RESPIRATORY CARE BOARD
Department of Consumer Affairs
California Code of Regulations. Title 16. Division 13.6 Respiratory Care Board

FINAL STATEMENT OF REASONS

Hearing Date: August 7, 2024.

Subject Matter of Proposed Regulations: Basic Respiratory Tasks and Services.

Sections Affected: Adopt section 1399.365 of Division 13.6, Title 16 of the California Code of Regulations (CCR)[1].

Updated Information

The Initial Statement of Reasons (ISOR) is included in the rulemaking file. The information contained therein is updated as follows:

At the Respiratory Care Board's (RCB's/Board's) March 28, 2024, meeting it was presented with, and approved, text to begin the rulemaking process.

On June 5, 2024, RCB staff filed the initial rulemaking package, and the 45-Day public comment period began upon publication on June 21, 2024, with a closing date to receive written comment of August 6, 2024. A hearing was held on August 7, 2024.

A total of six (6) comments, comprising 35 separate issues, were received from June 21, 2024, to August 7, 2024, and were presented to the RCB for its consideration at its meeting on October 14, 2024. A summary of each comment made regarding the specific adoption, or amendment, together with an explanation of how the proposed action was changed to accommodate each objection or recommendation, or the reasons for making no change are addressed in the "45-Day Comment Period: Summary of Comments and Board Responses" section below.

Additionally, the RCB received 15 untimely letters/emails after the August 7, 2024, closing date for public comment, which were also presented to the RCB at its October 14, 2024, meeting. And one (1) additional letter, was received on October 15, 2024, which was after the RCB's October 14, 2024, meeting, so it was shared with the RCB at its March 13, 2025 meeting. These letters/emails are identified in the "Untimely Letters and Emails Received Outside the Official Comment Period Regarding the Originally Published Text (45-Day)" section below.

Following consideration of the timely comments presented to the RCB at its October 14, 2024, meeting, the RCB directed staff to modify the text and notice the modified text for comment. On October 15, 2024, RCB staff issued a Notice of Availability of Modified Text as well as the modified text. The final day to submit written comment was October 31, 2024.

The following is a digest of each of the changes present in the modified text, CCR section 1399.365. Basic Respiratory Tasks and Services:

1. Subdivision (a) was added to define "assessment" as used in section 1399.365. This definition was added in response to Comment Nos. F-1 and D-12. Section 2518.5 of Division 25 of the CCR (BVNPT regulations) references assessment as "data collection." Section 2859 of the Business and Professions Code (B&P) describes the practice of vocational nursing as requiring "technical" and "manual" skills. Many of the comments infer and one actually states

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

(Comment No. D-12) that “respiratory assessment is a technical skill to assist with data collection.” However, to the contrary, the collection of data from observations is used to make an assessment.

The widely accepted understanding of the term “assessment” in the medical community, as defined in *Taber's Medical Dictionary*, is as follows: 1. An appraisal or evaluation of a patient's condition by a physician, nurse, or other health care provider, based on clinical and laboratory data, medical history, and the patient's account of symptoms. 2. The process by which a patient's condition is appraised or evaluated.

The RCB's proposed definition specifies that "assessment" involves analyzing and making judgments about a patient's condition, going beyond mere data collection. Defining the term “assessment” provides clarity and resolves confusion as to what “assessment” means in relation to CCR 1399.365. Additionally, the proposed definition provides important context for licensed respiratory care practitioners (RCPs), indicating that once assessments—defined as analysis and judgment—are being performed, the task exceeds basic respiratory care services, which are typically within the practiced scope of students or new licensees. The RCB believes the proposed text provides essential clarity regarding the roles of licensed vocational nurses (LVNs) and RCPs, promoting collaboration and ensuring the best possible care for patients

2. Subdivision (b), which was the preamble in the original text, was moved because of the inclusion of the definition of assessment in subdivision (a). The language of subdivision (b) was also amended to increase readability and be more succinct in response to Comment No. D6. As described below, all respiratory tasks and services that are considered “basic” are exclusively listed in subdivision (b), while respiratory tasks that are often associated with basic respiratory tasks and services but are beyond “basic” respiratory tasks and services are exclusively listed in subdivision (c).

   Specifically, the language “Pursuant to” in subdivision (b) was replaced with “For purposes of” to appropriately reflect the amendments in this section and maintain clarity.

