed.

In addition to fingerprinting, the Board will also run a check with the National Practitioner Databank if it appears that an applicant may have resided or obtained his or her education outside of California (this check is not performed on existing licensees during the renewal process). The Board also requires applicants who reveal they have been licensed out-of-state to have those states where licensure was held, submit a license verification directly to the Board, indicating if there is any history of disciplinary action.

Applicants with education from Canada must complete an education program recognized by the Canadian Board of Respiratory Care (§3740 (d) of the B&PC). Applicants with foreign education (with the exception of Canada) must have their education evaluated by an approved respiratory program to determine if their education is equivalent to requirements for all other applicants. Applicants may receive full equivalency or may be required to take some additional education to achieve equivalency (reference: §3740 (c) of the B&PC).

MILITARY APPLICATIONS

The Board has always held those who have or continue to serve as members of the U.S. military in the highest esteem. The Board recognized military experience via regulation in 2004 and has always put forth additional service to military members and their families, understanding sometimes the very quick turnaround time they are faced with after receiving new orders. In fact, in several instances, staff took it upon themselves (instead of the applicant) to contact other state licensing agencies or the national examination provider to obtain necessary verifications.

The following is legislation that has been passed since 2010 relating to the handling of applications or licenses for occupations for military personnel:

- AB 2783 (Statutes of 2010) - Section 35 of the B&PC was amended to include “and the Military Department” as an agency that shall be consulted when a board provides rules and regulations for methods of evaluating education, training, and experience obtained in the armed services.
- AB 1588 (Statutes of 2012) - Section 144.3 was added to the B&PC and provides that every board shall waive renewal fees, continuing education requirements and other renewal requirements, as applicable, for any licensee called to active duty.
- AB 1904 (Statutes of 2012) - Section 115.5 was added to the B&P and provides that the board shall expedite the licensure process for an applicant that is in a legal union with an active duty member of the Armed Forces and holds a current similar license in another state.
- AB 1057 (Statutes of 2013) - Section 114.5 was added to the B&PC and provides that every board shall inquire in every application for licensure if the individual applying for licensure is serving on or has previously served in the military.
- SB 1137 (Statutes of 2018) - Section 714 was added to the B&PC and provides that the Department of Veterans Affairs and the DCA shall both, in consultation with each other, take appropriate steps to increase awareness regarding professional licensing benefits available to veterans and their spouses.
- SB 607 (Statutes of 2021) - Section 115.5 of the B&PC was amended and provides that boards waive initial application fees for military spouses who are authorized to practice in another state or territory.
- AB 883 (Statutes of 2023) - Section 115.4 of the B&PC was amended and requires a board to expedite and assist in the initial licensure process for an applicant who supplies satisfactory evidence to the board that the applicant is an active duty member of a regular component of the Armed Forces of the United States enrolled in the United States Department of Defense SkillBridge program.

The Board has adopted regulations to formally recognize military service and experience. Relevant provisions are found in CCR, title 16, division 13.6:

CCR § 1399.330. Education Waiver Criteria
Added in 2004, this regulation allows qualifying military education and experience to be accepted in lieu of the standard associate degree education requirement.

CCR § 1399.354. Waiver of CE Requirements
Established in the 1990s, this section authorizes the Board to waive the CE requirement for a renewal cycle when military personnel are absent or on active duty for one year or more.

CCR § 1399.329. Handling of Military Personnel and Military Spouse Applications
Amended in 2022 to clarify for the public the special processing and accommodations available to military personnel and their spouses.

The Board's staff continue to prioritize and expedite licensure for military members and spouses, offering personalized guidance to navigate requirements and prevent delays so they can begin or resume practice quickly after a move or deployment.

As legislation has strengthened support for military families, the Board has updated its initial and renewal applications and enhanced its licensing database to capture all required information. These changes ensure applicants receive every benefit while maintaining accurate records for reporting and compliance. The current Application for Initial Licensure includes these military-related instructions and questions:

Instructions

"The Board expedites the licensure process for an applicant currently serving as an active-duty member of the Armed Forces of the United States, or has been honorably discharged, and for spouses and domestic partners of those on active duty in the Armed Forces. For an applicant's license to be expedited, the applicant must provide evidence that they are an active-duty member of the Armed Forces of the United States or were an active-duty member and was honorably discharged or that they are married to, or in a domestic partnership or other legal union with, an active-duty member of the Armed Forces of the United States who is assigned to a duty station in California under official orders. They must also hold a current RCP license in another state, district or territory of the United States.

Please note, pursuant to Business and Professions Code section 115.4, this does not mean a license must be issued, but simply requires the process to be accelerated.

Please refer to the Military Personnel and Military Spouses/Domestic Partners page for additional details.

Military Spouse/Domestic Partner Requirements
Note: If you meet the military spouse or domestic partner requirements, please attach the following documentation on the attachments page of this application (you may be asked to submit original documentation).

Certificate of marriage or domestic partnership or other legal union with an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders.

Verification of current licensure in another state, district, or territory of the United States in the profession or vocation for which you are seeking licensure."

Questions

- Have you ever served or are you currently serving in the United States Military?
- Are you the spouse or domestic partner of an active duty member of the Armed Forces, holding a current/active license in another state, requesting expediting of this application?
- Are you requesting expediting of this application for honorable discharged member of the U.S. Armed Forces?
- Pursuant to Business and Professions Code Section 115.4, beginning July 1, 2024, the board/bureau shall expedite the initial licensure process for an applicant who is an active duty member of the US Armed Forces and enrolled in the US Department of Defense SkillBridge program. Do you request expediting of your application under this authority?

Following is military data captured as it relates to applications for initial licensure.

Table 3e. Military Applications for Initial Licensure

	FY 21/22	FY 22/23	FY 23/24	FY 24/25
Applications Received—Military	126	109	97	103
Applications Received—Military Spouse	19	11	10	13
Applications Approved—Military	98	102	83	83
Applications Approved—Military Spouse	21	8	11	9
Military Education Waivers Requested	0	0	0	0
Military Education Waivers Approved	0	0	0	0

For nearly a decade, the Board has asked licensees on renewal forms whether they are currently serving or have previously served in the military. Through this process, about 1,700 licensees have been identified with current or prior military service. The Board grants waivers of renewal requirements for those called to active duty, which may include renewal fees, continuing education, and other requirements. The summary below reflects the number of military licensees who have requested such waivers.

Table 3f. Military Renewal Application Waivers

	FY 21/22	FY 22/23	FY 23/24	FY 24/25
Military Active Renewal Waiver	6	1	1	0
Military Inactive Renewal Waiver	4	0	2	0

The Board also added a page dedicated to Military Personnel and Military Spouses/Domestic Partners on its website. The page provides detailed information on all waivers and expeditious handling of applications.

EXAMINATION

Since January 2015, the Board has required applicants to pass an advanced respiratory credentialing examination as the official licensing examination to demonstrate competency prior to licensure (AB 1972, Statutes of 2014). To qualify for licensure as a RCP, an applicant must successfully pass two examinations administered by the National Board for Respiratory Care (NBRC): the Therapist Multiple-Choice (TMC) Examination and the Clinical Simulation Examination (CSE).

The TMC Examination is designed to objectively assess the essential knowledge, skills, and abilities expected of entry-level respiratory therapists. It consists of 160 multiple-choice questions—140 scored items and 20 pretest items—distributed across three primary content areas:

1. Patient data evaluation and recommendations
2. Troubleshooting and quality control of equipment and infection control
3. Initiation and modification of interventions

The CSE is designed to objectively measure essential knowledge, skills, and abilities required of advanced respiratory care practitioners. The CSE consists of 22 problems (20 scored items and 2 pretest items). The clinical setting and patient situation for each problem are designed to simulate reality and be relevant to the clinical practice of respiratory care, clinical data, equipment, and therapeutic procedures.

The NBRC also offers voluntary credentials upon passage of each exam, the CRT credential for passage of the TMC Examination and the RRT credential for passage of the CSE. While passage of the RRT examination is required for licensure, holding the actual credential is not, though the RRT credential is required for various reimbursements and is recognized by the medical community.

The NBRC exams are administered on a daily basis and candidates are not permitted to consecutively repeat an examination previously taken. Applicants may apply to take the examination online or via paper application. Upon verification of meeting entry requirements, applicants may schedule themselves to sit for either examination at one of 25 locations throughout California. Applicants are given three hours to complete the TMC Examination and four hours to complete the CSE (exceptions are made in accordance with the Americans with Disabilities Act). Once applicants have completed either examination, they are notified immediately of the results. Those results are then shared with the Board on a daily basis.

The NBRC, established in 1960, is a voluntary health certifying board dedicated to evaluating the professional competence of respiratory therapists. Sponsored by the American College of Chest Physicians, the AARC, the American Society of Anesthesiologists, and the American Thoracic Society, the NBRC has maintained its executive offices in the metropolitan Kansas City area since 1974. It is a member of the Institute for Credentialing Excellence (ICE), and both the TMC and CSE, along with several other NBRC examinations, are accredited by the National Commission for Certifying Agencies (NCCA). This accreditation confirms the NBRC's adherence to nationally recognized standards for psychometric quality, fairness, and validity in health care credentialing.

From fiscal year 2021–22 through fiscal year 2024–25, first-time pass rates for California candidates have remained strong, averaging approximately 79 percent for the written TMC examination and 69 percent for the CSE. These consistent outcomes compare favorably with national averages and demonstrate both the rigor of the NBRC's examinations and the overall strength of respiratory care education programs within the state. The Board monitors these trends to assess the effectiveness of educational preparation and to ensure that licensing standards continue to reflect the knowledge and skills required for safe, effective respiratory care in an evolving clinical environment.

Table 3g. Examination Data			
NATIONAL EXAMINATION FOR LICENSURE AS A RESPIRATORY CARE PRACTITIONER			
Exam Title: **RRT Part I Therapist Multiple-Choice Exam**			
			Pass %
FY 21-22	Number of First Time Candidates	1,047	76.3
FY 22-23	Number of First Time Candidates	1,171	77.5
FY 23-24	Number of First Time Candidates	1,142	80.6
FY 24-25	Number of First Time Candidates	1,252	80.1
Exam Title: **RRT Part II Clinical Simulation Exam**			
			Pass %
FY 21-22	Number of First Time Candidates	947	70
FY 22-23	Number of First Time Candidates	1,009	69.1
FY 23-24	Number of First Time Candidates	1,096	68.3
FY 24-25	Number of First Time Candidates	1,091	68.8
Date of Last Occupational Analysis: 2024			
Name of Occupational Analysis Developer: National Board for Respiratory Care			
Target Occupational Analysis Date: 2029			

SCHOOL APPROVALS

There are 36 respiratory care education programs in California that are approved by the Board by virtue of their accreditation status.

Pursuant to B&PC § 3740, the Board requires two components of education for licensure:

1) Completion of an education program for respiratory care that is accredited by the Commission on Accreditation for Respiratory Care (CoARC); and

2) Possession of 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 (USDOE).

In most cases these requirements are met through the same institution, although in certain circumstances, such as when a degree was issued before the 2001 revision of California's education requirements or when qualifying education was obtained outside the state, the degree may come from a separate institution.

Currently, 35 of the 36 approved programs award an associate degree, with Loma Linda University being the sole exception, offering only a bachelor's degree as entry to practice. Overall, the number of schools offering bachelor's-level education has steadily increased in recent years, as outlined below:

- Loma Linda University offers a direct bachelor's degree entry-to-practice program, as mentioned above.
- Eleven community colleges have been approved under Education Code § 78041 to award a bachelor's degree.
- One private school proprietor offers a bachelor's degree in respiratory care across its six campuses statewide.

This means that nearly half of California's approved respiratory care programs now include an authorized bachelor's track, whether as a primary entry-to-practice program or as an additional pathway alongside an associate degree. Several of these programs have only recently been approved, reflecting a measurable increase in bachelor's opportunities within the state's respiratory care education system.

To ensure programs maintain high standards, the Board's staff review each school one to two times annually to confirm continued accreditation and work with the Bureau for Private Postsecondary Education (BPPE) to verify private institutions remain in good standing.

All 36 California programs are accredited by CoARC, the national accrediting body for respiratory care education; 27 also hold Western Association of Schools and Colleges (WASC) accreditation, while the rest are accredited by other USDOE-recognized agencies and approved by the BPPE. Although the Board has no statutory authority to approve international schools, it verifies the accreditation and equivalency of any outside education presented by applicants.

CoARC accreditation entails annual reviews and full on-site evaluations at least every 10 years, ensuring that programs meet or exceed national standards. As an added safeguard, the Board publishes annual pass/fail rates on its website, allowing prospective students to compare program outcomes and assess preparation for the NBRC's licensing examinations.

The combination of growing bachelor's opportunities, strong accreditation oversight, and transparent reporting reflects the Board's commitment to keeping respiratory care education in California accessible, rigorous, and responsive to the profession's evolving standards.

CONTINUING EDUCATION

Each RCP must complete 30 hours of approved continuing education (CE) every two years to maintain an active license. In addition, during every other renewal cycle, each active RCP must also complete a Board-approved Law and Professional Ethics Course, which may be counted as three hours of leadership CE credit, as set forth in CCR §1399.350. This course, currently offered by the AARC and the CSRC, ensures that RCPs understand the professional standards and legal responsibilities expected of them in California. Approximately two-thirds of the curriculum focuses on workplace ethics scenarios, while the remaining one-third addresses laws and regulations governing acts that could jeopardize licensure, as outlined in CCR § 1399.350.5 and 1399.352.7.

Upon license renewal, active RCPs must attest, under penalty of perjury, that they have successfully completed the required CE hours, including the Law and Professional Ethics Course.

Framework Revision and New Requirements
In response to the 2017 Workforce Study, the Board implemented significant changes to its CE framework in 2023 to ensure that continuing education keeps pace with the profession's evolving needs. Previously, licensees were required to complete two-thirds, or 20 of the 30 required hours, in coursework directly related to clinical practice in any format. The revised framework now requires:

- 10 hours in leadership
- 15 hours directly related to clinical practice
- Up to 5 hours in courses or meetings indirectly related to practice

Additionally, at least half of the required hours (15 of 30) must be completed through live, real-time courses that allow interaction between participants and instructors.

Leadership and Preceptor Development
The Workforce Study revealed significant management gaps, including the anticipated retirement of roughly 35 percent of RCPs in leadership roles, and highlighted the need to strengthen clinical education and ensure a steady pipeline of qualified educators. In response, the Board established a leadership CE category to prepare more licensees for supervisory roles and to expand the pool of experienced preceptors, licensed RCPs who provide hands-on instruction to students in clinical settings.

Because many facilities face staffing constraints and preceptors often volunteer beyond their regular duties, the Board concluded that mandating preceptor participation could discourage facilities from hosting students. Instead, after reviewing the Workforce Study and related data, the Board adopted an incentive-based approach, offering CE credit to licensees who complete preceptor training. This strategy both strengthens the profession's leadership pipeline and supports the quality of clinical education statewide.

Live Format Requirement
The revised framework requires at least 15 of the 30 CE hours to be completed in a live format, in person or online, where participants and instructors can interact in real time. Live instruction fosters open discussion, immediate feedback, and deeper comprehension. To ensure equitable

access, especially for rural licensees, the Board broadened the definition of live courses to include interactive online sessions. All CE courses must also be provided or approved by entities listed in CCR § 1399.352(h) or (i) to maintain consistent quality and relevance.

Communication and Outreach
To prepare licensees for these changes, the Board launched a comprehensive communication and outreach effort, updating its website with detailed requirements, timelines, FAQs, and course guidance. Targeted renewal emails explained that current cycles remain under prior rules but that compliance with the new framework would be required at the next renewal. The Board also mailed a comprehensive CE booklet with renewal notices or renewed pocket licenses, ensuring every RCP received clear, advance notice.

Auditing and Enforcement
As part of its 2023–2027 Strategic Plan, the Board established Licensing Goal 2.8 to:

> *Audit a statistically significant sample of license renewals to determine compliance with CE requirements by 2023 and thereafter.*

During fiscal year 2021–22, audits were significantly affected by pandemic-related CE waivers that temporarily reduced enforcement. After the final waiver expired in March 2022, the Board resumed audits and now audits at least 5 percent of renewals each year, reinforcing its commitment to public protection and professional competency.

Table 3h. CE Audits Performed/Failed

	FY 21–22	FY 22-23	FY 23-24	FY 24–25
Renewals Audited	205	484	563	574
Audits Failed	3	5	4	4

* COVID-19 State of Emergency CE waivers allowed licenses expiring between March 31, 2020 and September 30, 2021 to complete CE by January 26, 2022 and licenses expiring on October 31, 2021 to complete CE by March 28, 2022.

The auditing process is both thorough and resource-intensive, designed to ensure that every licensee meets the CE and documentation requirements. Staff review each record to confirm that all required information and CE hours are complete and valid. When appropriate, they directly contact course providers to authenticate records, adding an extra layer of integrity.

Communication with licensees is a key part of this process. Staff use written correspondence and phone calls to clarify records, request missing details, and resolve discrepancies. If documentation is incomplete or coursework does not meet standards, licensees are given a defined window of time to submit additional proof or correct deficiencies before any formal action is taken.

This balanced, educational approach reflects the Board's commitment to fostering continuous professional development and maintaining high standards of respiratory care. By emphasizing compliance and learning, rather than penalties alone, the Board helps ensure that practitioners remain current in their knowledge and skills, ultimately protecting patient safety and supporting public confidence in the profession.

Enforcement Actions
Licensees who fail to provide evidence of CE completion or misrepresent compliance are deemed audit failures and referred to the Enforcement Unit. About 1% of licensees fail the audit, risking inactive status and investigation for unlicensed practice. If required documentation is still not provided after investigation, the Board may issue a citation and fine. Cases involving forged certificates are referred for formal disciplinary action. Citations may address only the CE violation or include additional offenses such as perjury or unlicensed practice.

Table 3i. CE Violations/Citation and Fine Guidelines

	Fine Amount
Non-Compliance/No Response to 30-day and 10-day initial requests (and subsequently cleared)	$250
Each CE unit deficient	$15
Perjury on renewal form	$300
Unlicensed practice (per day worked) up to 30 days	$50
Unlicensed practice (per day worked) beyond 30 days	$100

Table 3i provides a clear, enforceable schedule of fines for CE-related violations when a licensee has no prior disciplinary history, ranging from per-unit charges for deficient CE hours to daily penalties for unlicensed practice.

Auditing of New Framework
Beginning in 2026, audits will specifically check compliance with the new CE framework adopted in 2023. Licensees have had over two years' notice and a full renewal cycle to meet these requirements. The Board anticipates broad compliance and will enforce standards fairly and consistently to protect patients and ensure RCPs remain current.

Section 4
Enforcement Program

The Board's enforcement program is charged with investigating complaints, issuing penalties and warnings, and overseeing the administrative prosecution against licensed RCPs and unlicensed personnel for violations of the Respiratory Care Practice Act (RCPA). The enforcement program is key to the Board's success in meeting its mandate and highest priority of consumer protection.

PERFORMANCE MEASURES

In 2010, the Board established performance targets for measures developed by DCA, as a result of the Consumer Protection Enforcement Initiative. DCA also developed the criteria and program to calculate these days, according to its measures.

The Board's overall goal for all cases to be completed, from the date the complaint is received to final adjudication, is 540 days (18 months). From fiscal year 2021–22 through fiscal year 2024–25, the Board averaged 444 days to complete the entire process, and fell way under its target processing times for every category within its control. The only exception was the category that includes prosecution, as the Board has little to no control over the time spent on cases once they are referred to the Office of the Attorney General (OAG).

A detailed description of each column is as follows:

- PM1 reflects the number of complaints and rap sheets received.
- PM2 reflects the average cycle time from complaint receipt to the date it is assigned to an investigator.
- PM3 marks the average cycle time from complaint receipt to closure of the investigation process. PM3 does not include cases sent to the Office of the Attorney General.
- PM4 represents the average number of days to complete the entire enforcement process for cases resulting in formal discipline (includes intake and investigation by the Board, and final disposition by the Office of the Attorney General).
- PM7 reflects the average number of days from probation monitor assignment to the date the monitor makes first contact with the probationer.
- PM8 marks the average number of days from the date a violation is reported to the date an assigned probation monitor initiates appropriate action.

The OAG has made significant progress in reducing processing times and is largely responsible for the marked improvements over the past four years, enabling the Board to meet its "Intake, Investigation, and AG" PM4 target. Since fiscal year 2021–22, the Board has met its goal of

resolving cases within 540 days (18 months) in all but three quarters, with delays generally attributable to unusually complex cases. Under the leadership of Senior Assistant Attorney General Gloria L. Castro, who oversees the OAG's Health Quality Enforcement Section, the Board has maintained open dialogue and greatly appreciates Ms. Castro's efforts to improve processing times.

The overall Intake and Investigative time (PM3) falls well below the Board's target of 210 days with average days between 44 and 51 over the last four years.

Table 4a. Enforcement Performance Measures	Volume PM1	Intake (in days) PM2	Intake & Inv. PM3	Intake, Inv. & AG (in days) PM4	Probation Intake (in days) PM7	Probation Violation Response (in days) PM8
TARGETS (in days)	**-**	**7**	**210**	**540**	**6**	**10**
FY 2021-22						
Quarter 1: July–Sept. 2021	183	1	38	370	3	1
Quarter 2: Oct.–Dec. 2021	177	1	40	712	7	1
Quarter 3: Jan.–March 2022	145	1	41	494	2	2
Quarter 4: Apr.–June 2022	162	1	57	382	3	2
FY 2022-23						
Quarter 1: July–Sept. 2022	194	1	50	230	5	1
Quarter 2: Oct.–Dec. 2022	173	1	42	348	4	1
Quarter 3: Jan.–March 2023	202	1	46	620	4	1
Quarter 4: Apr.–June 2023	164	1	47	465	2	5
FY 2023-24						
Quarter 1: July–Sept. 2023	177	1	64	321	1	2
Quarter 2: Oct.–Dec. 2023	145	1	50	403	1	1
Quarter 3: Jan.–March 2024	165	1	35	415	3	2
Quarter 4: Apr.–June 2024	160	1	53	405	2	2
FY 2024-25						
Quarter 1: July–Sept. 2024	174	1	43	481	2	1
Quarter 2: Oct.–Dec. 2024	166	2	53	611	2	0
Quarter 3: Jan.–March 2025	149	2	42	448	2	1
Quarter 4: Apr.–June 2025	161	2	45	396	2	1

ENFORCEMENT STATISTICS

Enforcement statistics have stayed fairly steady over the past four years, though there are some areas of interest.

Convictions Received

In its 2022 sunset report, the Board's staff noted a significant decrease in the number of RAP sheets received from the onset of the pandemic through the end of the 2020 calendar year. At the time, the Board was uncertain whether this decline was solely related to the impacts of COVID-19. However, the continued reduction in convictions suggests the trend may be more permanent. For example, during the 2016–17 sunset review period, the Board averaged 533 convictions per year, compared to an average of 377 convictions during the more recent period—a clear indication of a sustained downward trend.

Table 4b. Enforcement Statistics

	FY 21/22	FY 22/23	FY 23/24	FY 24/25
COMPLAINT				
Intake				
Received	293	342	274	280
Closed without Referral for Investigation	35	38	42	40
Referred to Investigation	258	304	230	242
Pending (close of FY)	0	0	2	0
Conviction/Arrest				
Convictions Received	374	391	373	370
Convictions Closed without Referral for Investigation	12	4	12	9
Convictions Referred to Investigation	362	387	361	361
Convictions Pending (close of FY)	0	0	0	0
Source of Complaint				
Public	17	23	26	28
Licensee/Professional Group	385	406	373	391
Governmental Agencies	237	257	197	191
Internal	7	13	18	10
Other	0	0	0	0
Anonymous	21	34	33	30
Average Days to Refer for Investigation (from receipt of complaint/conviction to closure at intake)	1	1	1	2
Average Days to Closure without Referral to Investigation (from receipt of complaint/conviction to closure at intake)	2	2	2	2
Average Days at Intake (from receipt of complaint/conviction to closure or referral to investigation)	1	1	1	2

Table 4b. Enforcement Statistics (continued)				
	FY 21/22	FY 22/23	FY 23/24	FY 24/25
INVESTIGATION				
Desk Investigations				
Closed	618	663	686	571
Average Days to Close	33	35	35	35
Pending (close of FY)	50	56	48	51
Non-Sworn Investigation				
Closed	37	78	75	56
Average Days to Close (from Desk Inv to Expert Review to Inv)	234	189	205	163
Pending (close of FY)	34	41	23	40
Sworn Investigation				
Closed	0	0	1	0
Average Days to Close (from Desk Inv to Inv Closed)	0	0	183	0
Pending (close of FY)	0	0	0	0
All Investigations				
Opened (First Assigned)	620	691	591	603
Closed	655	741	686	627
Average Days for All Investigation Outcomes (from start inv to inv closure or referral for prosecution)	44	51	54	47
Average Days for Investigation Only—No Prosecution Referral	44	51	53	47
Avg. Days for Investigation Only—Cases Referred for Prosecution	129	203	146	105
Average Days from Receipt of Complaint to Inv Closure	44	51	54	47
Pending (close of FY)	84	97	71	91
CITATION AND FINE				
Citations Issued	41	50	53	40
Average Days to Complete (from complaint receipt to citation issued)	95	59	58	70
Amount of Fines Assessed	$38,950	$55,910	$39,123	$24,075
Reduced, Withdrawn, Dismissed	$0	$0	$615	$1,000
Amount Collected	$27,881	$59,601	$46,692	$28,316
CRIMINAL ACTION				
Referred for Criminal Prosecution	0	0	0	0

Table 4b. Enforcement Statistics (continued)				
	FY 21/22	FY 22/23	FY 23/24	FY 24/25
ACCUSATION				
Accusations Filed	16	25	31	18
Accusations Declined	0	0	0	0
Accusations Withdrawn	0	1	0	0
Accusations Dismissed	0	0	0	0
Average Days to File ACC (from Date Sent to AG to Date Filed)	83	95	80	105
INTERIM ACTION				
ISOs Issued	1	0	2	2
PC 23 Orders Issued	2	3	1	1
Compel Examination Orders	1	0	0	1
LICENSEE DISCIPLINE				
AG Cases Initiated (cases referred to the AG in FY)	35	31	32	22
AG Cases Pending Pre-Accusation (close of FY)	13	15	8	2
AG Cases Pending Post-Accusation (close of FY)	9	16	16	13
Disciplinary Outcomes				
Revocation	7	5	7	10
Voluntary Surrender	2	1	2	3
Suspension	0	0	0	0
Probation with Suspension	0	1	4	2
Probation	11	10	17	6
Public Reprimand	1	0	1	0
Other	0	0	0	0
Disciplinary Actions				
Proposed Decisions	3	0	1	2
Default Decisions	5	5	6	8
Stipulations	13	12	24	11
Proposed Decisions (Avg Days from Accusation Filed to Imposing Discipline)	363	0	57	339
Default Decisions Avg Days from Accusation Filed to Imposing Discipline)	98	138	145	196
Stipulated Decisions (Avg days from Accusation Filed to Imposing Discipline)	247	198	203	237
Average Days from Date Accusation Filed to Imposing Discipline	228	192	187	231
Average Days from Closure of Investigation to Imposing Discipline	312	291	267	339
Average Days from Date Complaint Received to Final Outcome	486	477	427	546

Table 4b. Enforcement Statistics (continued)				
	FY 21/22	FY 22/23	FY 23/24	FY 24/25
PROBATION				
Probations Successfully Completed	13	11	16	16
New Probationers	11	16	23	11
Probationers Tolling (close of FY)	8	9	11	10
Active Probationers (close of FY)	45	50	57	52
Cease Practice Orders				
Cease Practice Orders Issued	4	3	7	2
Orders Upheld	2	2	4	2
Orders Dissolved	2	1	3	0
Subsequent Discipline				
Accusation and/or Petition to Revoke Probation	3	2	2	5
Probations Revoked	2	2	0	3
Probations Surrendered	1	0	1	1
Probations Voluntary Surrendered (no discipline)	2	1	2	0
Probations Extended	0	0	1	1
Substance Abusing Licensees				
Probationers Subject to Drug Testing (entire FY)	23	26	26	23
Drug Tests Ordered	621	585	598	612
Positive Drug Tests	63	58	14	27
Number of Probationers Testing Positive	4	8	8	5
Positive Drug Tests for Banned Substances				
Positive Drug Tests	2	7	6	2
Number of Probationers w/Positive Drug Tests	2	4	4	2
PETITIONS				
Petitions to Modify Probation				
Granted	0	0	0	0
Denied	0	0	0	0
Petitions to Terminate Probation				
Granted	3	1	4	1
Denied	0	0	0	0
Petitions for Reinstatement of License				
Granted	0	1	1	1
Granted with Probation	0	4	1	2
Denied	2	0	0	3

Average Days for Investigation Only - Cases Referred for Prosecution

On page 38, the Average Days for Investigation Only—Cases Referred for Prosecution decreased from 129 days in FY 2021–22 to 105 days in FY 2024–25. Although there was a temporary increase in FY 2022–23, this was due to a vacancy in a Non-Sworn Special Investigator position, which was filled in FY 2023–24. Investigation timelines also improved as investigators were able to begin revisiting facilities with the easing of pandemic restrictions. The Board anticipates continued improvement in investigation timeframes as these conditions stabilize.

Disciplinary Actions

On page 39, under "Disciplinary Actions," the Board added three additional rows of data:

Average Days by Decision Type	FY 21/22	FY 22/23	FY 23/24	FY 24/25
Proposed Decisions (Avg Days from Accusation Filed to Imposing Discipline)	363	0	57	339
Default Decisions (Avg Days from Accusation Filed to Imposing Discipline)	98	138	145	196
Stipulated Decisions (Avg days from Accusation Filed to Imposing Discipline)	247	198	203	237

Stipulated decisions account for 67%, and default decisions account for 27%, of the total caseload. By breaking down the "Average Days from Accusation Filed to Imposing Discipline" to each decision type, the Board can better identify where improvements can be made in the processing times at the Office of the Attorney General (OAG). The OAG has much less control over those few cases (between three and five cases) referred for hearing that result in proposed decisions. However, the Board intends to continue working with the OAG to improve processing times for default and stipulated decisions.

Probation

SB 1441 (Statutes of 2008), created the Substance Abuse Coordination Committee (SACC), which was charged with developing uniform standards for each healing arts board to use in addressing substance-abusing licensees placed in diversion or on probation. The “Uniform Standards Regarding Substance-Abusing Healing Arts Licensees” were adopted in April 2011.

As a result of this movement and ultimately the adoption of the standards, the Board increased the number of times probationers are tested for banned substances:

Table 4c. Probation Random Testing Schedule	
	Random Tests Per Year Per Probationer
First Year of Probation	52-104
Second Year+ of Probation	36-104
Not Working in Health Care Field	12

Table 4d. Positive Drug Tests for Banned Substances				
	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
Number of Probationers w/Positive Drug Tests	2	4	4	2
Probationers Subject to Drug Testing (entire FY)	23	26	26	23
% of Probationers Testing + to Probationers Subject to Drug Testing	8.7%	15.4%	15.4%	8.7%

Data from fiscal year 2021–22 through fiscal year 2024–25, as shown in Table 4e, reflects that 25% of probationers subject to drug testing, test positive in the first three months, 41% in the first year, 17% within the second year, and 17% in years 2–5.

Table 4e. Days to Initial Positive Test						
	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	Totals	% of 12 Total
0–90 days	-	2	1	-	3	25%
0 days–1 year	2	1	2	-	5	41%
1–2 years	-	1	-	1	2	17%
2+ years	-	-	1	1	2	17%

Between fiscal years 2021–22 and 2024–25, a total of 12 initial positive drug tests for banned substances were reported across varying testing frequencies. The majority of these positive results, 75%, occurred under the most frequent testing schedule of 52 times per year, while 17% occurred under the 36-times-per-year schedule, and only 8% were associated with the 12-times-per-year schedule. Most positive tests were detected early in the monitoring period, with three occurring within the first 90 days and five more within the first year. Fewer cases were reported after the first year, with two positives identified between one and two years, and two occurring beyond the two-year mark. These results suggest that frequent and early drug testing is more effective in identifying substance use, particularly within the first year of a monitoring program.

In addition to examining the timing of positive tests, the Board also analyzed the testing frequency assigned to each probationer at the time of their initial positive result, as shown in Table 4f. Of the 12 total positives, nine occurred under a 52-times-per-year testing schedule, and two under a 36-times-per-year schedule. While this may reflect the increased likelihood of detection with more frequent testing, further analysis of the "1–2 years" period provides a contrary view. During this timeframe, one of the two positives was reported under the lower-frequency schedule of 12x per year, while the other was reported during the highest-frequency schedule of 52x per year. Typically, probationers transition to a reduced testing frequency of 36 times per year after the first year. Therefore, a probationer still being tested at the 52-times-per-year level beyond year one likely reflects prior concerns or continued risk, such as suspicious test results.

Although the dataset is limited and does not support firm conclusions, this small sample suggests that reducing the testing frequency after the first year may be equally effective as maintaining the highest level of testing beyond that point. These findings, while preliminary, offer valuable insights and may help inform ongoing development of the Board's probation monitoring practices.

Table 4f. Testing Schedule at Time of Initial Positive Test				
: FY 2021–22 to FY 2024–25 Data	12x a year	36x a year	52x a year	Totals
0–90 days	-	-	3	3
0 days–1 year	-	-	5	5
1–2 years	1	-	1	2
2+ years	-	2	-	2
% of 12 Total	8%	17%	75%	100%

Enforcement Aging

Table 4g shows that 76% of cases in which formal discipline of a license or denial of an application was pursued through the Office of the Attorney General were closed within one year. This is consistent with the percentage reported in the previous Sunset Report. Additionally, 99% of all cases during this reporting period were closed within two years, a slight increase from 97% reported previously.

A similar trend is observed in the Board's investigations. In the prior Sunset Report, the Board noted that 93% of investigations were completed in under six months. That figure remained steady but with a slight increase to 94% during this reporting period.

Table 4g. Enforcement Aging						
	FY 2021–22	FY 2022–23	FY 2023–24	FY 2024–25	Cases	Average
Attorney General Cases (Average %)						
CLOSED WITHIN:						
0–1 Year	22	23	32	20	97	76%
1–2 Years	7	5	7	10	29	23%
2–3 Years	0	0	0	1	1	1%

3–4 Years	0	0	0	0	0	0%
Over 4 Years	0	0	0	0	0	0%
Total Cases Closed	29	28	39	31	127	100%
Investigations (Average %)						
CLOSED WITHIN:						
90 Days	584	623	579	534	2,320	86%
91 - 180 Days	33	71	55	62	221	8%
181 - 1 Year	29	37	33	20	119	4%
1 - 2 Years	9	10	19	11	49	2%
2 - 3 Years	0	0	0	0	0	0%
Over 3 Years	0	0	0	0	0	0%
Total Investigations Closed	655	741	686	627	2,709	100%

STATUTE OF LIMITATIONS

The Board operates within a statute of limitations as provided in B&PC § 3750.51. Since this section was enacted in 2000, no cases have been lost or not pursued as a result of these limitations. It is the Board's policy to ensure cases are adjudicated accordingly.

> § 3750.51. Limitations period for filing accusation against licensee.
>
> (a) Except as provided in subdivisions (b), (c), and (e), any accusation filed against a licensee pursuant to Section 11503 of the Government Code shall be filed within three years from the date the board discovers the alleged act or omission that is the basis for disciplinary action, or within seven years from the date the alleged act or omission that is the basis for disciplinary action occurred, whichever occurs first.
>
> (b) An accusation filed against a licensee pursuant to Section 11503 of the Government Code alleging the procurement of a license by fraud or misrepresentation is not subject to the limitations set forth in subdivision (a).
>
> (c) The limitation provided for by subdivision (a) shall be tolled for the length of time required to obtain compliance when a report required to be filed by the licensee or registrant with the board pursuant to Article 11 (commencing with Section 800) of Chapter 1 is not filed in a timely fashion.
>
> (d) If an alleged act or omission involves a minor, the seven-year limitations period provided for by subdivision (a) and the 10-year limitations period provided for by subdivision (e) shall be tolled until the minor reaches the age of majority.