   The text “B&P” replaced “Business and Professions code” in subdivision (b) because section 1399.302 of the CCR provides this definition.

   The language “(‘tasks’), described more specifically below,” was removed from subdivision (b) to no longer abbreviate “basic respiratory tasks and services” because it was found to be unnecessary given the other amendments made to the text and that the phrase “basic respiratory tasks and services” is only used twice in the modified text.

   The text, “only require manual, technical skills, or data collection,” was deleted from subdivision (b) because it was found to be unnecessary and duplicative to repeat language already contained in section 3702.5 of the B&P as referenced.

   The text, “Basic respiratory tasks do not include manipulation of an invasive or non-invasive ventilator,” was moved from subdivision (b) to subdivision (c)(1) because, as discussed in #6 and #8 below, the text was amended so that all tasks that do not constitute basic respiratory care tasks and services are located under one subdivision.

   The text of subdivision (b), “and do not include assessment or evaluation of chest auscultation” was deleted, reconsidered, and restructured creating new sections (b)(8) and (c)(2) to provide consistency in aligning tasks that are considered basic tasks in subdivision (b) and those that are beyond basic tasks, but often performed in concert with basic tasks by RCPs, in subdivision (c).

The text, “basic respiratory tasks,” was deleted from the end of subdivision (b) to improve readability following the text amendments to subdivision (b) described above.

The language “the following” was added as a non-substantive change to improve readability.

3. A non-substantive change was made to all the numbering of subdivisions in section 1399.365(b) from alpha leaders to numerical leaders as appropriate to increase clarity and for better organization following changes to the text described in #2 above.

4. Subdivision (b)(1) was amended to add the word “Patient” and a non-substantive change (i.e. removing the capitalization) to the word “data” to improve clarity and be more precise as to the type of data collected.

5. A non-substantive change was made to subdivision (b)(2) to change the word “the” to “a” to increase clarity and maintain consistency with the writing and formatting style found in other parts of these regulations.

6. The last sentences of subdivisions (b)(3), (b)(4), and (b)(5), which identify respiratory tasks and services that are not considered “basic,” were moved to new subdivision (c) to increase clarity and improve organization. Specifically, these sentences were moved to a new subdivision (c) so that all respiratory tasks and services that are considered “basic” are exclusively listed in subdivision (b), while respiratory tasks that are often associated with basic respiratory tasks and services but are beyond “basic” respiratory tasks and services are exclusively listed in subdivision (c).

7. Subdivision (b)(8) was added as a result of moving and modifying language from the preamble in the original text to provide clarity in response to Comment Nos. F2 and F6. The RCB acknowledges that some tasks involved in a chest examination are basic respiratory tasks and services, including reporting on or gathering data from chest auscultation, palpation and percussion. To provide clarity, the RCB modified the text to include, “Observing and gathering data from chest auscultation, palpation and percussion,” as part of basic respiratory tasks and services. While “assessment or evaluation” of this data was added to what is not included as a basic respiratory tasks and service in subdivision (c)(2).

8. The addition of subdivision (c) which provides, “For purposes of subdivision (a) of section 3702.5 of the B&P, basic respiratory tasks and services do not include the following:” was made to separate respiratory tasks and services that are considered “basic” from respiratory tasks and services that are beyond “basic” but often part of a respiratory service associated with the basic tasks when performed by a licensed RCP. The restructuring of the language in this way provides clarity of which tasks may and may not be performed when providing a respiratory service and allows for language prohibiting tasks, which was previously in the preamble and subdivisions (a)-(g) of the original text, to be placed all in one subdivision. This change provides greater clarity and user readability.

9. Subdivision (c)(1) added the language, “Manipulation of an invasive or non-invasive ventilator,” which was previously found in the preamble of the original text (also shown as deleted text of subdivision (b) in the modified text). Moving this language to subdivision (c) increases readability and succinctness by having those tasks that go beyond what would be considered basic respiratory tasks and services in one subdivision.

10. Subdivision (c)(2) added the language, “Assessment or evaluation of observed and gathered data from chest auscultation, palpation, and percussion,” (previously found in part in the original preamble or the deleted text of subdivision (b) of the modified text), to distinguish that

while “observing and gathering” data is a basic respiratory task as noted in subdivision (b)(8), the “assessment or evaluation” is beyond basic respiratory tasks and services.