(e) An accusation filed against a licensee pursuant to Section 11503 of the Government Code alleging sexual misconduct shall be filed within three years after the board discovers the act or omission alleged as the ground for disciplinary action, or within ten years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first.

(f) The limitations period provided by subdivision (a) shall be tolled during any period if material evidence necessary for prosecuting or determining whether a disciplinary action would be appropriate is unavailable to the board due to an ongoing criminal investigation.

CASE PRIORITIZATION

The Board uses the following guidelines which are intended to assist staff in distinguishing the level of attention and priority in which each complaint is handled. Of course these are merely guidelines, as many complaints have extenuating circumstances that may warrant more or less attention. Overall, these guidelines are in line with DCA's Complaint Referral Guidelines for Investigation established in August 2016. The workflow charts on pages 48–49 also show how urgent complaints are handled differently through the intake and investigative processes versus how high-priority and routine complaints are handled.

With all complaints, special consideration is given to whether a child, any dependent adult, or even an animal was affected or could have been affected by the willful or negligent behavior or incompetence of the licensee, at or away from work (this information is often found in an arrest or initial report). Such commissions or omissions in the care for children, dependent adults, and animals who cannot fend for themselves and place their trust in their care with the respondent warrants a higher level of complaint handling and discipline.

Within each level, some complaints take higher priority. In addition, at any time during an investigation, if it is found the complaint poses a greater risk, the complaint is elevated.

Urgent Complaints
Respondent has allegedly engaged in conduct that poses an imminent risk of serious harm to the public health, safety, and welfare. The time that has lapsed since the act occurred may be weighted in the "imminent" risk factor. In general, complaints that rise to this level include:

- Acts of serious patient/consumer harm, great bodily injury, or death.
- Mental or physical impairment of licensee with potential for public harm.
- Practicing while under the influence of drugs/alcohol (including criminal convictions for the use of alcohol/drugs en route to a work shift).
- Repeated allegations of drug/alcohol abuse.
- Narcotic/prescription drug theft; drug diversion; other unlawful possession.
- Sexual misconduct whether or not with a patient.
- Physical/mental abuse of a patient.
- Gross negligence/incompetence resulting in serious harm/injury.
- Media/politically sensitive cases.

- The time to pursue a complaint pursuant to B&PC § 3750.51, statute of limitations, is jeopardized.

High Priority Complaints
Respondent has allegedly engaged in conduct that poses a risk of harm to the public heath, safety, and welfare. Some complaints that rise to this level include:

- Prescribing/dispensing without authority.
- Unlicensed practice/unlicensed activity.
- Aiding and abetting unlicensed activity.
- Criminal violations including but not limited to prescription forgery, selling, or using fraudulent documents and/or transcripts, use, possession or sale of narcotics, major financial fraud, financial elder abuse, insurance fraud, etc.
- Exam subversion where exam is compromised.
- Mandatory peer review reporting (B&PC § 805).
- Threat that evidence may be compromised, destroyed, or made unavailable.
- History of similar complaints.

Routine Complaints
Routine complaints are strictly paper cases where no patient harm is alleged. Expert or additional investigation is not anticipated. These complaints do not generally require medical records, but may require personnel/employment records that are routine in nature and are requested on a regular basis for similar complaints. Some complaints at this level may include:

High-Level Routine Complaints
- General unprofessional conduct and/or general negligence/incompetence resulting in no injury or minor harm/injury (non-intentional act, non-life threatening).
- Subsequent arrest notifications (no immediate public threat).
- Exam subversion (individual cheating where exam is not compromised).
- Patient abandonment.
- False/misleading advertising (not related to unlicensed activity or criminal activity).
- Applicant misconduct.

Low-Level Routine Complaints
- Unsanitary conditions.
- Failure to release medical records.
- Continuing education violations.
- Declaration and record collection (e.g., licensee statements, medical records, arrest and conviction records, employment records).
- Complaints of offensive behavior or language (e.g., poor bedside manner, rude, etc.).
- Quality-of-service complaints.

- Complaints against licensee on probation that do not meet other category criteria.
- Anonymous complaints unless the Board corroborates it meets other category criteria.
- Other minor violations that generally result in the issuance of a citation and fine or warning (e.g., failed to report a change of address).

MANDATORY REPORTING

The Board received an average of 50 mandatory reporting complaints per year, over the last four fiscal years. B&PC § 3758, 3758.5, and 3758.6 provide mandatory reporting requirements. The majority of reports received are based on compliance with section 3758, which provides that any employer of a respiratory care practitioner is required to report to the Board any leave, resignation, suspension, termination, or request to place on a 'do not call' list for the following causes of any practitioner in their employ:

(1) Suspected or actual use of controlled substances or alcohol to such an extent that it impairs the ability to safely practice respiratory care.
(2) Suspected or actual unlawful sale of controlled substances or other prescription items.
(3) Suspected or actual patient neglect, physical harm to a patient, or sexual contact with a patient.
(4) Suspected or actual falsification of medical records.
(5) Suspected or actual gross incompetence or negligence.
(6) Suspected or actual theft from patients, other employees, or the employer.

B&PC § 3758.5 provides that, if a licensee has knowledge that another person may be in violation of the RCPA, he or she must report that information to the Board. B&PC § 3758.6 provides that any employer reporting an RCP who has been subject to leave, resignation, suspension, or termination for cause, include the name, professional licensure type and number, and title of the person supervising the licensee.

UNLICENSED ACTIVITY

Unlicensed activity of respiratory care has been noticed most often in home care and subacute facilities. It can range from providing breathing treatments to more complicated tasks of manipulating ventilator settings and/or circuits.

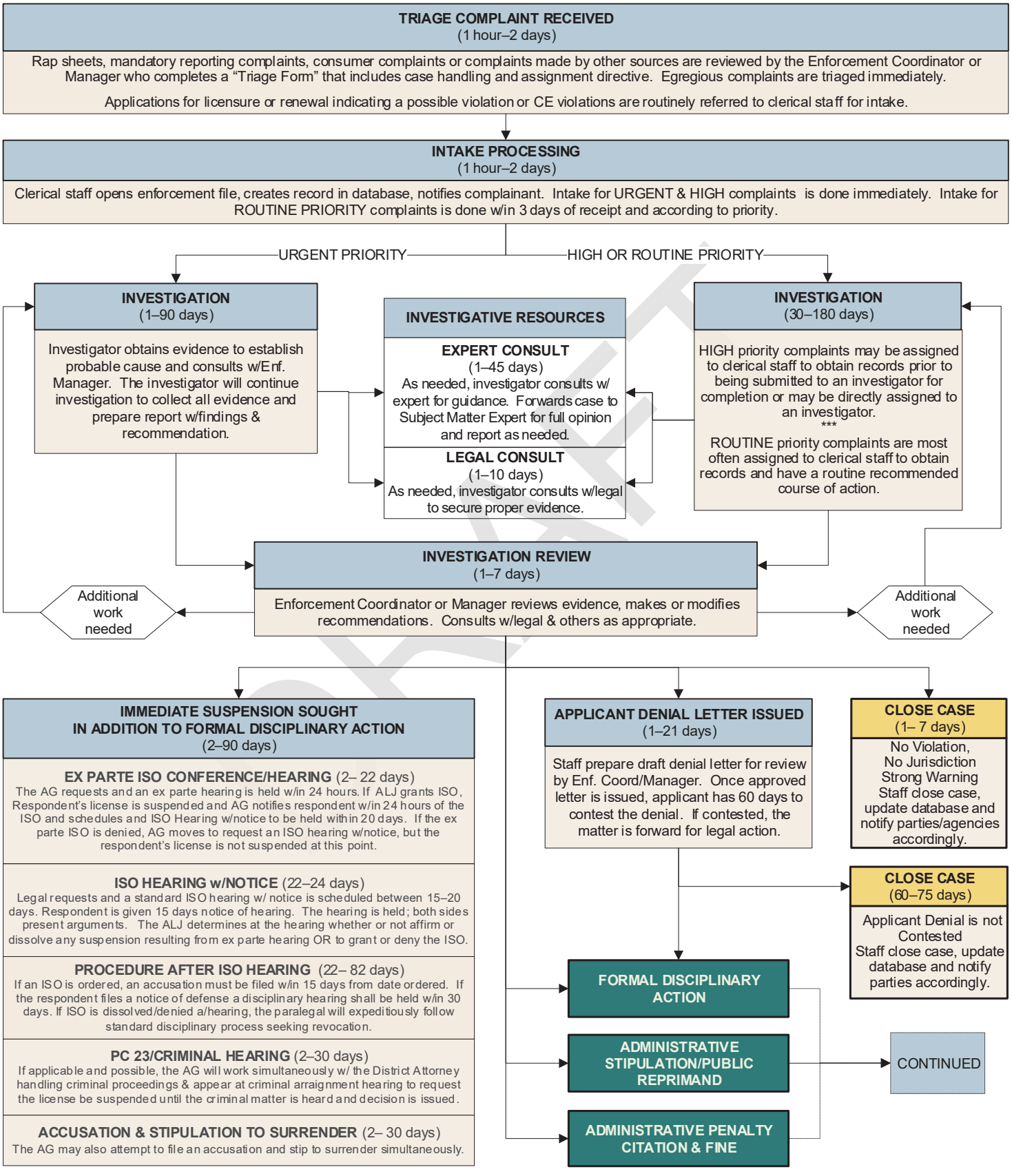
Unlicensed practice occurring in homes (including home medical device retail facilities) and subacute care facilities is addressed through joint efforts of the Board and the California Department of Public Health and the Department of Health Care Services. The Board has provided presentations to inspectors to familiarize them with respiratory care and shared investigative resources.

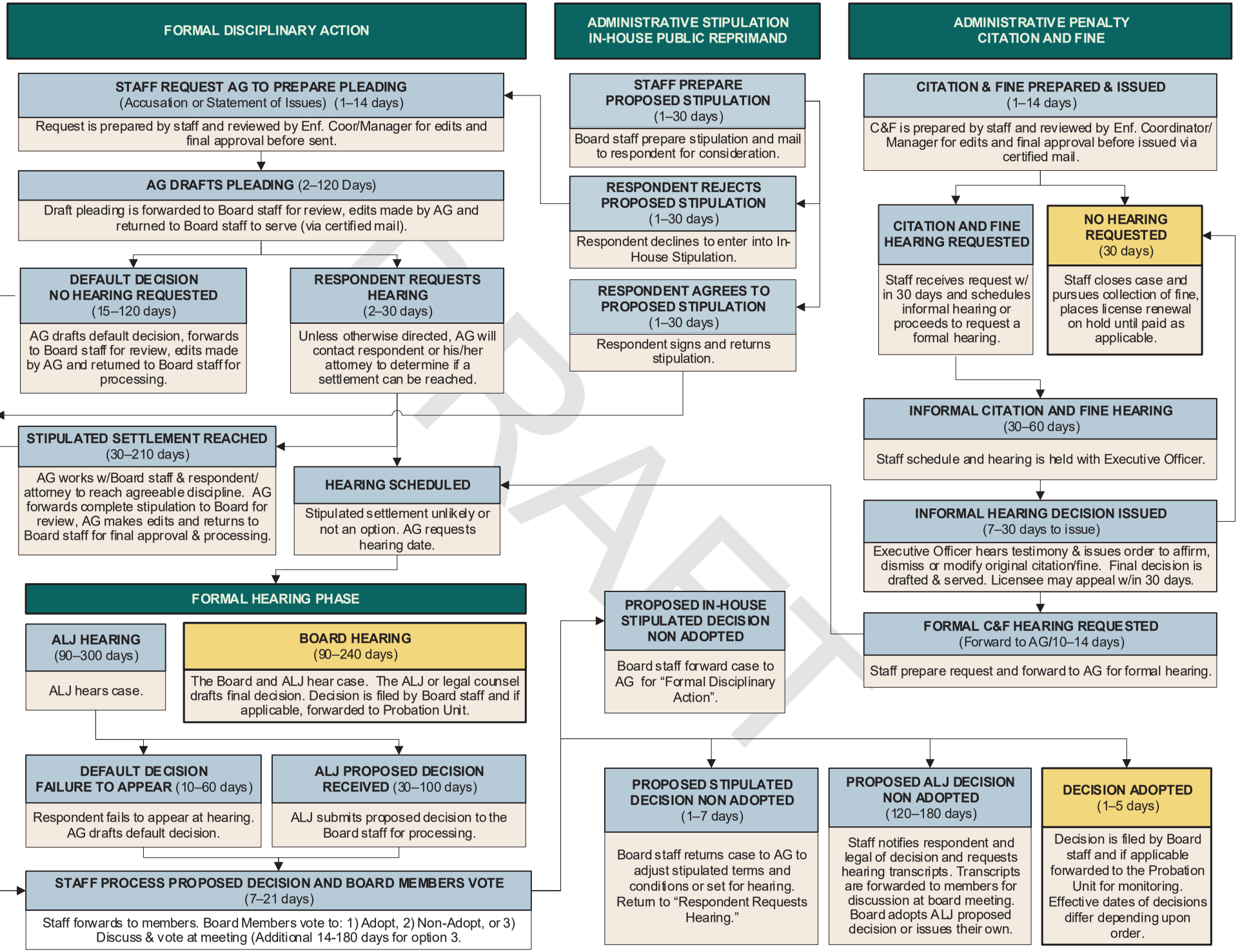
The Board may issue a citation and fine to employers, as well as to unlicensed or unauthorized persons, practicing respiratory care. Egregious cases of unlicensed practice are sent to the appropriate district attorney for consideration to file criminal charges.

Respiratory Care Board of California

ENFORCEMENT PROCESS OVERVIEW

(Revised 10/14/21)




FORMAL DISCIPLINARY ACTION
ADMINISTRATIVE STIPULATION IN-HOUSE PUBLIC REPRIMAND
ADMINISTRATIVE PENALTY CITATION AND FINE
STAFF REQUEST AG TO PREPARE PLEADING (Accusation or Statement of Issues) (1–14 days)
Request is prepared by staff and reviewed by Enf. Coor/Manager for edits and final approval before sent.
AG DRAFTS PLEADING (2–120 Days)
Draft pleading is forwarded to Board staff for review, edits made by AG and returned to Board staff to serve (via certified mail).
DEFAULT DECISION NO HEARING REQUESTED (15–120 days)
AG drafts default decision, forwards to Board staff for review, edits made by AG and returned to Board staff for processing.
RESPONDENT REQUESTS HEARING (2–30 days)
Unless otherwise directed, AG will contact respondent or his/her attorney to determine if a settlement can be reached.
STAFF PREPARE PROPOSED STIPULATION (1–30 days)
Board staff prepare stipulation and mail to respondent for consideration.
RESPONDENT REJECTS PROPOSED STIPULATION (1–30 days)
Respondent declines to enter into In-House Stipulation.
RESPONDENT AGREES TO PROPOSED STIPULATION (1–30 days)
Respondent signs and returns stipulation.
CITATION & FINE PREPARED & ISSUED (1–14 days)
C&F is prepared by staff and reviewed by Enf. Coordinator/ Manager for edits and final approval before issued via certified mail.
CITATION AND FINE HEARING REQUESTED
Staff receives request w/ in 30 days and schedules informal hearing or proceeds to request a formal hearing.
NO HEARING REQUESTED (30 days)
Staff closes case and pursues collection of fine, places license renewal on hold until paid as applicable.
INFORMAL CITATION AND FINE HEARING (30–60 days)
Staff schedule and hearing is held with Executive Officer.
INFORMAL HEARING DECISION ISSUED (7–30 days to issue)
Executive Officer hears testimony & issues order to affirm, dismiss or modify original citation/fine. Final decision is drafted & served. Licensee may appeal w/in 30 days.
FORMAL C&F HEARING REQUESTED (Forward to AG/10–14 days)
Staff prepare request and forward to AG for formal hearing.
STIPULATED SETTLEMENT REACHED (30–210 days)
AG works w/Board staff & respondent/ attorney to reach agreeable discipline. AG forwards complete stipulation to Board for review, AG makes edits and returns to Board staff for final approval & processing.
HEARING SCHEDULED
Stipulated settlement unlikely or not an option. AG requests hearing date.
FORMAL HEARING PHASE
ALJ HEARING (90–300 days)
ALJ hears case.
BOARD HEARING (90–240 days)
The Board and ALJ hear case. The ALJ or legal counsel drafts final decision. Decision is filed by Board staff and if applicable, forwarded to Probation Unit.
DEFAULT DECISION FAILURE TO APPEAR (10–60 days)
Respondent fails to appear at hearing. AG drafts default decision.
ALJ PROPOSED DECISION RECEIVED (30–100 days)
ALJ submits proposed decision to the Board staff for processing.
STAFF PROCESS PROPOSED DECISION AND BOARD MEMBERS VOTE (7–21 days)
Staff forwards to members. Board Members vote to: 1) Adopt, 2) Non-Adopt, or 3) Discuss & vote at meeting (Additional 14-180 days for option 3.
PROPOSED IN-HOUSE STIPULATED DECISION NON ADOPTED
Board staff forward case to AG for "Formal Disciplinary Action".
PROPOSED STIPULATED DECISION NON ADOPTED (1–7 days)
Board staff returns case to AG to adjust stipulated terms and conditions or set for hearing. Return to "Respondent Requests Hearing."
PROPOSED ALJ DECISION NON ADOPTED (120–180 days)
Staff notifies respondent and legal of decision and requests hearing transcripts. Transcripts are forwarded to members for discussion at board meeting. Board adopts ALJ proposed decision or issues their own.
DECISION ADOPTED (1–5 days)
Decision is filed by Board staff and if applicable forwarded to the Probation Unit for monitoring. Effective dates of decisions differ depending upon order.

CITE AND FINE

The Board's Cite and Fine (C&F) program allows the Board to penalize licensees rather than pursue formal discipline for less serious offenses or offenses where probation or revocation are not appropriate. The goal of the C&F program is to provide public notice, inform licensees that repeated actions will negatively affect their licensure, and establish a record should future violations occur that will support formal disciplinary action.

The Board amended its regulations, effective July 1, 2012, to increase nearly all fine amounts to the maximum of $5,000 pursuant to B&PC §125.9. The Board also has authority to cite and fine other specific violations up to $15,000 as follows:

- § 3717 Failure of an employer to provide records as part of an investigation (Maximum fine: $10,000 per violation).
- § 3758 Failure to report the suspension or termination for cause of a licensed RCP (Maximum fine: $10,000 per violation).
- § 3758.6 Failure to report the supervisor of the licensee who was suspended or terminated for cause. (Maximum fine: $10,000).
- § 3767 Unlicensed Practice or knowingly employing unlicensed personnel (Maximum fine: $15,000 per violation).

The Board issued an average of 46 citations annually between fiscal years 2021–22 and 2024–25. Over the four-year period, 71% of citations issued were for driving under the influence of alcohol convictions (with no priors within seven years), 4% were issued for CE violations, and the remaining 25% were issued for various violations including unlicensed practice, perjury, and other less egregious criminal convictions.

To qualify for a citation and fine, there must be no pattern of repeated behavior, and no child, dependent adult, or animal may have been neglected or involved as a victim or in any criminal activity. Roughly 71% of these citations carry fines of either $250 or $500. Over the past four fiscal years, 184 citations have been issued; only 4 (2 %) were appealed, all of which were resolved through informal conferences, with none proceeding to a hearing before an Administrative Law Judge (ALJ).

COST RECOVERY

Over the past four fiscal years, the Board has identified between 19 and 33 cases annually with potential for cost recovery, totaling 102 cases. In every one of these matters, the Board sought full cost recovery to recoup investigative and enforcement expenses incurred in protecting the public. Costs were ultimately ordered in all 102 cases.

The Board generally pursues full cost recovery whenever it is legally and practically feasible. In rare instances, however, it may determine that continued pursuit is not warranted. This can occur when evidence supports the *Zuckerman v. Board of Chiropractic Examiners* precedent, which limits recovery if costs are deemed disproportionate or not reasonably related to the violation, or when the time and resources required to reject or "non-adopt" a proposed decision would outweigh the benefit, particularly in situations where immediate action such as license revocation is necessary to protect consumer safety.

These considerations ensure that the Board balances fiscal responsibility with its primary mandate of consumer protection, focusing resources where they have the greatest impact on safeguarding the public.

Table 4h. Cost Recovery

	FY 2021–22	FY 2022–23	FY 2023–24	FY 2024–25
Total Enforcement Expenditures	$509,363	$485,047	$705,203	$580,726
Potential Cases for Recovery	24	19	33	26
Cases Recovery Ordered	24	19	33	26
Amount of Costs Ordered	$198,419	$162,499	$343,308	$418,728
Amount Collected	$165,037	$185,159	$174,333	$201,947

Over this four year period, the total "Amount of Costs Ordered" and "Amount Collected" were $1,122,954 and $726,476, respectively. The Board collected 65% of the costs ordered during this time frame (costs collected may also include costs ordered in years prior to FY 2021–22). The Board is most successful in collecting costs in cases that result in probation or a public reprimand, because licensees are more vested in retaining licensure. In nearly all cases where a licensee surrenders their license, the Board agrees, primarily to expedite stipulated decisions and avoid unrecoverable hearing costs, to defer cost recovery until the individual petitions for reinstatement. All costs must be paid in full before such a petition will be considered. The most difficult cases from which to collect costs are those resulting in revocation.

The average cost recovery amount ordered per case increased from $8,264 in FY 2021–22 to $16,105 in FY 2024–25. While payment is typically due within one year of the order date, the Board remains flexible in granting payment schedules or extensions.

To support collection, the Board employs several mechanisms to recover costs, including:

- Franchise Tax Board Intercept Program
- Renewal hold
- The Board's monthly billing
- Collection agency contract

The Board began participating in the Franchise Tax Board (FTB) Intercept Program in 1996. Under this program, if a licensee is due to receive a state tax refund, the funds may be intercepted and redirected to the Board to satisfy outstanding financial obligations. In addition, the Board has statutory and regulatory authority to place a “hold” on the renewal of a license for failure to pay 1) probation monitoring costs once they are off probation (B&PC § 3753.1), 2) cost recovery (B&PC § 3753.5), or 3) fines (CCR §1399.385). These enforcement mechanisms have proven to be highly effective in recovering costs from individuals who continue to maintain an active license.

Since 2003, the Board has utilized a Cost Recovery Database to track fines, cost recovery, and probation monitoring costs as ordered through disciplinary actions. In 2013, the Board transitioned to a similarly configured component within the BreEZe system, which includes the added functionality of generating invoices. This feature has proven effective in supporting timely payments from individuals on probation or those issued a public reprimand.

While payment schedules are typically arranged on a monthly or quarterly basis, the Board maintains flexibility and allows respondents to propose alternative schedules or extensions, provided they demonstrate a good faith effort to fulfill their financial obligations. Invoices are routinely issued on a monthly basis.

For licensees who fail to respond or remit payment by the due date, the Board places a hold on the license, preventing renewal until the outstanding balance is addressed. For non-licensees who fail to make contact within 90 days of a missed due date, the Board issues a final notice indicating that the account will be referred to the Franchise Tax Board's Intercept Program within 30 days.

Additionally, since 2003, the Board has contracted with a collection agency to assist with debt recovery. The contractor is compensated with approximately 15% of the amounts it successfully collects. The Board exercises discretion in referring accounts to collections, ensuring that all other reasonable efforts to resolve the matter have been exhausted beforehand.

Section 5
Public Information Policies

WEBSITE/EMAIL

The Board continues to prioritize transparency and stakeholder engagement through the effective use of its website and digital communication platforms. The Board's website serves as a primary source of public information and is structured to provide a user-friendly experience while ensuring timely access to critical updates. Key materials available on the website include:

- Upcoming meeting dates and locations
- Meeting agendas and related materials/attachments
- Meeting minutes
- Proposed regulatory amendments
- Topics of interest
- E-Newsletters
- Strategic plans

To further support stakeholder outreach, the Board utilizes email as an official channel for distributing notices and updates. The public can subscribe to receive these communications via a dedicated sign-up link on the Board's website.

Additionally, the Board now has the ability to send targeted communications directly to licensees who have provided email addresses within the Department of Consumer Affairs' BreEZe licensing system. This enhanced functionality allows the Board to disseminate information more efficiently and ensure that licensees remain informed of regulatory developments, policy changes, and the Board's initiatives.

These outreach strategies align with the Board's commitment to transparency, accessibility, and proactive engagement with both licensees and the public.

SOCIAL MEDIA

Although the Board has maintained a LinkedIn account for several years, it significantly expanded its social media presence in early 2025, recognizing that social media is the future of effective information distribution. As part of this effort, the Board launched official Facebook, X, and Instagram accounts and implemented a comprehensive social media plan to ensure consistent, strategic communication with stakeholders. Since the expansion, the Board has gained over 600 new followers across platforms, generated more than 34,000 views and 1,100 content interactions, and now publishes about six posts per month. Engagement continues to grow steadily, with posts averaging hundreds of impressions and reactions each month. The DCA's Office of Publications, Design and Editing has played a key role throughout this process, producing high-quality graphics that complement and elevate the Board's messaging.

BOARD MEETINGS

The Board has publicly posted meeting information since 2001. Each year, meeting dates and general locations for the following calendar year are published at the end of the preceding year, giving the public and stakeholders ample time to plan for participation. Agendas with specific meeting locations are always posted at least 10 days in advance, in full compliance with the Bagley-Keene Open Meeting Act. Once an agenda is posted, the Board distributes email notices with direct links to the agenda and all supporting materials to subscribers on its interested-parties list. A limited number of hard-copy agendas and materials are mailed to the Board's members and to those who specifically request them.

Since February 2011, the Board has also posted all agenda materials and attachments online at the same time as the agenda, making them immediately accessible to the public. Meeting minutes are approved at the next regularly scheduled meeting and promptly added to the website, ensuring that the official record is complete and easy to access.

The Board also provides broad public access to its proceedings through live and recorded formats. When scheduling permits, the Board has used the DCA webcast services and recordings of meetings dating back to 2016 are available on YouTube for on-demand viewing. In recent years, as public expectations have shifted toward virtual participation, the Board has made a deliberate effort to provide meetings via WebEx, allowing interested parties to participate in real time or view remotely.

This shift to hybrid and virtual formats has enhanced the Board's ability to reach stakeholders across California, including licensees, educators, students, and members of the public who might otherwise face geographic or scheduling barriers. DCA's technical support and moderation have been instrumental in ensuring a seamless experience for participants.

OUTREACH

The Board uses multiple methods of outreach to keep licensees, educators, and the public well informed. The Board publishes and distributes an e-newsletter two to three times per year containing updates on regulations, licensing requirements, and other matters of interest to all licensees and subscribed stakeholders. It also provides information on new license renewal requirements through email and letters sent by mail to respiratory care department managers, ensuring that details reach both individuals and healthcare institutions directly.

The Board further relies on direct email communication with education program directors when new requirements or developments could affect their programs, current students, or incoming students. Program directors have proven to be a valuable resource in disseminating information to students.

The Board's members also participate in outreach whenever possible, helping to advance the profession's visibility and share expertise. For example, Board Member Michael Terry contributed to a peer-reviewed research article, "Advanced Practice Respiratory Therapy in the State of California: A Cross-Sectional Needs Assessment Study," published in the Journal of Multidisciplinary Healthcare on June 25, 2025, further demonstrating the Board's commitment to professional engagement and knowledge sharing.

COMPLAINT DISCLOSURE POLICY

Upon receipt of a consumer inquiry, the Board provides information and records in accordance with the Public Records Act (sections 6250–6270 of the Government Code).

The Board's Complaint Disclosure Policy (adopted on May 18, 2001, based on legal advice) provides for the disclosure of information once an accusation or statement of issues (SOI) has been filed and includes the complete disclosure of the details contained within those documents. The policy also provides for the disclosure of subsequent formal actions and any public information available concerning whether a district or city attorney has the case for review or has filed charges. In addition, these documents are made public once they have become final or a judge has issued an order:

- Citations, fines, and orders of abatement
- Interim suspension orders (ISOs)
- Suspensions/restrictions via Penal Code section 23

All of the above information is available on the Board's website and is listed with each individual license record, as applicable, through the online license verification component. Non-licensees are not listed online, including applicants, until they are licensed.

The Board also publishes disciplinary summaries that allows a inquirer to look at the summary of all the disciplinary action taken each quarter. The information posted dates back to October 2016.

Every record request made pursuant to the Public Records Act for information not listed above is reviewed by the Board's legal counsel to determine which records are legally permitted to be released and/or which records must be redacted. The Board receives between one and three Public Records Act requests per year.

Section 6
Online Practice Issues

Telehealth is becoming an integral part of the delivery of healthcare today. This is especially important, as studies show that telehealth reduces hospital readmissions, improves quality of life, and reduces costs.

California law already provides a comprehensive framework for telehealth. B&PC § 2290.5, which applies to all healing arts licensees, including RCPs, defines "telehealth" as:

> "The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers."

The American Association for Respiratory Care also defines two additional terms:

> "Remote patient monitoring is conducted via a coordinated system that uses one or more home-based or mobile monitoring devices that automatically transmit vital-sign data or other information as part of a patient's plan of care wirelessly, or through a telecommunications connection to a server, allowing review and interpretation of that data by a healthcare professional.
>
> Store-and-forward telehealth involves the acquisition and storing of clinical information (e.g., data, image, sound, video) that is then forwarded to (or retrieved by) another site for clinical evaluation (e.g., analogous to sending a picture via text message). For Medicare, this means the information would be transmitted from the originating site where the beneficiary is located to the distant site where the physician/practitioner is located for review at a later date."

Telehealth provided by RCPs may include:

Patient Assessment and Monitoring

- Remote monitoring of vital signs (e.g., oxygen saturation, respiratory rate)
- Evaluation of symptoms or exacerbation signs
- Review of home-use ventilators or CPAP/BiPAP data

Patient and Caregiver Education

- Training on proper inhaler, nebulizer, or oxygen equipment use
- Disease-specific education (e.g., asthma, COPD, cystic fibrosis)
- Smoking cessation support

Therapy Management and Follow-Up

- Pulmonary rehabilitation check-ins and progress tracking
- Adjustment of oxygen therapy or ventilator settings (in collaboration with physicians)
- Monitoring adherence to prescribed therapies

Triage and Care Coordination

- Early identification of clinical deterioration to reduce ER visits
- Coordination with physicians, nurses, and case managers
- Support in transitions of care (e.g., hospital to home)

Virtual Pulmonary Rehabilitation

- Supervised exercise training and breathing techniques via video
- Coaching and motivational support

Chronic Disease Management Programs

- COPD, asthma, interstitial lung disease, and heart failure
- Regular check-ins to support symptom control and medication compliance

Sleep Disorder Support

- Education and troubleshooting for sleep apnea patients using CPAP/BiPAP
- Review of compliance data from cloud-connected devices

In March 2025, the Board took a support position on federal legislation, H.R. 783, the Sustainable Cardiopulmonary Rehabilitation Services in the Home Act, which aims to permanently expand Medicare coverage for cardiac and pulmonary rehabilitation services delivered via telehealth in patients' homes. Originally made possible through temporary COVID-19 waivers, this bill would make those flexibilities permanent, removing geographic restrictions and allowing patients to receive care at home regardless of location. It expands the list of eligible providers, including physicians, nurse practitioners, physician assistants, and hospital-based programs, to deliver these services virtually. The bill also grants the Department of Health and Human Services authority to define standards for when a patient's home qualifies as an eligible site and to establish criteria for telehealth-based rehab programs. Overall, H.R. 783 seeks to increase access to care for patients with cardiovascular and pulmonary conditions, improve health outcomes, reduce hospital readmissions, and support cost-effective home-based care.

RCPs are uniquely qualified to provide telehealth services, given their expertise in managing respiratory disease states ranging from routine outpatient care to the most acute emergencies.

Although the Board does not have laws or regulations specific to telehealth, California's existing telehealth statute (B&PC § 2290.5) already governs RCPs and other licensed providers when practicing remotely. The Board's current statutes and regulations, including those addressing competence, negligence, and unprofessional conduct, apply equally to telehealth encounters.

To date, the Board has not received any complaints involving telehealth practice.

Section 7
Workforce Development and Job Creation

The Board's 2007 Workforce Study suggested California would need an available supply of 19,000 RCPs by 2025 and 21,000 RCPs by 2030. At the end of fiscal year 2024–25, California had 21,390 active licenses. Accordingly, the Board does not foresee a workforce shortage.

However, the Board's 2017 Workforce Study highlighted the expected retirement of 35% of people ***in management*** in the coming years. The following indicators suggest the Board is currently witnessing this attrition.

	FY 21/22	FY 22/23	FY 23/24	FY 24/25	Difference/Sum
Active	20,467	20,845	21,268	21,390	923
Retired*	1,201	1,296	1,377	1,474	273
New Licenses Issued	1,240	1,347	1,369	1,232	5,188

*A licensee has the option of placing their license in a retired status at any time, though it is not required. Many licensees still allow their license to lapse and then eventually cancel.

While there have been 5,188 new licenses issued since fiscal year 2021-22, the number of active licenses has only increased by 923, leaving 4,265 licenses that either retired or allowed their license to become delinquent (delinquent licenses cancel after three years) over a period of four years. There is no data to determine how many of these are held by RCPs in management. This means that about 20% of the state's 21,000-member workforce has moved from active and current licensure to a non-working status over the four-year period.

The California Employment Development Department (EDD) published the following occupational outlook for RCPs:

Estimated Year–Projected Year	Employment		Employment Change		Annual Average Openings
	Estimated	Projected	Number	Percent	
2020-2030	16,600	20,700	4,100	24.7	12,790

The U.S. Bureau of Labor Statistics provides:

"Employment of respiratory therapists is projected to grow 13 percent from 2023 to 2033, much faster than the average for all occupations.

About 8,200 openings for respiratory therapists are projected each year, on average, over the decade. Many of those openings are expected to result from the need to replace workers who transfer to different occupations or exit the labor force, such as to retire." [Generally, the California RCP workforce represents 10% of the national RCP workforce.]

Growth in the older adult population will lead to an increased prevalence of respiratory conditions such as pneumonia, chronic obstructive pulmonary disease (COPD), and other disorders that restrict lung function. This, in turn, will lead to increased demand for respiratory care services and treatments, mostly in hospitals.

In addition, a growing emphasis on reducing readmissions to hospitals and on providing patient care in outpatient facilities may result in more demand for RCPs in health clinics and in doctors' offices.

Other respiratory conditions that affect people of all ages, such as problems due to smoking and air pollution, long COVID, or those arising from emergencies, will continue to create demand for RCPs.

The Board remains aware of the need to process applications timely and remove any unnecessary barriers. Education programs are kept informed by direct e-mail of any changes that may impact incoming or existing students as it relates to the application and licensure process. The Board periodically revises its booklet, "Licensure and the Application Process" and disseminates multiple copies to each education program. The last revisions were completed in 2023.

The Board continuously examines its laws and regulations, and business processes to determine if they can be re-engineered to further streamline the application process. In support of these efforts, respiratory care programs have been notified that initial application filing will go completely electronic in 2026. This change is aimed at ensuring greater efficiency, reducing processing times, and enhancing the overall experience for applicants.

COMMITMENT TO DIVERSITY, EQUITY, INCLUSION, AND ACCESSIBILITY (DEIA)

The Board remains deeply committed to promoting equity and inclusivity across all its programs and regulatory functions. Guided by broader state initiatives and principles of social responsibility, the Board continuously evaluates its practices and policies to ensure they are reflective of the diverse populations it serves. While this is an ongoing effort, the Board has taken steps to foster greater awareness and sensitivity to the needs of vulnerable and underserved communities. Through increased engagement and internal reflection, the Board strives to uphold fairness and accountability, while working to identify opportunities that support positive outcomes for all Californians. In support of these efforts, the Board's Executive Officer volunteered to serve on the Department's Diversity, Equity, Inclusion, and Accessibility (DEIA) Executive Steering Committee which was created to: 1) support workplace inclusion and diversity; 2) expand culturally competent communications; and 3) provide DEIA-related training to all staff.