As noted in the response to Comment D6 below, assessment and evaluation of chest auscultation is not a basic respiratory task because, in the RCB’s experience and in the common practice of respiratory care, it requires pulmonary and cardiopulmonary education and training specific to numerous respiratory conditions and contraindications to which requires a comprehensive analysis to achieve the best intended patient outcomes. Pursuant to B&P section 3740, to become licensed as an RCP, an applicant must complete an education program that is accredited by the nationally recognized Commission on Accreditation for Respiratory Care (CoARC).

There are both associate degree and baccalaureate respiratory care degree programs. However, even the RCP associate degree programs take a minimum of three years to complete with full-time attendance, and the programs are weighted heavily with courses specific to respiratory care. While other health care disciplines may include a high-level review of respiratory care in their education programs, respiratory care students delve into the intricacies of the practice, which also requires advanced math and science.

Respiratory care is considered a health care specialty that takes thousands of hours of education to be prepared to pass the national competency exam and begin practicing at the minimum competency level. The addition of this language to this section provides clarity.

11. Subdivision (c)(3) added the language, “Pre-treatment or post-treatment assessment,” which was taken in part from deleted text of subdivision (b)(3) to distinguish more clearly that while medication administration by aerosol as described in subdivision (b)(3) is a basic respiratory task, pre-treatment and post-treatment assessments are beyond basic respiratory tasks and services. The addition of this language to subdivision (c)(3) and deletion from subdivision (b)(3) increases readability and succinctness.

12. Subdivision (c)(4) added the language, “Use of medical gas mixtures other than oxygen,” which was taken in part from deleted text of subdivision (b)(3) to distinguish more clearly that while medication administration by aerosol as described in subdivision (b)(3) is a basic respiratory task, the use of medical gas mixtures, other than oxygen, is beyond basic respiratory tasks and services. The addition of this language to subdivision (c)(4) and deletion from subdivision (b)(3) increases readability and succinctness.

13. Subdivision (c)(5) added the language, “Preoxygenation, or endotracheal or nasal suctioning,” which was taken in part from deleted text of subdivision (b)(3) to distinguish more clearly that while medication administration by aerosol as described in subdivision (b)(3) is a basic respiratory task, preoxygenation, or endotracheal or nasal suctioning are beyond basic respiratory tasks and services. The addition of this language to subdivision (c)(5) and deletion from subdivision (b)(3) increases readability and succinctness.

14. Subdivision (c)(6) added the language, “Initial setup, change out, or replacement of a breathing circuit or adjustment of oxygen liter flow or oxygen concentration,” which was taken from the deleted text of subdivision (b)(4), to distinguish more clearly that while oxygen tank replacement as described in subdivision (b)(4) are basic respiratory tasks, initial setup, change out, or replacement of a breathing circuit or adjustment of oxygen liter flow or oxygen concentration move beyond basic respiratory tasks and services. The addition of this language to subdivision (c)(6) and deletion from subdivisions (b)(4) increases readability and succinctness.

15. Subdivision (c)(7) added the language, “Tracheal suctioning, cuff inflation/deflation, use or

removal of an external speaking valve, or removal and replacement of the tracheostomy tube or inner cannula," which was taken from the deleted text of subdivision (b)(5) to distinguish that while hygiene care as described in subdivision (b)(5) are basic respiratory tasks, tracheal suctioning, cuff inflation/deflation, use or removal of an external speaking valve, or removal and replacement of the tracheostomy tube or inner cannula are beyond basic respiratory tasks and services. The addition of this language to subdivision (c)(7) and deletion from subdivision (b)(5) increases readability and succinctness.

During the 15-day comment period from October 15, 2024 through October 31, 2024, the Board received a total of 44 timely comments, organized into a total of 20 distinct issues, and the comments were presented to the RCB for its consideration at its meeting on March 13, 2025. Comments were compiled by issue regarding the modified text with an explanation of the reasons for rejecting the comments and declining to make any changes, which is addressed in the "Modified Text 15-Day Comment Period: Summary of Comments and Board Responses" section below.