Section 8
Current Issues

BreEZe (ENFORCEMENT AND LICENSING SYSTEM)

The Board was among the first boards to transition to BreEZe in October 2013. The system was designed to consolidate multiple databases previously maintained by the Board, including its cost recovery database, probation monitoring database, and several tracking spreadsheets. The initial rollout proceeded relatively smoothly, and within the first six months, the Board submitted nearly 130 change requests, all of which were resolved in a timely manner and to the Board's satisfaction. Currently, the Board submits an average of 10 system change requests per fiscal year, primarily in response to business process changes, with most resolved within one to three months. The DCA staff who led the initial implementation did an exceptional job, and the Department's continued commitment to supporting the system remains commendable.

With BreEZe offering online functionality across multiple areas, staff continue to revise business practices to maximize the system's efficiency. For example, data from fiscal year 2023–24 showed that 81% of initial applications were submitted online, and nearly 97% of renewals were processed electronically. Reflecting this shift, the Board replaced its multi-page renewal notice with a simplified postcard to reduce printing and postage costs. The postcard reminds licensees when it's time to renew and directs them to the BreEZe website. Those who prefer not to renew online may still request a paper application by mail.

Similarly, as noted on the preceding page, the decision to transition to an exclusively online initial application process in 2026 is based on the advantages offered by the BreEZe system, such as:

- Prevention of application form deficiencies, as all mandated fields are required to be completed before the application can be submitted;
- Ability to attach supporting documents;
- Ability to view and monitor outstanding application requirements, including viewing updates when outstanding items have been fulfilled; and
- Online notification when the application has been approved.

Applicants and licensees are also encouraged to submit information electronically by using the BreEZe attachment feature to upload supporting documents, audit responses, and completed forms, helping to expedite the processing of these items.

The Quality Business Interactive Reporting Tool (QBIRT) has proven to be an ***extremely*** valuable tool that was not available prior to the implementation of the BreEZe system. Staff can now extract data in various formats, enabling management to more effectively identify organizational strengths and areas for improvement. Additionally, DCA continues to enhance reporting functionality by developing standardized definitions to ensure consistent data reporting across all programs.

INSERT GRAPH OF BreEZe FUNCTIONALITY

Section 9
Board Action and Response to 2021–2022 Sunset Review Issues

BOARD ADMINISTRATION ISSUES

ISSUE #1: (REGULATIONS.) What is the current timeframe for the Board regulatory packages to be approved and finalized?

Background: Promulgating regulations is at the heart of the Board's work to implement the law and establish a framework for consumer protection. According to the Office of Administrative Law (OAL), a "regulation" is any rule, regulation, order or standard of general application or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it. When adopting regulations, every department, division, office, officer, bureau, board or commission in the executive branch of the California state government must follow the rulemaking procedures in the Administrative Procedure Act (APA) (Government Code section 11340 et seq.) and regulations adopted by OAL, unless expressly exempted by statute from some or all of these requirements. The APA requirements are designed to provide the public with a meaningful opportunity to participate in the adoption of regulations or rules that have the force of law by California state agencies and to ensure the creation of an adequate record for the OAL and judicial review.

The rulemaking process does provide some discretion to agencies. While each agency must comply with timeframe requirements and must produce the same uniform documents supporting rulemaking efforts to submit to OAL, there are not the same standards for how regulation packages are determined, written, and produced.

Prior to 2016, boards and bureaus like the Board that are organized within DCA filed rulemaking packages directly with OAL. Boards and bureaus were not required to submit rulemaking packages to DCA or the overseeing agency for review and approval prior to submission for publication in the Notice Register. OAL reported that this process was unusual within state government as most programs must submit regulations packages to their respective agency for approval. As a result, in September 2016, the Secretary of the Business, Consumer Services and Housing Agency (BCSH) changed the procedures requiring boards and bureaus to submit rulemaking packages to the department and BCSH for review prior to filing with OAL. BCSH stated that the reason for the decision was an increase in the number of regulations disapproved by OAL for failing to meet their statutory requirements.

According to a 2019 DCA report to the Legislature, Internal Review of Regulation Procedures, "the resulting enhanced scrutiny from Agency and DCA's Legal Affairs Division successfully reduced the number of disapproved regulation packages, with the number of disapprovals falling from nine in 2016 to only one in 2018." The report also found that "while disapproval rates plummeted, a consequence was lengthened timelines to adopt regulations. Several boards and bureaus raised objections to the lengthened review time and reported difficulty obtaining

timely updates about regulation packages under review." The "pre-review" process required regulations to go through DCA's entire review process prior to the package being submitted for public comment. DCA established a formal Regulations Unit to "minimize the length of time it currently takes to review regulatory packages; allow board and bureau attorneys to focus on the increased workload of non-regulatory work; respond to the demand of regulation packages under review and the increase of regulation packages from AB 2138 (Chiu and Low; Chapter 995, Statutes of 2018); avoid the habitual carry-over of regulation packages; and, enhance the level of regulation training provided to boards and bureaus to improve the quality of regulations and create efficiencies by having better quality packages submitted for review."

It would be helpful for the Committees to have a better understanding of the status of necessary Board regulations, the timeframe for regulations to be processed and complete and what efficiencies the Board has realized since the creation of the Regulations Unit.

Staff Recommendation: The Board should provide the Committees with an update on pending regulations and the current timeframes for regulatory packages. In addition, the Board should inform the Committees of any achieved efficiencies in promulgating regulations in recent years.

2022 Board Response: The Board has had a handful of regulatory packages that have been processed by DCA's new regulation unit in the last four years. There is one regulatory package pending at OAL that is expected to be approved in April that was initiated mid 2019 and we are in the process of finalizing language and the accompanying required documents to begin the rulemaking process for another package. While the Board has noticed an increase in processing times it has also seen a marked increase in quality.

Under the new framework, time to process a regulation package is not dependent solely upon the new DCA Legal Affairs-regulation unit, but also the board or bureau developing the product and DCA Executive Office and Agency in approving a package.

The Board understands that DCA has had close oversight of this new unit and has witnessed process reengineering aimed at efficiency. From executive leadership down to practicing attorneys, there has been a sincere commitment to continual improvement.

The Board is confident that in the coming years, processing times will improve while maintaining a quality product.

2025 Board Update
In Fiscal Year 2024–25, the Board processed one regulation package. Compared to regulatory efforts over the past decade, this package was the most complex from every perspective. At the outset of the process, the DCA assigned a new regulation attorney to support the Board.

Having now worked with two regulatory legal counsels under the new Regulation Unit within Legal Affairs, the Board can affirm that the process was significantly more efficient with the second counsel. Both attorneys were highly detail-oriented and thorough. However, the second counsel demonstrated greater confidence and exercised appropriate discretion, offering substantive legal review without excessive scrutiny of every word. This approach facilitated progress while maintaining legal integrity.

Ultimately, the Administration holds the authority to determine whether regulation packages advance. As such, regardless of the internal process, regulation packages must be submitted

with a high level of review and a comprehensive presentation. This demands a unique skill set from regulation attorneys. They must balance precision with discernment—identifying which content is critical, which elements are subjective, and which may unnecessarily hinder the process. Additionally, they must be available for the Board meetings, responsive to multiple rounds of review, and capable of managing the sometimes-competing needs of client boards and the Administration.

The Assistant Deputy Director, Grace Arupo Rodriguez, has shown exceptional leadership in cultivating this unit. Her ability to recruit talented attorneys, balance competing demands, and maintain responsiveness has been instrumental to the unit's success. Her continued leadership is vital; should she depart, it will be essential to fill her role with someone possessing equivalent expertise and dedication.

A key challenge the Board faced was the need to allocate sufficient internal resources to support the regulatory process. The current framework demands far more detailed preparation and deeper analysis at each stage of review. Coordinating the process to align with the Board's meeting schedule within a one-year timeframe requires ongoing planning and attention.

Boards that only occasionally submit regulation packages can no longer assign such efforts as secondary tasks to staff. Instead, regulation packages require dedicated personnel who are released from other responsibilities to focus solely on the regulatory process. Additionally, the evolving nature of regulatory requirements presents difficulties for boards unfamiliar with frequent regulatory activity. Although DCA has provided extensive training and support, only the Administration can evaluate whether the investment in resources yields the intended benefits.

BOARD BUDGET ISSUES

ISSUE #2: (PRO RATA IMPACTS TO FUND CONDITION AND FEES.) Licensee renewal fees are at the statutory cap and have gone up $100 over the past four years. The Board pays almost 20 percent of its revenue to pro rata costs charged for various services

Background: The DCA is almost entirely funded by a portion of the licensing fees paid by California's state-regulated professionals in the form of "pro rata." Pro rata funds DCA's two divisions, the Consumer and Client Services Division (CCSD) and the Division of Investigation (DOI). CCSD is the primary focus of this issue and contains the Administrative and Information Services Division (the Executive Office, Legislation, Budgets, Human Resources, Business Services Office, Fiscal Operations, Office of Information Services, Equal Employment Office, Legal, Internal Audits, and SOLID training services), the Communications Division (Public Affairs, Publications Design and Editing, and Digital Print Services), and the Division of Program and Policy Review (Policy Review Committee, Office of Professional Examination Services, and Consumer Information Center). Pro rata is apportioned primarily based on the number of authorized staff at each board, rather than based on the amount of DCA's services programs use. DCA does charge boards based on actual use for some services, such as the Office of Information Services, the Consumer Information Center, the Office of Professional Examination Services, and DOI. Based on DCA's own figures, actual pro rata costs for every board have increased of an average of over 100 percent since FY 2012-13.

The Board pays pro rata from its fund, the majority of revenue for which comes from licensing and renewal fees. In turn, over the last four years, the Board has raised renewal fees from $230

to $330, primarily due to increased pro rata costs, after two decades of not raising the fee. According to the Board, “ongoing rates at 17% to 19% are excessive and threaten the stability of the Board’s fund.” Following fee increases, the fund condition has stabilized. The statutory cap for renewal fees is set at $330.

Staff Recommendation: The Board should report back to the Committees as soon as possible if there is a need to increase the statutory cap. The Board should also continue utilizing strategies to save costs where possible and report to the Committees if statutory changes needed to accomplish cost savings.

2022 Board Response: At this time, the Board does not foresee the need for a fee increase. The Board’s fund is stable through FY 2022-23 and beyond and the Board itself has no plans in the immediate future to increase any expenditures. However, as mentioned in the report, costs outside the Board’s control (e.g. personnel and benefits, Statewide and DCA pro rata) will eventually cause the Board to seek a statutory fee increase.

It would be beneficial for the Board to raise its statutory fee authority for its renewal fee, just as a means to have a safety net. Given that the Board had not raised fees for nearly 20 years, exemplifies its commitment to reducing unnecessary expenditures and the effectiveness of it reengineering its processes. However, there are a number of reasons the Board has taken pause: 1) The Board is currently looking at operations to see where additional reductions and process reengineering can be effective. 2) It is our understanding that currently to raise a fee statutorily requires a fee study, which would likely require contracting for services at an estimated cost of $100,000. This cost itself is counterproductive consuming approximately 3% of the Board’s average annual expenditures. Moreover, it would reveal similar data -- including how expenses were reduced--that has been reported via sunset review over the years. 3) The chief complaint among licensed stakeholders are fees. Given that the Board just increased their renewal fee by $100, a statutory fee increase will not be supported and possibly opposed by the profession at this time.

The Board’s fund currently has room to withstand some increases that are outside its control-even considering the current rate of inflation (approximately 7-10%). This coupled with the Board’s efforts to reduce expenditures is expected to keep the Board’s fund solvent for several years. The Board believes it can maintain its fiscal solvency for a minimum of ten years and hopes it can reach near the 20-year mark again.

2025 Board Update
As reported in 2022, the Board does not anticipate the need for a fee increase in the near future. However, it may be prudent to proactively pursue a modest statutory fee increase. Doing so would provide a safeguard against potential future changes, such as legislative or regulatory mandates or unanticipated fee increases imposed by other agencies. This issue will be addressed under New Issues, beginning on page 84.

BOARD LICENSING AND WORKFORCE ISSUES

ISSUE #3: (WORKFORCE LANDSCAPE.) After a workforce study highlighting needs for the profession, there has been growing concern from the Board about the appropriate level of training to prepare the workforce. Since the sunrise of the Board, an Associates degree is the minimum education standard. Is an Associates degree still appropriate? If the minimum

education level is raised, will it exacerbate the workforce shortage? Are there alternatives to preparing the workforce for changing needs than a Bachelor's degree? Should Respiratory Care Therapists have a Bachelor's degree to practice?

Background: The Board conducted a workforce study in 2007 citing the need for 19,000 RCPs by 2025 and 21,000 RCPs by 2030. From FY 2016-17 until FY 2021-22, there has been a 25% decline in licensees including new licensees and licensee that left the field. The need for RCPs has been highlighted by the COVID-19 pandemic as well as the increase in long term care needs. However the 2017 Workforce Study suggests there is also a need for more advanced RCPs. The study found the need to develop and strengthen critical thinking and critical reasoning among entry-level therapists, as well as the need for additional time to cover the entire breadth of respiratory therapy. The Board is currently working on amending regulations to adjust CE to better address workforce needs; however, the Board is also taking a review to determine how best to incorporate a Bachelor's degree into the Respiratory Care Practice Act. No determination has been made whether the Bachelor's degree would replace the Associate degree requirement, be used as a ladder for advanced practice, or another possible outcome. Of the 35 education programs in California, three currently offer a Respiratory Care Bachelor's degree. Is a Bachelor's degree the only or most appropriate way to train RCPs?

Staff Recommendation: The Board should report back to the Committees on their findings and understanding of the best way to incorporate a Bachelor's degree without creating further barriers to entry to the profession.

2022 Board Response: The 2007 workforce study predicted the need for 19,000 RCPs by 2025 and 21,000 RCPs by 2030. The Board had 20,248 active licensees as of July 1, 2021; 1,248 more RCPs than the expected need in 2025.

Licensing Data	FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21
Active and Current	19,668	19,588	19,676	20,052	20,248
Delinquent	3,028	2,968	2,956	2,649	2,657
Inactive and Current	777	891	858	887	827
Retired	684	775	865	940	1,017
New Licenses Issued	1,106	1,061	1,124	1,137	1,175

However, the Board is aware that since the implementation of fee increases in 2017, the growth in active licensure has not been steady from year to year. In FY 17/18 there was even a (.04%) drop of 80 active licensees from the previous fiscal year.

In 2016, the Board advised licensees that renewal fee increases would be taking place beginning with licenses that expired July 1, 2017. The renewal fee was increased each year from $230 to $330 with the last fee increase effective with licenses expiring on or after July 1, 2020. (B&PC § 3775(d) required step increases). The 2007 Workforce Study noted that approximately 10% of active licenses were outside of the workforce. Half of those had jobs outside respiratory care and 12% were retired but maintained licensure. It is surmised that the fluctuation in active license numbers over the last four years may be a direct result of the fee increases and licensees who were not active in the field deciding to allow their license to become delinquent and ultimately cancel. A small percentage also take advantage of the option to place their license in a retirement status since a provision was established in 2004 (B&P § 3775.6).

The Board's Professional Qualifications Committee charged with the review to incorporate a bachelor's degree into the Practice Act has explicitly stated its intention to have stakeholder involvement and that the review would take a minimum of two years, likely four-five years, to complete in order to ensure every aspect is considered.

At the Board's sunset hearing on March 7, 2022, legislators provided feedback in response to increasing education levels in any manner including:

- A suggestion to exercise caution in increasing education levels from an associate to a bachelor's degree (creating a barrier to licensure), unless significant consumer protection issues exist.
- A request to identify with some degree of specificity the differences between the "clinical experiences" for an associate program vs. bachelor's program (e.g. is clinical work done most entirely at the associate level and does the baccalaureate degree simply add liberal arts).
- A request to identify potential impact of having a bachelor's program working alongside or against an associate program specific to the clinical training and the availability of clinical training slots.
- A request to identify the potential impact on preference of hiring; Would increasing education to a bachelor's degree make associate programs irrelevant? Would the bachelor's degree be the gold standard or minimum requirement and if not how would it be implemented and received by the industry?
- A request to explain how additional education will benefit daily practice? Will the additional education be used and needed for the expected number of licensees earning a bachelor's degree or is it additional education that will not be required for all respiratory positions? [Example cited was additional training is necessary to performing ECMO, but it is rarely required. We would not need all licensees formally educated to perform ECMO].
- A request to identify the potential impact of a workforce shortage.
- A request to consider whether current and possibly future licensees with an associate degree be pushed out of the profession?

The Legislature is a key Board stakeholder and the Board will ensure that every comment, request and suggestion is part of the education review. Further, as part of examining the workforce supply, the Professional Qualifications Committee will conduct in-depth analyses of its license population to identify trends and projections in concert with other outside data as one segment of its education review. The Board genuinely appreciates the words of caution and concern expressed at the hearing that will help shape the education review that is still in its infancy.

2025 Board Update
Please see New Issues, Section 10, beginning on page 84 for an update regarding the Board's position to increase the minimum education standard to a bachelor's degree.

ISSUE #4: (STRATEGIC PLAN IMPLEMENTATION RELATED TO WORKFORCE.) The California Respiratory Care Workforce Study was completed and integrated into the Board's strategic plan. Is the Board's current implementation strategy reflective of the findings of the Workforce Study?

Background: During the 2017 Sunset Review, the Committees requested an update on the 2015 study from Institute for Health Policy Studies at the University of California, San Francisco. The study was set to determine the feasibility and impact of requiring new applicants to obtain a baccalaureate degree; the need to modify current requirements regarding clinical supervision of RCP Students; the effectiveness of the current requirement to take a Professional Ethics and Law continuing education course, and the benefit or need to increase the number of continuing education hours and/ or its curricular requirements.

The California Respiratory Care Workforce Study was completed and integrated into the Board's strategic plan. The two goals taken from the study are as follows:

- Develop an action plan to establish laws and regulations or accrediting standards for student clinical requirements to increase consumer protection and improve education outcomes.
- Develop an action plan to incorporate a baccalaureate degree provision in the Respiratory Care Practice Act (RCPA) to ensure education requirements meet the demand of the respiratory care field.

The study revealed two significant training shortcomings for RCPs: 1) consistent quality preceptor training, and 2) clinical internship availability. The Board was concerned that requiring additional preceptor training would limit access, so as an alternative RCPs are encouraged and able to do the training as CE, pending regulation approval. Additionally, the Commission on Accreditation for Respiratory Care (CoARC) is currently working on new standards for clinical training.

In response to the study, the Board drafted regulations to revamp the CE requirements. The regulations are currently pending. The proposed language adds CE incentives to participate in preceptor training and as a preceptor for clinical education students. It also provides an incentive for hospitals to provide the training in the interest of developing leaders and improve the quality of training for future prospective employees.
The proposed regulations drastically change from a general requirement that two-thirds or 20 hours of the required 30 hours of CE be directly related to clinical practice in any format. The new framework would require:

- A minimum of 10 hours in leadership,
- A minimum of 15 hours directly related to clinical practice, and
- Up to five hours in courses or meetings indirectly related to the practice.

Staff Recommendation: The Board should report back to the Committees on the effectiveness of on the implementation of their strategic plan as it pertains to the workforce.

2022 Board Response: The Board appreciates this issue being highlighted. We believe offering CE incentives for licensees to voluntarily take approved preceptor training and provide clinical oversight will have a noticeable impact on the quality of clinical education. The Board looks forward to reporting back to the Committees on the impact and effectiveness of this strategy.

2025 Board Update
The implementation of the Board’s new CE framework has been purposefully gradual to ensure fairness and provide adequate notice to all licensees. To support a smooth transition, licensees

were given a full renewal cycle to prepare for compliance. The first group required to certify completion of CE under the new framework will be those whose licenses expire on December 31, 2025.

Beginning in January 2026, the Board will incorporate a survey as part of its CE audit process to gather feedback from licensees on their experience with the revised requirements. This will help assess the framework's effectiveness and identify potential areas that may require additional amendments. Additionally, staff will begin formally tracking CE credit earned through qualifying preceptor activities, as permitted under the new provisions. By tracking this information, the Board aims to: 1) monitor how many licensees are using this option; 2) evaluate how effective and popular this method is; and 3) determine whether including experiential learning activities like preceptorship is contributing meaningfully to professional development.

BOARD ENFORCEMENT ISSUES

ISSUE #5: (VENTILATOR CARE.) Licensed Vocational Nurses (LVNs) have been providing ventilator support to patients based on a guidance issued from the Board of Vocational Nursing and Psychiatric Technicians (BVNPT). Is patient care in jeopardy by allowing LVNs to perform ventilator services? Is there any circumstance LVNs can safely assist in ventilator services?

Background: Dating back to May 1, 1996, LVNs and RCPs have struggled to determine the appropriate scope of practice for administering respiratory services such as managing patients. The Board contends LVNs should not be administering any ventilator services. The BVNPT guidance to licensees permitted LVNs to adjust ventilator settings. The Board has maintained this policy was an underground regulation without any authority to allow this practice. The Board has made numerous requests throughout the last 25 years to rescind the policy, but BVNPT has failed to revoke any policy regarding respiratory services and continues to take the position that LVNs should be able to adjust ventilators. The Board provided five examples adverse incident reports in the past 25 years resulting in death or serious harm from LVNs performing ventilator services.

The two boards began to work collaboratively in 2019 and issued a joint statement clarifying RCP and LVN roles relating to patient care on mechanical ventilators. After feedback from various types of facilities and organizations, there was expressed desire to further clarify its respective regulations regarding patient care. The boards hosted a stakeholder meeting to further discuss the joint statement and concerns grew about expanding places LVNs can conduct ventilator services to home based settings as well. According to the Board, BVNPT backed out of the agreement and began exploring CE to train LVNs to perform ventilator services in more setting. The Board has offered legislative options to clarify scopes of practice, but has not come to an agreement with BVNPT on a solution moving forward.

Staff Recommendation: The Board should advise the Committees on an agreed upon solution from both boards and stakeholders including statutory changes. The Board may also wish to provide further case studies or additional adverse outcomes from LVNs performing respiratory services.

2022 Board Response: The Board appreciates the Committees highlighting this issue that has indeed been resolved only to resurface later on multiple occasions.

In 2005, the BVNPT accepted its legal counsel's office recommendations at its September board meeting and agreed to no longer dispense advice stating LVNs were permitted to manage ventilators. Less than one year later, in June 2006, the Board was provided documentation that the BVNPT was again advising LVNs they could perform ventilator care.

In 2007, the Board received and shared with BVNPT, an informal legal opinion from the Office of the Attorney General that provided in part:

> "Basic assessment or data collection does not anticipate the independent assessment of breath sounds and is therefore outside [the] scope of practice of an LVN. Clearly respiratory therapist[s] can interpret breath sounds in the scope of their practice under Business and Professions Code section 3702..... While a respiratory care therapist and a physician can assess a patient's respiratory status and alter the ventilator setting, in my opinion, an LVN who does so acts outside their scope of practice."

Upon receiving several complaints in or around 2015, the Board attempted again, to find data to show harm done as a result of LVNs practicing respiratory care. The Board had attempted to find this data previously through various reporting systems, but found that such reporting systems only provide the underlying cause of death and pay no attention to the health care providers' competence. For example, a patient could be admitted to a sub acute facility with a chronic lung disorder. If that patient later dies because an LVN or for that matter an RCP did not provide proper care, the death is attributed to the lung condition for which the patient was initially admitted or other complications that may have arisen due to lack of qualified care. Outside of malicious and witnessed intent to kill, there are no records, and rarely even an investigation into the competency of providers. Rather the public and inspectors expect healthcare providers to be qualified through their licensure based on education and competency exams. The reason the Board found the five examples in 2015 was simply because families of the patients witnessed the LVN providers behavior. In addition, after the discovery of these five cases back in 2015, the BVNPT updated their website so that the public could no longer search for such records. It should be noted that during the Board's investigations, many LVNs have expressed their concern and insecurities in performing respiratory tasks. They acknowledge the tasks are outside their education and training and are uncomfortable performing these duties, but feel obliged to follow their employers' direction.

Also in 2015 and 2016 Board members, staff, and legal counsel met with Agency to try and correct the problem. At that time, there were several specific tasks noted as outside the LVN scope of practice. The BVNPT members, staff and experts flip-flopped several times on which tasks they believed LVNs could perform.

In December 2017, the governor announced the appointment of a new executive officer for the BVNPT effective January 2, 2018. Shortly thereafter, the Board reached out to the BVNPT's new executive officer to discuss the long history of this issue and existing concerns. Both the executive officer and assistant executive officer of the BVNPT displayed genuine concern and interest to resolve this issue. Over 12 months the executive officers and assistant executive officers of both boards met several times and built an amiable relationship with mutual respect and the same goal: consumer protection. Together they brought all the key players together for several meetings in 2018 and 2019.

In order to produce an open and honest discussion, both executive officers agreed it would

benefit all parties if the discussion was facilitated by the DCA's SOLID Training and Planning Solutions team. Arrangements were made and these representatives participated in a series of meetings that began in June 2018:

Respiratory Care Board
President and Vice president.
Executive officer and Assistant executive officer.
Enforcement manager.
Investigators.

Board of Vocational Nursing and Psychiatric Technicians
President and Vice president.
Executive officer and Assistant executive officer.

Experts
Supervising nursing education consultant (on staff w/BVNPT).
Nursing education consultant (on staff w/BVNPT).
Respiratory care practitioner expert (contracted w/Board).

Legal Counsel
Legal counsel representing BVNPT.
Legal counsel representing Board.

Administration
DCA assistant deputy director.

Business, Consumer Services and Housing Agency
Several representatives in attendance at various meetings.

The goal for the Board was to have an agreed-upon interpretation of existing law concerning which services LVNs are authorized to perform. Specifically, Board had noticed increases in complaints, primarily in Southern California, of subacute facilities using LVNs to perform respiratory care. Incidents which included failure to respond timely or appropriately, to emergencies to failing to plug in a ventilator, all leading to the deterioration of patients. It was also found that employers were asking the one or two licensed RCPs on staff to co-sign or sign for work that was not performed by them.

Employers had given new titles to LVNs, calling them “respiratory nurses.” Employers were caught telling their employees to lie to our investigators about LVNs performing respiratory care. All of these acts violate the Business and Professions Code. Respiratory tasks require comprehensive assessment, formal education and training, and competency testing. Both boards agreed and repeated on numerous occasions that consumer protection was the utmost priority in developing the joint statement.

The main focus throughout the discussions was on long-term care, specifically subacute facilities. In these meetings, it was suggested that home care be included. While home care was ultimately included in the joint statement, the Board understands that it is unique and has a different set of circumstances. But the Board also has evidence of five separate incidents of child deaths that occurred as a result of incompetence and/or negligence of the LVN care

provider and therefore it did not object to its inclusion.

In April 2019, a joint statement was reached and published by both boards. The joint statement was not pursued as a regulation, because it was understood to interpret existing law. However, once the joint statement was published in April 2019, several entities came forward in objection to the joint statement, primarily home care and adult and pediatric day care facilities. As a result, the DCA suggested that the items in the joint statement be placed in regulation allowing the public to comment. An update to the joint statement was released in May 2019, which read in part:

> "In the next few months, both the Board and the BVNPT intend to pursue regulations on the issues identified on the joint statement. As part of the rulemaking process, draft regulatory language will be issued and considered at upcoming board meetings. The Board plans to consider such regulatory language as part of its June 2019 meeting, and the BVNPT plans to do the same at its August 2019 board meeting."

In June 2019, the Board reviewed and considered regulations to this effect. There were numerous home care providers at the Board's teleconference board meeting who provided comment. It was noted that approving or not approving the regulations did not change the existing law. By passing the regulations, it would have given the appearance that the Board was not moved by the testimony. As a result, the Board did not approve the regulations and instead passed a motion to "exclude home care from [the] language and continue to work with the BVNPT to modify the joint statement accordingly."

The Board minutes from its June 2019 meeting reflect:

> "While the Joint Statement still stands as written, because of the way home care is set up, there appears to be a need for some type of exemption or certification training for LVNs to perform some respiratory tasks in home care only. The proposed language was based on communication prior to receiving much feedback from the home care industry. The legislation passed last year, which this regulatory language is based on, allows the [Board] to define basic, intermediate, and advanced tasks and creates an avenue to allow for public comment. Currently, the language does not include or exclude home care. It has however picked up the momentum that it is tied to home care."

In June 2019, BVNPT and the Board held a stakeholder meeting. Those in attendance were overwhelmingly from the home care industry, adult and pediatric day care facilities and congregate living.

Following the Board and stakeholder meetings in June, the joint statement was revised for the final time as follows:

The update in the July 2019 revision included this language:

> "Both boards agreed to remove 'home care locations' from the Joint Statement in response to numerous comments received at the Board's teleconference board meeting held June 7, 2019 and a stakeholder meeting held June 27, 2019. At the Board meeting, the board passed a motion 'to move forward with excluding home care and continuing working with the BVNPT to modify the Joint Statement.

It was noted at all meetings that services provided in home care, as well as Adult Day Health Care Facilities, Congregate Living Health Facilities, and Pediatric Day Health & Respite Care Facilities [including transport to/from and care during daily outside activities (e.g. school)] serve a population who may need greater access to care and may hold different expectations for care given consideration to patients' quality of life and healthcare reimbursement allowed. For this reason, both the BVNPT and the Board will continue conducting research in this area to determine how greater consumer protection safeguards may be put in place such as possible standardization of training in some areas. Any such actions are expected to be addressed through regulations and/or legislation where public comment is encouraged."

In August 2019, an issue arose that hinted the BVNPT had changed course. On September 25, 2019, the Board's staff was made aware through an outside source that BVNPT was preparing language for a legislative change though it was presented as a regulation change up to the date of release. On October 1, 2019, BVNPT confirmed that it had changed course after the release of the joint statement in April 2019 in response to objections to the joint statement. This action placed a strain on relations between the two boards, but some positive interactions have taken place since.

On October 9, 2019, BVNPT held the final stakeholder meeting presented as a joint meeting of the BVNPT and the Board. The sole focus of the meeting was to get feedback from the stakeholders on BVNPT proposed legislation. BVNPT proposed draft legislation provided an avenue for LVNs and psychiatric technicians to take a continuing education course to qualify to provide mechanical ventilator care. The legislation did not specify or limit any tasks or any locations. It did not require formal education or training or competency testing. Currently, LVN formal education consists of a cursory course that includes an overview of respiratory care. The proposed legislation was never picked up by an author.

As of August 2021, the Board continues to display the original and revised joint statements on its home page. However, BVNPT at some point in 2020 or 2021 removed the joint statements from its website and replaced it with the following notice completely reversing course. Needless to say, after entering discussions with key players in good faith and coming to a joint agreement, it is disheartening and concerning to see the recent turn of events.

Given the extensive history, the Board is turned to the Senate Committee on Business, Professions and Economic Development and the Assembly Committee on Business and Professions providing Sunset Review Oversight to consider the following legislative alternatives to resolve this issue and/or facilitate another avenue to resolve this issue.

Sample regulations are provided in the Sunset Report should this legislation move forward and the BVNPT would be invited and encouraged to help shape these regulations. The overarching goal is to make sure consumers continue to have access to respiratory care in all settings, while minimizing the risks in the quality of respiratory care to meet consumer demands for their and their loved one's quality of life. Either of the following legislative proposals, combined with regulations formulated by stakeholders, will accomplish this goal.

ALTERNATIVE RESOLUTION #1
Amend B&PC § 2860 (LVN Practice Act)

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

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

(c) Notwithstanding subdivision (a) a licensed vocational nurse may qualify to perform respiratory services identified by the Respiratory Care Board through their employment with a home health agency licensed by the California Department of Public Health in a non-licensed home setting upon demonstrating competence in patient-specific tasks as provided by the Respiratory Care Board of California.

(d) The Respiratory Care Board of California shall adopt regulations to effectuate subdivisions (b) and (c) of this section. In adopting rules and regulations, the Respiratory Care Board of California shall comply with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

ALTERNATIVE RESOLUTION #2
Amend B&PC § 2860 (LVN Practice Act)

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

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

Amend B&PC § 3765 (Respiratory Care Practice Act) 3765.
This act does not prohibit any of the following activities:

(a) The performance of respiratory care that is an integral part of the program of study by students enrolled in approved respiratory therapy training programs.

(b) Self-care by the patient or the gratuitous care by a friend or member of the family who does not represent or hold himself or herself out to be a respiratory care practitioner licensed under the provisions of this chapter.

(c) The respiratory care practitioner from performing advances in the art and techniques of respiratory care learned through formal or specialized training.

(d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their specialty.

(e) Respiratory care services in case of an emergency. “Emergency,” as used in this subdivision, includes an epidemic or public disaster.

(f) Persons from engaging in cardiopulmonary research.

(g) Formally trained licensees and staff of child day care facilities from administering to a child inhaled medication as defined in Section 1596.798 of the Health and Safety Code.

(h) The performance by a person employed by a home medical device retail facility or by a home health agency licensed by the State Department of Public Health of specific, limited,

and basic respiratory care or respiratory care related services that have been authorized by the board.

(i) The performance by a vocational nurse licensed by the Board of Vocational Nursing and Psychiatric Technicians, employed by a home health agency licensed by the California Department of Public Health, with patient-specific training as identified by the board, of respiratory tasks and services identified by the board.

(j) 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.

2025 Board Update

The Board has made significant progress in addressing the scope of practice for LVNs and their role in respiratory care. Since the last sunset review, two legislative bills have been enacted, one regulatory package has been finalized, and a second regulatory package is expected to begin rulemaking in late 2025 or early 2026.

SB 1436 (Chapter 624, Statutes of 2022) – Enacted January 2023

SB 1436 addressed ongoing concerns related to patient safety and the scope of LVN practice. It introduced the following key provisions:

- Codification of the VN Practice Act:
  B&PC § 2860(a) was amended to state explicitly that LVNs have no authority to provide respiratory care services or treatment. This provision resolved years of confusion created by BVNPT guidance that suggested otherwise and aligned the LVN Practice Act with the Respiratory Care Practice Act.
  > B&PC § 2860(a): “This chapter confers no authority to practice medicine or surgery, to provide respiratory care services and treatment, or to undertake the prevention, treatment, or cure of disease, pain, injury, deformity, or mental or physical condition in violation of any provision of law."

- Limited Exemption for Basic Tasks:
  New language in B&PC § 2860(b) and 3702.5(a) authorized LVNs, with appropriate training, to perform only those basic respiratory tasks expressly identified by the Board. These tasks must be manual or technical in nature or involve data collection, and they may not require any form of patient assessment. This ensures that LVN involvement in respiratory care is restricted to narrowly defined, non-clinical activities that do not overlap with the specialized judgment and skills of RCPs.

- Expanded Exemption for LVNs in Home Health Agencies:
  Recognizing the unique care needs in home settings, SB 1436 created a more limited and time-phased exemption in § 3765(i):
  - Until January 1, 2025: Training requirements are defined by the LVN’s employer, leaving discretion to home health agencies.
  - On or after January 1, 2025: Training requirements must conform to guidelines developed by the Board in consultation with BVNPT, ensuring a standardized, competency-based framework and preventing inconsistent employer-driven practices.

Basic Respiratory Tasks and Services Regulations – First Attempt (2022–2023)

Following the enactment of SB 1436, the Board proposed regulatory language in October 2022 to define "basic respiratory tasks" pursuant to Business and Professions Code sections 3702.5(a) and 2860(b). The intent of these rules was to clarify which tasks trained LVNs could legally perform under the law.

During the public comment period in December 2022, however, the proposal generated significant misunderstanding. Many stakeholders mistakenly believed the regulations were creating new prohibitions on LVN practice, even though LVNs were already prohibited from providing respiratory care unless covered under specific exemptions. In reality, the regulations did not restrict LVNs further; instead, they would have allowed certain basic tasks and services to be performed legally for the first time. The Board's goal was to bring clarity to both the respiratory care profession and exempted LVNs.

Despite these intentions, widespread concerns were raised by home health and community-based facilities. In response, the Board determined in March 2023 that broader statutory exemptions would better align with the framework established by SB 1436. Accordingly, the Board withdrew the proposed regulations in June 2023 to allow time for legislative solutions to be pursued.

SB 1451 (Chapter 481, Statutes of 2024) - Enacted January 2025
SB 1451 extended and expanded exemptions for LVNs performing respiratory tasks in home and community-based settings. Key provisions include:

- Extension of Home Health Agency Exemption (§ 3765(i)):
  SB 1451 extended the existing exemption for LVNs employed by licensed Home Health Agencies to provide Board-approved respiratory tasks beyond basic services.