On March 13, 2025, the RCB considered the comments and declined to make changes to the proposed regulatory text. The RCB approved and adopted the proposed regulations as described in the modified text and notice from October 2024 after reviewing the timely comments received during the 15-day modified text public comment period. No further substantive changes were made to the proposed text after the RCB's March 13, 2025, approval.

Local Mandate

This regulatory package does not impose a mandate on local agencies or school districts.

Anticipated Benefits of this Proposal

The Board has determined that this regulatory proposal will have the following benefits to the health and welfare of California residents:

This regulatory proposal benefits the health and welfare of California residents by further defining, interpreting, and identifying basic respiratory tasks and services that may be safely performed by properly trained health care personnel, including LVNs, consistent with the underlying statutory requirements. This will help ensure the most up-to-date standards and practices of respiratory care are met and will help protect patients in need of respiratory care.

The RCB's highest priority is protection of the public in exercising its licensing, regulatory, and disciplinary functions. The RCB is mandated to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care. In support of its mandates, the RCB must ensure only qualified personnel are providing respiratory care beyond basic tasks and services that only require manual, technical skills, or data collection.

In addition, all stakeholders (i.e., health care practitioners, facilities, employers, and patients) benefit by having a clear and precise understanding of which respiratory tasks and services may be performed by LVNs. Providing such clarity will overall enhance the timely delivery of health care monitoring and attention by maximizing resources of the health care teams to perform duties and functions at their skill levels without interruption to health care delivery or planning or reducing the quality of care delivered.

This regulatory proposal does not affect worker safety because it does not involve worker safety.

This regulatory proposal does not affect the state's environment because it does not involve the environment.

Small Business Impact

The RCB has determined that the proposed regulations will not have a significant statewide adverse economic impact directly affecting small businesses, including the ability of California businesses to compete with businesses in other states.

The RCB investigates between one and five facilities each year based on complaints of unlicensed or unauthorized practice stemming directly from LVNs violating the Respiratory Care Practice Act (Act) (B&P §§ 3700 et seq.), some unknowingly, at the behest of their employer. This proposed regulation aims to reduce these complaints, and at the same time, increase complaints for other facilities that have not yet been reported. Businesses in compliance with existing law will have no impact. Those not in compliance may need to adjust their procedures.

Economic Impact

This regulatory proposal will have the following effects:

- It will not create or eliminate jobs within the State of California because the regulation does not make any changes or provide for any new provisions that would affect the creation or elimination of jobs. The regulation is aimed primarily at reenforcing existing law by providing specific detail of what constitutes basic respiratory tasks and services.

- It will not create new business or eliminate existing businesses within the State of California because the regulation does not make any changes or provide for any new provisions that would result in the creation or elimination of new businesses. The regulation is aimed at ensuring existing businesses employing health care personnel understand which respiratory care tasks and services may be performed by LVNs.

- It will not result in expansion of any businesses currently doing business within the State of California because the regulation does not make any changes or provide for new provisions that would directly affect the expansion of any businesses. The regulation is not expected to create new jobs nor expand businesses.

- This regulatory proposal will benefit the health and welfare of California residents because this proposal will ensure LVNs are only performing those basic respiratory tasks and services for which they are trained and demonstrate competency satisfactory to their employer, and when directed by a physician or surgeon, to perform. This ensures patients requiring respiratory care beyond basic tasks and services are receiving such care from qualified health care personnel.

- This regulatory proposal does not affect worker safety because it only makes the respiratory care practice more specific by identifying basic respiratory tasks and services. The regulatory proposal does not involve worker safety.

- This regulatory proposal does not affect the state's environmental safety because it only makes the respiratory care practice more specific by identifying basic respiratory tasks and services. The regulatory proposal does not involve environmental issues.

Fiscal Impact

There is no fiscal impact to the State in the form of federal funding or any cost or savings to any state agency. The proposed regulation identifies basic respiratory tasks and services. The Board does not anticipate an increase in workload or costs resulting from the proposed regulations, and any workload and costs of implementation are a result of current law

Consideration of Alternatives

No reasonable alternative to the regulatory proposal would be either more effective in carrying out

the purpose for which the action is proposed or would be as effective or less burdensome to affected private persons and equally effective in achieving the purposes of the regulation in a manner that ensures full compliance with the law being implemented or made specific. No alternative would be more effective to affected private persons.