  - Until January 1, 2028: Training requirements remain defined by the employer, allowing agencies to determine sufficiency.
  - On or after January 1, 2028: Training must follow guidelines issued by the Board in collaboration with BVNPT, ensuring competency-based instruction and eliminating reliance solely on employer discretion.

- New Exemption for Additional Community-Based Settings (B&PC § 3765(j)):
  Beginning January 1, 2028, LVNs may perform Board-approved respiratory tasks in a broader range of residential and day health facilities, provided that they:

  - Are licensed under Chapter 6.5 (commencing with § 2840).
  - Complete patient-specific training deemed satisfactory by their employer.
  - Obtain a valid competency certification for each respiratory task from a board-recognized organization (e.g., the California Association of Medical Product Suppliers or the California Society for Respiratory Care).

  Note: Home health agencies may meet training requirements under subdivision (i), which does not require external certification, or subdivision (j), which does.

  Eligible Practice Settings:
  - At a congregate living health facility licensed by the State Department of Public Health that is designated as six beds or fewer.

- At an intermediate care facility licensed by the State Department of Public Health that is designated as six beds or fewer.
- At an adult day health care center licensed by the State Department of Public Health.
- 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.
- At a pediatric day health and respite care facility licensed by the State Department of Public Health.
- At a small family home licensed by the State Department of Social Services that is designated as six beds or fewer.
- 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.

Both provisions become fully operative on January 1, 2028.

Basic Respiratory Tasks and Services Regulations – Second Attempt (2024–2025)
In March 2024, the Board advanced its statutory mandate under SB 1436 (2022) and SB 1003 (2018) by initiating the first of several new regulatory packages to define "basic respiratory tasks and services" (i.e., the Board-approved basic respiratory care tasks and services that LVNs may lawfully perform). This package explicitly listed the tasks that could be considered basic, while also clarifying the limits of LVN practice. The rulemaking was approved by the Office of Administrative Law on June 5, 2025, and became effective on October 1, 2025.

To support implementation, 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. In addition, the Board developed a dedicated webpage as a centralized resource, providing information and guidance for RCPs, LVNs, facility administrators, and patients on the new regulation and its implications.

It should be noted the Board always intended to adopt a separate regulation to implement the statutory exemptions for home health or home and community-based settings. These settings were provided carve-out exemptions to ensure continuity of patient care that also require the Board to develop regulations specific to those environments. However, after the "basic tasks and services" regulation became effective, the Board was made aware of concerns that the regulations will limit the scope of care LVNs may provide in those settings, too. The Board will move forward expeditiously to implement new regulations for these settings to minimize any disruption in care. The Board also welcomes any legislative solutions the Committee may wish to consider to address this matter as swiftly as possible.

Respiratory Care in Home and Community-Based Settings – Future Regulations (2026–2027)
At its March 2025 meeting, the Board introduced conceptual regulatory language as the first step toward developing final regulations required under SB 1451. These regulations will:

- Define the scope of respiratory tasks LVNs may perform in the specified community-based settings; and
- Establish training guidelines, including certification requirements, for LVNs practicing under the new exemptions

Initial feedback was generally positive, and the Board raised no objections to including advanced respiratory tasks within the scope of discussion. The Board's staff have begun meeting with training providers and plan to collaborate closely with the BVNPT and affected stakeholders to refine the proposed regulatory language. Barring any unforeseen changes, the final regulatory package is expected to be completed and adopted before the January 1, 2028, implementation date.

That being said, staff has been apprised of a potential legislative proposal from stakeholders to combine the training requirement options in B&P § 3765 (i) and (j). The proposal would allow employers to choose between providing in-house training or requiring certification through CAMPS and/or CSRC, while making clear that patient-specific training remains the employer's responsibility in all practice settings. The proposal also seeks to delay implementation of these sections until January 1, 2029. While the Board is aware of this proposal, it will not take a formal position unless and until it is introduced in a legislative bill.

Finally, Senate Bill 389 (Chapter xxx, Statutes of 2025) amended B&P Code § 3765 to add an exemption authorizing LVNs to perform suctioning and basic respiratory care tasks in a school setting, under the supervision of a credentialed school nurse.

ISSUE #6: (REGISTRY REPORTING.) Currently, RCPs are not being reported to the Board in cases involving registries. This results in RCPs continuing to work without discipline and without public disclosure of harm potentially caused. Should mandatory reporting be expanded?

Background: Respiratory care practitioners are not reported by facilities in instances where they were advised to resign instead of face termination. Facilities rightfully claim they do not have to report RCPs who were employed by registries. Instead, facilities using registry employees notify the registry that they do not want the employee assigned to their facility ever again. And while in most instances the registry is made aware of the reason the facility refuses assignments by certain RCPs, the registry (nor the facility) is obligated to inform the Board, even in those cases of serious violations as outlined in B&PC § 3758. As a result of this gap within mandatory reporting, RCPs are able to continue to work without discipline.

Staff Recommendation: The Committees may wish to amend the reporting requirements in the Act to ensure all violations are reported to the Board.

2022 Board Response: The language as introduced in SB 1436 on February 18, 2022, authored by Senator Roth addresses this concern with precision. The Board appreciates Senator Roth's and the Committees' assistance in resolving this issue.

2025 Board Update
In June 2023, the Board notified all health care registries and hospitals of expanded mandatory reporting requirements under B&PC § 3758, as amended by SB 1436 (Statutes of 2022). Hospitals and registries were advised they must report to the Board within 10 days any adverse employment actions involving licensed RCPs, including terminations, suspensions, administrative leaves, or resignations that occur during or in lieu of an investigation. Registries were also advised of their requirement to also report if a facility refuses to accept future placements of a practitioner ("do not call" requests) due to such concerns.

SB 1436 also expanded the scope of reportable conduct by requiring that not only confirmed

incidents, but also *suspected* causes including substance abuse, patient harm, or gross negligence, to be reported. These changes closed a regulatory loophole and provided comprehensive oversight by ensuring the Board is promptly alerted to potential violations that may affect patient safety, even when practitioners transfer between facilities or avoid formal disciplinary action.

TECHNICAL CHANGES

ISSUE #7: (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 the Board's operations and the enforcement of the Act.

Background: There are instances in the Respiratory Care Practice Act where technical clarifications may improve the Board's 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.

2022 Board Response: The Board is unaware of any technical changes proposed, but is pleased to work with the Committees' in this endeavor.

2025 Board Update
The Board remains unaware of any technical changes proposed, but remains committed to working with the Committee's if issues are identified.

COVID-19

ISSUE #8: (SUPPORT FOR COVID-19 PROVIDERS.) Under ordinary circumstances, frontline healthcare providers and first responders often face difficult situations that are mentally and emotionally challenging. Are there new issues arising from, or ongoing issues being worsened by, the extreme conditions of the COVID-19 pandemic?

Background: Throughout the COVID-19 pandemic, frontline healthcare workers and first responders, such as physicians, nurses, respiratory care therapists, paramedics, and more, have been caring for COVID-19 patients through multiple deadly surges, including a record-shattering death toll surge in December of 2020.

The Centers for Disease Control notes that "[p]roviding care to others during the COVID-19 pandemic can lead to stress, anxiety, fear, and other strong emotions…. Experiencing or witnessing life-threatening or traumatic events impacts everyone differently. In some circumstances, the distress can be managed successfully to reduce associated negative health and behavioral outcomes. In other cases, some people may experience clinically significant distress or impairment, such as acute stress disorder, post-traumatic stress disorder (PTSD), or secondary traumatic stress (also known as vicarious traumatization). Compassion fatigue and burnout may also result from chronic workplace stress and exposure to traumatic events during the COVID-19 pandemic."

Frontline healthcare workers are essential to the State of California. Given the length and the unique conditions of the COVID-19 pandemic, it may be beneficial to track trends and identify

potential challenges and solutions in delivering mental health care and support for frontline healthcare workers who have been under extreme physical and mental pressure since the start of the coronavirus pandemic.

Staff Recommendation: The Board should discuss any findings related to the mental and behavioral healthcare needs of frontline healthcare providers arising from the COVID-19 pandemic.

2022 Board Response: The Board offers the following article written by the Board president, Ricardo Guzman for the Board's 2021 annual newsletter. His sentiment was expressed by those RCPs who contacted the Board over the course of the pandemic.

"We must recognize that 2021 was a difficult year for everyone, but even more so for those on the front line fighting the COVID-19 pandemic. Respiratory care practitioners, along with other health care workers, have reported stress, anxiety, and depressive symptoms because of the challenges associated with taking care of those afflicted with COVID-19. As a bedside practitioner of 38 years, I can attest that this has been unlike anything we have ever experienced.

Those of us in critical care had grown accustomed to enjoying moderate to high success in preventing patients from having to go on life-support and/or in liberating them when they required it. Over the past two years, we have had to adjust our expectations in the realization that so many of our patients would not be going home to their loved ones. Week after week, our patients got sicker faster and for longer than before, despite our knowledge, our sophisticated equipment, and the evolving recommendations from the health care community. All of this, while having to manage our own health and that of our families and friends during lock downs, travel restrictions, and while having to wear a mask everywhere we went, even in our break rooms.

Yet, the courage and determination I see every day is nothing short of amazing. Although at the end of our shifts we are exhausted and sometimes discouraged, we remain committed to do it again on our next shift and to offer greater compassion to not only our patients and their families, but also to each other as we recognize that we are in this together. As an educator for two decades, I have been a great proponent of the important role we play in the lives of our patients. Today, I am more proud to be a respiratory therapist than ever before. May we not lose heart as we head into a new year for brighter days are ahead. We will win this fight and emerge stronger, and at the same time gentler than we used to be."

2025 Board Update
Since the Board's last report in 2022, no new concerns or issues related to the mental or behavioral health of RCPs have been brought forward. While the COVID-19 pandemic placed considerable demands on healthcare systems and professionals in its early stages, those challenges have largely stabilized. RCPs have continued to demonstrate resilience and professionalism throughout the public health response and into the recovery phase.

ISSUE #9: (IMPACTS OF THE COVID-19 PANDEMIC.) Since March 2020, there have been a number of waivers issued through Executive Orders that impact the Board's operations, the Board's licensees, providers, and patients throughout the state. Do any of these waivers warrant an extension or statutory changes? How has the Board addressed issues resulting from the pandemic?

Background: In response to the COVID-19 pandemic, a number of actions were taken by the Governor, including the issuance of numerous executive orders in order to address the immediate crisis. Many executive orders directly impact the state's healthcare workforce. On March 4, 2020, the Governor issued a State of Emergency declaration which immediately authorized the Director of the Emergency Medical Services Authority (EMSA) to allow licensed healthcare professionals from outside of California to practice in California without a California license. Under B&PC § 900, licensed professionals are authorized to practice in California during a state of emergency declaration as long as they are licensed and have been deployed by the Director of EMSA. Following that executive order, on March 30, 2020, the Governor issued Executive Order N-39-20 authorizing the Director of DCA to waive any statutory or regulatory professional licensing relating to healing arts during the duration of the COVID-19 pandemic – including rules relating to examination, education, experience, and training.

Many of the waivers impact the Board's work and RCPs. The Board states in their sunset report that they were immediately concerned about an insufficient number of RCPs. The Board identified the need to allow for other health professionals, students or groups to perform respiratory services during an emergency which includes an endemic or public disaster.

Staff Recommendation: The Board should update the Committees on the impact to licensees and patients stemming from the pandemic and potential challenges for future RCPs. The Board should discuss the impact of waivers on patient safety and note any statutory changes that are warranted as a result of the pandemic.

2022 Board Response: In response to the COVID-19 State of Emergency Order, a dramatic shift in how the Board conducted business occurred virtually overnight. Throughout March and April 2020, while the Board's staff were implementing safety protocols and transitioning to telework, they were also working fervently to respond to floods of calls and emails requesting information and waivers.

The first and most profound challenge the Board identified in response to the State of Emergency was the possibility of an insufficient number of RCPs available to respond to a virus that was known to attack the lungs in serious cases. RCPs are the experts in diagnosing and treating respiratory ailments across the medical spectrum. Severe cases of COVID-19 lead to low oxygen saturation levels, and extreme cases almost always result in the need for mechanical ventilation: both of which are areas of RCP specialty. Knowing that the lives of patients would be dependent upon having enough respiratory therapists available to respond made finding legal pathways to supplement the workforce the Board's top priority. The Board immediately began working with Legal Counsel to determine the Board's authority to allow various waivers and allow students, retirees, and out-of-state licensees to fill anticipated gaps. The daily calls and emails requesting guidance and action were mounting in intensity as each day passed. At this same time, the Administration wanted to have a unified response, so the Board turned our attention to working with DCA for waiver approvals.

On March 31, 2020, the first waiver (DCA 20-02) to allow retired, cancelled and inactive licensees to return to temporary practice was issued. The Board has not received any complaints for the 148 people allowed to practice under this waiver.

In addition the Emergency Medical Services Agency (EMSA) adopted policies and procedures

governing the use of out-of-state medical personnel to respond to the COVID-19 outbreak. The EMSA authorized 900 people, licensed as RCPs in respiratory care in other states to practice during the State of Emergency. To date, we have been notified that two of these individuals had their authorization rescinded, but we are unaware of any detail that led to the rescission. Students were another resource the Board turned to, to relieve expected staffing pressure. A waiver was not necessary to permit students to assist during the pandemic, but they were still subject to direct supervision. Nonetheless, respiratory care students that had completed their education and part of their clinical training could be beneficial in performing tasks where they had shown competency and other manual respiratory tasks (e.g. moving equipment). The greatest concern for students was the issue of financial compensation. While the Board has no prohibitions to this, the education accrediting agency does. The Board reached out to the accrediting agency to express concerns, and the agency subsequently temporarily lifted the prohibition, allowing students to be financially compensated with the understanding that such activity would not count toward the required clinical practice hours. In addition, those students that were within three months of graduation were encouraged to apply early, so that upon graduation they would either have a work permit or license in hand.

Following the messaging of these efforts through April 2020, the phone calls to the Board noticeably dropped. The Board has received maybe one or two calls a month thereafter. The Department of Health Care Services reached out to the Board a few times for assistance in 2020 to find RCPs for placement in subacute facilities, to which the Board's president, Ricardo Guzman responded and resolved.

Overall, no concerns for patient safety were raised for licensees or students under its jurisdiction. However, the Board did identify areas where statutes could be improved from its perspective.

BUSINESS AND PROFESSIONS CODE, SECTION 3765
B&PC § 3765(e) is flawed and can easily be interpreted to mean any person could perform respiratory care services during an emergency.

B&PC § 3765.
"This act does not prohibit any of the following activities: ...

(d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their specialty.

(e) Respiratory care services in case of an emergency. 'Emergency,' as used in this subdivision, includes an epidemic or public disaster. ..."

B&PC § 3765.
This act does not prohibit any of the following activities:...

(e) The temporary performance, by other healthcare personnel, students or groups, of Respiratory care services as identified and authorized by the Board, in the event case of an emergency. "Emergency," as used in this subdivision, includes of an epidemic, pandemic, or public disaster or emergency. ...

NEWLY PROPOSED BUSINESS AND PROFESSIONS CODE, SECTION 3723
In addition, the following language is provided for your consideration to determine if this or similar language would be beneficial to consumers during a State of Emergency. The Board

would have the means to provide a temporary response in as little as two days.

B&PC § 3723.

(a) In the event a state of emergency is declared, the Board may, for a period of up to 60 days from the date of the declaration, temporarily waive any requirement in the Respiratory Care Practice Act it deems necessary and as commensurate in response to the circumstances known surrounding the cause of the state of emergency, provided there are no gubernatorial objections.

(b) For purposes of this section, the Board may hold an "Emergency Meeting" as provided in section 11125.5 of the Government Code. The Board may hold the meeting, open to the public, through the means of information technology, however the Board shall not be subject to the provisions in sections 11123 or 11123.5 of the Government Code requiring a physical location be made available to the public.

2025 Board Update

SB 1436 (statutes of 2022) resolved this issue by making amendments to B&PC § 3765(e) to provide relief, clarifying that other healthcare providers may provide respiratory care during an epidemic, pandemic, public disaster or emergency as follows:

B&PC § 3765.

This act does not prohibit any of the following activities:

…

(e) Respiratory care services in case of an emergency. "Emergency," as used in this subdivision, includes an epidemic or public disaster. Temporary performance, by other health care personnel, students, or groups, of respiratory care services, as identified and authorized by the board, in the event of an epidemic, pandemic, public disaster, or emergency.

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

ISSUE # 10: (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 will be reviewed again on a future date to be determined.

2022 Board Response: The Board's highest priority is consumer protection and it aims to provide this through effective application review and investigative services and meaningful application of the law. Moreover, the Board strives to provide excellent customer service and efficiency in state government. The Board would like to thank members of both the Senate Business, Professions and Economic Development Committee and the Assembly Business and

Section 10
New Issues

ISSUE #1: ESTABLISHING A BACHELOR'S DEGREE AS THE MINIMUM EDUCATION REQUIREMENT FOR RESPIRATORY CARE PRACTITIONERS

Respiratory care is rapidly advancing, with increasing complexity in cardiopulmonary medicine, therapeutic interventions, and diagnostic technology. Since California first licensed respiratory therapists in 1985, the profession's scope and responsibility have grown dramatically. To ensure patient safety and high-quality care, the Board proposes establishing a bachelor's degree as the minimum education requirement for licensure. This elevated standard will prepare California's RCPs to manage complex cardiac and pulmonary conditions effectively and advance patient outcomes, aligning California with national trends and strengthening the profession for the future.

Transformation of Healthcare Calls for Action
Healthcare as a whole is transforming at an unprecedented pace. Technological innovations, an aging population, and increasingly complex patient care needs require practitioners who can think critically, adapt quickly, and manage highly specialized interventions often in high acuity situations. RCPs are on the front lines of life-saving care, managing advanced ventilator systems, performing critical diagnostics, and providing essential patient education. The current associate degree standard no longer reflects the breadth and depth of these responsibilities.

Elevating Standards to Advance Patient Care
A bachelor's degree equips RCPs with deeper knowledge in respiratory pathophysiology, pharmacology, and evidence-based practice. It sharpens critical thinking, research literacy, and problem-solving abilities, skills that directly translate into better patient outcomes. Bachelor's programs also address emerging needs in healthcare analytics, interprofessional collaboration, and chronic disease management, ensuring RCPs can respond effectively to both acute and long-term patient care challenges.

In high-pressure situations, whether in the ICU, emergency department, or during complex home care transitions, there is no substitute for advanced preparation. Raising the minimum education standard strengthens consumer protection by reducing the risk of medical errors, enhancing patient communication, and ensuring RCPs are ready to deliver safe, effective, and informed care.

Aligning with the Healthcare Workforce of the Future
RCPs are frontline clinicians who manage ventilators and provide critical support to patients with life-threatening conditions. Most allied health professions already require a bachelor's or higher degree for entry into practice. Aligning respiratory care with these professions meets public expectations that professionals who are treating patients directly have a thorough education and a complete understanding of patients' ailments, especially as it pertains to pulmonary ailments that can mean the difference between life and death.

Another important consideration in support of raising the minimum education requirement for licensure from an associate degree to a bachelor's degree is that the profession has already demonstrated a strong commitment to higher education. Of the approximately 21,400 active licensees, 4,261 have self- reported they already hold a bachelor's degree or higher. This represents nearly one in five licensees who have voluntarily pursued advanced education beyond the minimum requirement. The fact that such a significant proportion of practitioners have already obtained a higher degree underscores that the need and value for elevated educational standards are widely recognized within the profession itself. Formalizing this expectation through a bachelor's degree requirement would align the minimum entry-level standard with the trajectory many licensees have already taken, while also ensuring future practitioners are better prepared to meet the increasingly complex needs of patients and health care systems.

Employers increasingly value bachelor's prepared RCPs, particularly in competitive job markets. Establishing the bachelor's degree as the standard supports consistent preparation and expands pathways to leadership, education, and specialized practice, while continuing to recognize the contributions of all respiratory care professionals.

Bachelor's educated practitioners are also well-positioned to pursue advanced certifications, graduate education, or credentials such as the Advanced Practice Respiratory Therapist (addressed in detail under New Issue Item #5). These pathways are essential for meeting future workforce needs in complex, multidisciplinary healthcare environments.

Preparing California for the Future of Care

While no state currently mandates a bachelor's degree for initial licensure, several are taking steps toward this goal. New York has introduced legislation to require a bachelor's degree, Ohio and North Carolina are actively considering similar measures to expand the educational landscape for RCPs by offering advanced academic pathways, and other states are exploring early-stage proposals. These initiatives signal a profession-wide shift toward higher educational standards to improve patient outcomes and support advanced practice.

California has long set the standard in healthcare licensure, being the first state to license RCPs and to require the advanced-level Registered Respiratory Therapist credential in 2015. As other states begin to advance educational requirements, California has an opportunity to maintain its leadership. While some employers already prefer bachelor's educated RCPs, a statutory standard would ensure a consistently prepared workforce and expand pathways to leadership, education, and specialized practice.

National and Statewide Support for a Bachelor's Standard

The American Association for Respiratory Care (AARC) advocates for a nationwide bachelor's degree requirement to create uniformity in education and licensing, improve licensure portability, and ensure all RCPs are prepared to deliver high-quality care. A standardized educational foundation would also better position the profession to address public health priorities such as preventive care, chronic disease management, and patient-centered care models.

Here in California, the California Society for Respiratory Care (CSRC), the state's professional association representing RCPs, also strongly supports this change. As CSRC leadership has stated:

> “California’s patients deserve respiratory care practitioners who are fully prepared to meet the increasing complexity of modern healthcare. Raising the entry-level standard to a bachelor’s degree ensures our workforce will continue to deliver the safest, most advanced, and most effective care possible.”

Addressing Concerns and Ensuring Access

Some may argue that an associate degree is sufficient for entry-level practice or that higher requirements could deter future students. However, these concerns can be addressed through a deferred implementation and degree advancement support. As indicated in Section 7, Workforce Development and Job Creation, California’s existing workforce already exceeds the projected number of licensees needed for 2030, and is strong enough to accommodate any temporary dip in new graduates that may occur during implementation, ensuring no disruption to patient care. Additionally, there are now far more bachelor’s degree programs in respiratory care available statewide, including many offered through community colleges. These programs provide an affordable pathway to the degree, lowering the financial barrier for students and expanding access to higher education in the profession.

This initiative will not affect current licensees or impose additional requirements on them. Bridge programs are available for practitioners who wish to further advance their knowledge and enhance patient care. The goal is to raise educational standards while keeping pathways open for all qualified candidates.

Mitigating Potential Declines in Applications

The Board recognizes the importance of ensuring a stable and sufficient respiratory care workforce during the transition to a higher minimum education standard. Importantly, the increased requirement will apply only to new applicants for licensure on or after the effective date. Existing licensees will not be affected and may continue to practice under their current license, ensuring continuity of care and stability in the workforce.

To minimize any potential decline in new applications, the Board has and continues to take proactive measures to strengthen the educational pipeline, support access to bachelor’s degree programs, and promote respiratory care as a rewarding and sustainable career choice. Bridge and degree-completion programs will be emphasized, and the Board will continue to support community college bachelor's programs to provide affordable and accessible pathways for students who begin their education at the associate level.

The Board also intends to work collaboratively with educational institutions, employers, and professional associations to advocate for program availability and reduce barriers. This includes supporting online and hybrid models to increase geographic reach, encouraging employer-sponsored tuition assistance, and advocating for scholarships to ease the financial burden on students.

Finally, the Board will engage in clear, proactive communication with prospective students, current practitioners, and the public. By framing the higher educational requirement as an opportunity for professional advancement, aligning respiratory care with other advanced allied health professions such as nursing, physical therapy, and occupational therapy, the Board will highlight the benefits of this change for both practitioners and patients.

Through these actions, the Board is confident that any short-term fluctuations in program applications can be effectively mitigated, while the long-term benefits of a better-educated, more highly trained respiratory care workforce will strengthen patient safety and elevate the profession as a whole.

Moving Forward
Raising the minimum educational requirement to a bachelor's degree is not just a professional milestone—it is a necessary step to safeguard patients, modernize the workforce, and reaffirm California's leadership in healthcare. This change will:

- Improve patient outcomes through advanced clinical knowledge and critical thinking.
- Enhance consumer protection and maintain trust by ensuring consistent, high-level preparation for all RCPs.
- Increase professional recognition and align respiratory care with other healthcare disciplines.
- Support workforce development by preparing practitioners for leadership, education, and advanced practice.

The proposed legislative change represents a critical investment in both the profession and the health of our communities. By raising the standard now, we ensure that every Californian has access to safe, high-quality, and equitable respiratory care for decades to come.

Proposed legislative resolution:

Amend B&PC § 3740 as follows:

(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, 203x, 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.

Finally, the Board has received substantial input regarding the quality of, and variance in, clinical education. Stakeholders have noted these inconsistencies are contributing to deficits in the preparedness of new graduates, leaving some inadequately equipped to meet the expectations and responsibilities of professional practice. In addition to the proposal to increase the minimum education requirement to a bachelor's degree, the Board's Professional Qualifications Committee continues to actively evaluate these concerns to determine what measures are necessary to ensure the public is protected. Moving forward, the Board may consider proposing additional statutory amendments to Business and Professions Code section 3740 to address these issues.

Professions Committee for the many comments of appreciation for the respiratory care profession, especially during the pandemic, at the March 7 hearing. The Board would also like to acknowledge and sincerely thank the Committees and their staffs' for their thorough review of the Board and bringing to light several recommendations that lead to greater efficiency and/or consumer protection.

2025 Board Update
SB 1436 (statutes of 2022) amended B&PC § 3710 and 3716, to extend the effective dates of the Respiratory Care Practice Act and the Board's authority to employ an executive officer from 2023 to 2027.

ISSUE #2: EXAMINATION NAME CHANGE

The Board has been informed of upcoming changes to the National Board for Respiratory Care's (NBRC) examination structure, which will necessitate a technical revision to the exam title referenced in B&PC § 3739.

Effective January 2027, the NBRC will implement a redesigned credentialing process intended to streamline entry into the respiratory care profession while maintaining the rigor and integrity of its standards. This initiative includes consolidating current examinations to reduce barriers for new graduates and enhance accessibility. Additionally, the NBRC will integrate the evaluation of clinical judgment into a comprehensive multiple-choice format, ensuring a more holistic assessment of a candidate's knowledge, decision-making, and readiness for practice.

Proposed Legislative Resolution:

Amend B&PC § 3735(a) as follows:

> (a) Except as otherwise provided in this chapter, an applicant shall not receive a license under this chapter without first successfully passing the National Board for Respiratory Care's ~~Therapist Multiple-Choice~~ Respiratory Therapy Examination (RTE), at the cut-off level required to qualify for the ~~Clinical Simulation Examination, and the Clinical Simulation Examination~~ Registered Respiratory Therapist (RRT) credential, or any succeeding examinations.

ISSUE #3: AUTHORITY FOR AUTOMATIC SUSPENSION AND REVOCATION OF LICENSE FOLLOWING SPECIFIED FELONY CONVICTIONS

The Board is mandated to protect the health and safety of consumers by ensuring only competent and ethical practitioners are licensed to provide respiratory care services in California. RCPs routinely provide high-acuity, life-sustaining care in critical settings such as intensive care units, emergency departments, and long-term care facilities, often to vulnerable patients who cannot advocate for themselves.

The Board currently has disciplinary authority under the following statutes:

- B&PC § 3750 – Establishes general grounds for suspension, revocation, or probation of a license.

- B&PC § 3752 – Specifies that a guilty plea, guilty verdict, or conviction based on a "nolo contendere" (no contest) plea for an offense related to a respiratory care practitioner's duties will be considered a conviction. Disciplinary action proceeds once the appeal period has passed or a probation order suspending the sentence is issued.

- B&PC § 3752.5 – Makes a crime involving bodily injury or attempted bodily injury a crime substantially related to the qualifications, functions, or duties of a respiratory care practitioner.

- B&PC § 3752.6 – Makes a crime involving sexual misconduct or attempted sexual misconduct, whether or not with a patient, a crime substantially related to the qualifications, functions, or duties of a respiratory care practitioner.

- B&PC § 3752.7 – Establishes mandatory license revocation without the possibility of a stay for licensees who engage in sexual misconduct with patients or commit certain sex offenses. However, this statute requires administrative proceedings and does not provide authority for immediate, automatic action upon conviction.

- B&PC § 3755 – Establishes grounds for suspension, revocation, or probation of a license for unprofessional conduct.

While these statutes allow the Board to pursue disciplinary action, the current process requires case-by-case adjudication, even in the most serious cases. As a result, licensees convicted of serious or violent felony offenses may continue practicing while their administrative case proceeds, a process that can take months. The Board lacks the ability to act swiftly when immediate intervention is necessary to protect the public.

Under existing law, even the most egregious criminal convictions, such as sexual misconduct or serious acts of violence, require lengthy administrative steps to revoke or suspend a license. This can include filing an accusation, holding a hearing, issuing a proposed decision, and waiting for the Board's final action. These steps can collectively take several months, during which the licensee may still practice, putting patients at risk.

Although the Board may seek suspension during criminal proceedings through the Penal Code § 23 (PC 23) process, that authority ends when the case concludes. Once the conviction is final, the Board must pursue a separate interim suspension order (ISO), which requires additional time and procedural steps.

To address this gap, the Board proposes the establishment of a statute within the Respiratory Care Practice Act modeled after B&PC § 2232.5 (Medical Board of California). The statute would authorize:

- Automatic license suspension upon felony conviction for specified offenses.
- Automatic license revocation once the conviction becomes final.

This approach provides an enforceable mechanism to protect patients without unnecessary delays while maintaining due process through limited hearings on procedural issues.

This proposal enhances patient safety by closing a critical enforcement gap. RCPs often work

in unsupervised, high-acuity environments caring for vulnerable patients who cannot self-advocate. Allowing licensees convicted of egregious felony offenses to continue practicing during extended administrative proceedings undermines public trust and jeopardizes patient safety.

The proposal is narrowly tailored to apply only to the most serious criminal convictions, such as sexual misconduct and violent felonies, and is modeled on recent legislative trends granting similar authority to other healing arts boards. It balances the need for swift action with due process by preserving a licensee's right to a hearing limited to procedural matters.

The proposal relies on existing conviction reporting systems and reduces costs associated with preparing accusations, hearings, and enforcement actions in qualifying cases. Any additional hearings can be absorbed within current resources. As such, minimal fiscal impact is anticipated.

The Board requests enactment of Business and Professions Code section 3752.8, which would authorize automatic suspension and revocation for licensees convicted of specified felony offenses involving sexual misconduct or serious violence.

Proposed Legislative Resolution:

Add B&PC § 3752.8 – Automatic Suspension and Revocation for Specified Felony Convictions:

(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 the 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.

ISSUE #4: RENEWAL FEE CEILING INCREASE, PERMANENT ELIMINATION OF INITIAL LICENSE FEE WHICH POSES A BARRIER TO LICENSURE, AND ELIMINATION OF OUTDATED FEE-RELATED PROVISIONS

As reported during its last sunset review, the Board does not anticipate the need for a fee increase in the near future. However, it may be prudent to proactively pursue a modest statutory renewal fee ceiling increase. This action would 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. With an increased statutory fee ceiling already in place, a regulatory fee adjustment could be implemented in less than one year, ensuring the Board remains financially stable and responsive to evolving fiscal demands.

It is our understanding that generally pursuing a statutory fee increase requires completion of a fee analysis. While the Board respects the value of such a process, this level of review may be of limited necessity given the Board's comprehensive knowledge of its own budget and fiscal history. Much of the information such a review would produce has already been documented in prior reporting, including detailed expense reductions highlighted through multiple sunset review cycles. In addition, while other miscellaneous fees could be raised to their statutory caps, doing so would not generate sufficient revenue to meaningfully address any underlying fiscal challenges.

Additionally, as noted in its prior sunset review reports, the Board eliminated its initial license fee in 2012 to reduce application processing times and increased the application fee from $200 to $300, also as part of efforts to streamline processing with a near-neutral cost impact. While the Board recognizes that it is generally recommended to implement all other fees to their statutory ceilings before pursuing a renewal fee increase. However, the initial license fee presents a greater barrier to licensure by placing an additional financial burden on students and applicants. For this reason, the Board is proposing to remove the fee entirely.

The Board also proposes to repeal provisions in B&PC section 3775(d) that were added more than two decades ago and are no longer applicable, including the requirement to set renewal fees to maintain a six-month reserve and the limitation that renewal fee increases not exceed ten percent from the prior year. A six-month reserve is no longer sufficient, and Business and Professions Code section 128.5(b) already provides that if, at the end of any fiscal year, a board's unencumbered funds equal or exceed its operating budget for that year, the board must reduce its fees accordingly, effectively limiting the reserve to a maximum of 24 months of expenditures. Additionally, the ten-percent cap could impede the Board's ability to respond promptly to fiscal needs by restricting fee adjustments even when additional revenue is required.

The Board recognizes that fee increases are often unpopular and will continue to exercise fiscal responsibility to minimize the need for increases in the near term. Should a renewal fee increase become necessary, the rulemaking process will be initiated, providing stakeholders with an opportunity to provide input.

Proposed legislative resolution:

Amend B&PC § 3775 as follows:

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 ($2330). 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.~~

ISSUE #5: SUPPORT FOR LEGISLATIVE EFFORTS TO ESTABLISH AN ADVANCED PRACTICE RESPIRATORY THERAPIST (APRT) CLASSIFICATION IN CALIFORNIA

The California Society for Respiratory Care (CSRC) is spearheading efforts to establish an Advanced Practice Respiratory Therapist (APRT) classification in California. In line with Strategic Plan Goal 2.4 to "Collaborate with professional organizations and schools to perform a needs assessment for the advanced respiratory practitioner role in California to address the projected shortage of physicians and the evolving role of being a physician extender," the Board supports this initiative and recognizes its potential to enhance consumer protection by expanding access to highly skilled respiratory care professionals.

California faces significant and growing shortages of physicians—especially in pulmonary medicine, critical care, and underserved rural and urban areas. According to the Association of American Medical Colleges (AAMC), the physician shortfall could be as high as 120,000 by 2030, with more than 70% of pulmonologists over the age of 55. The aftermath of COVID-19 has further increased both the number of patients and the intensity of care required, creating months-long wait times and forcing some patients to seek emergency care in lieu of timely appointments.

Respiratory care practitioners, already trained to manage complex cardiopulmonary conditions such as COPD, asthma, and respiratory failure, are uniquely positioned to help close critical gaps in care. Establishing the APRT 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, particularly in critical care, pulmonary medicine, and underserved regions where workforce shortages are most acute.

The Board is committed to collaborating with the CSRC to ensure that any legislative language developed in support of the APRT classification prioritizes patient safety and public protection, aligns with the standards of the Respiratory Care Practice Act, and maintains appropriate licensure, oversight, and accountability mechanisms to ensure safe and effective care.

The states of Ohio and North Carolina are already advancing legislation to establish the APRT role, and the VA health system has adopted a physician-supervised advanced practitioner model intended to expand across its network, with strategic oversight, advanced clinical duties, and a focus on meeting veterans' complex pulmonary needs.

The Board also acknowledges national progress, including the National Board for Respiratory Care's (NBRC's) work on developing an outcome assessment for APRT programs that can be used by accredited schools, state licensure agencies, and employers. As accredited academic programs designed to prepare future APRTs continue to emerge, the NBRC may consider creating a credentialing examination for the advanced practice category.

The Board looks forward to working with the CSRC and other stakeholders to help shape a responsible, consumer-focused path forward. Establishing the APRT in California, guided by strong regulatory standards and public protection priorities, will strengthen the healthcare system and ensure Californians continue to receive safe, timely, and high-quality respiratory care.

Section 11
Attachments

ORGANIZATIONAL CHARTS

Fiscal Year 2021–22 Organizational Chart

Fiscal Year 2022–23 Organizational Chart

Fiscal Year 2023–24 Organizational Chart

Fiscal Year 2024–25 Organizational Chart

WILL BE ADDED TO FINAL REPORT

RESPIRATORY CARE BOARD ADMINISTRATIVE MANUAL

Provided under separate cover.