Set forth below are the alternatives which were considered and the reasons each alternative was rejected:

1. Not adopt the regulations as drafted. This alternative was rejected because the regulatory proposal is based on multi-year reviews and discussions with various stakeholders of the issues. Further, the need to define basic respiratory tasks and services is necessary to increase public safety, clarify ambiguities in the field, and align practices with the current law.

2. Adopt the regulations as drafted. The RCB determined that this alternative is the most feasible because the regulatory proposal provides increases in consumer protection.

No Reports Required
There are no reports required by this regulatory proposal.

Incorporation by Reference
There are no documents incorporated by reference.

Nonduplication Statement - 1 CCR § 12
These proposed regulations do not republish a state or federal statute or regulation and satisfy the "clarity" standard of Government Code subsection 11349.1(a)(3).

45-Day Comment Period: Summary of Comments and Board Responses
During the 45-day comment period from June 21, 2024 through August 6, 2024, and at the hearing held August 7, 2024, the RCB received six (6) timely comments, objections, or recommendations, comprising 35 separate issues, on the proposed rulemaking from the following in the form of written letters, emails, or oral testimonies:

Commenter A: Naomi Bugayong, California Society for Respiratory Care (Oral comment on August 7, 2024 hearing)
Commenter B: Julie McGill, Long Beach City College (Email dated June 30, 2024)
Commenter C: Theresa Becker, Palo Verde College (Email dated August 1, 2024)
Commenter D: Mary Adorno and Dean Chalios, California Assoc. for Health Services at Home (Email dated August 5, 2024)
Commenter E: Elaine Yamaguchi, Board of Vocational Nursing and Psychiatric Technicians (Email dated August 5, 2024)
Commenter F: Elaine Yamaguchi, Board of Vocational Nursing and Psychiatric Technicians (Letter dated 12/13/2022 attached to email dated August 5, 2024)

These timely comments in addition to other untimely comments from emails, letters, and documents received outside the 45-day comment period (identified in the sections that follows) were presented to the RCB at its October 14, 2024, and March 13, 2025, meetings.

The following is a summary of each timely objection or recommendation made regarding this specific adoption and amendments, with an explanation of how the proposed action has been changed to accommodate each objection or recommendation, or the reasons for making no change.

COMMENTER A: NAOMI BUGAYONG

via: Hearing Held August 7, 2024

I am employed at UC Davis Health as an adult clinical educator as well I am the secretary for the CSRC which is the California Society for Respiratory Care. My opinions given are my personal opinions.

1) I really appreciate this proposal. I think that the enunciated 7 tasks within 1399.365 give the freedom for LVNs to perform those seven tasks, I do appreciate that support, and I do appreciate the LVN community for their support for our patients and that the freedom of those seven tasks are ideal. And so, in my personal opinion, I do feel like the enunciated tasks within 1399.365 are appropriate.

Response: The RCB acknowledges this comment and appreciates the support, no text changes are deemed necessary in response to this comment.

2) Moving forward beyond that I would like to give my personal opinion that a return demonstrated competency would be ideal to protect patients and facilities and that I am dedicated to providing the resources for returned demonstrated competencies for colleagues who are LVNs providing patient care for California people that have families and lives and want to be well cared for and I think that's important- so I appreciate the RCB and I appreciate the LVN Community for always looking forward to keeping patients safe and I would love to begin the opportunity to participate in the future of these bills.

   Ms. Bugayong clarified that the comments that fall under this second comment are for future regulations unrelated to this regulatory package. She stated that the returned demonstrated competency should be for tasks beyond the seven tasks that are contained in this regulatory proposal, section 1399.365.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text because this comment is unrelated to this regulatory package as returned demonstrated competency is beyond the subject of basic respiratory tasks and services.

COMMENTER B: JULIE MCGILL
Long Beach City College
via: Email Dated June 30, 2024

I would like to notify the RCB of my concerns regarding the proposed statement regarding respiratory care. My concerns are several.

1) What would be the role of a student. It sounds to me like respiratory care would be a post-licensure skill. The students would not have the opportunity to perform the skill while in the direct observation of an instructor while during the VN [vocational nursing] program.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. Given the context of the entire comment, it is assumed that the student(s) in question are vocational nursing students. Senate Bill (SB) 1436 *(statutes of 2022)* amended the Vocational Nursing Practice Act (VN Act) (B&P §§ 2840 et seq.) at subdivision (a) of B&P section 2860 to state that the VN Act provides “no authority” for LVNs to “provide respiratory care services and treatment” unless other conditions are satisfied.

Specifically, subdivision (b) of B&P section 2860, which is the subject of these regulations, states that LVNs who have received training and who demonstrate competency satisfactory to their employer may, when directed by a physician and surgeon, perform respiratory tasks and services expressly identified by the RCB pursuant to subdivision (a) of B&P section 3702.5. The specific

tasks outlined in this proposed regulation package will be the only respiratory care tasks that LVNs may perform at any healthcare site, apart from other exemptions carried in SB 1451 *(statutes of 2024)*, which are limited to specific home and community-based settings.

This regulatory proposal does not limit what is taught in an LVN classroom. However, pursuant to B&P sections 3741 and 3742, a student must be enrolled in an approved respiratory care training program to render respiratory care services during the period of any clinical training. Pursuant to B&P section 3742, the student shall be under the direct supervision of a licensed RCP. In order to practice an authorized basic respiratory task or service on a patient after becoming licensed as an LVN, the LVN must receive training and demonstrate competency satisfactory to their employer.

2) Also, I know that a lot of our LVN's become employed at Sub-acute facilities. This limitation may reduce employment options.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. The prompting of recent legislative and regulatory changes occurred because of the unlicensed and unauthorized practice of respiratory care occurring at some licensed facilities, including several subacute facilities, as detailed in the *RCB 2022 Sunset Oversight Review* report (item 2 of underlying data in the Initial Statement of Reasons (ISOR)), beginning at page 87. LVNs are not authorized to practice respiratory care at these sites beyond the basic tasks provided in this regulatory proposal if approved.

3) In addition, as facilities are already financially tight, they may just hire RN's [registered nurse] that can do the work of the RT [respiratory therapist] and LVN.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. These facilities are free to use an RN or an RCP to provide respiratory care services as it best meets the demand for their patients.

RNs have the appropriate educational and training foundation to acquire the respiratory skills necessary to perform respiratory care competently and safely. However, it should be noted that respiratory care is not a “skilled nursing service” and may not be counted toward the legally required patient-to-nurse ratio.

RTs or RCPs also have the statutory authority to provide “therapy, management, rehabilitation, diagnostic evaluation, and care for nonrespiratory-related diagnoses” as provided in subdivision (c) of B&P section 3701.

4) We are seeing that current RT, who thought this was already in process are not aware how to apply this to a teamwork approach with an LVN.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon because the comment is unclear. RCPs are educated and trained to work as a vital component of any disciplinary health care team for patients with respiratory ailments. RCPs are, however, subject to disciplinary action against their license for the aiding or abetting of any person to engage in the unlawful practice of respiratory care, pursuant to subdivision (i) of B&P section 3750.

COMMENTER C: THERESA BECKER
Interim Associate Dean of Nursing and Allied Health
Palo Verde College
via: E-Mail Dated August 1, 2024

1) I have a question that I hope you can answer. We have our VN students take a class in ventilator management. At the completion of this course, they are certified in ventilator management. They have competencies such as tracheostomy care and suctioning the instructor (sic). Will this allow these students to provide those kinds of treatments to patients? I look forward to your response.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text because the comment appears to be an inquiry that provided no objection or recommendation. The RCB provided a written response to the inquiry on October 14, 2024, as follows:

> Thank you for your inquiry. SB 1436 *(statutes of 2022)* amended the Vocational Nursing Act to codify that the Vocational Nursing Practice Act provided "no authority" for LVNs to "provide respiratory care services and treatment" with limited exceptions as identified through regulation.
>
> **Vocational Nursing Practice Act, Business and Professions Code**
>
> **2860.**
> (a) This chapter confers no authority to practice medicine or surgery, to provide respiratory care services and treatment, or to undertake the prevention, treatment, or cure of disease, pain, injury, deformity, or mental or physical condition in violation of any provision of law.
>
> (b) Notwithstanding subdivision (a), a licensed vocational nurse who has received training and who demonstrates competency satisfactory to their employer may, when directed by a physician and surgeon, perform respiratory tasks and services expressly identified by the Respiratory Care Board of California pursuant to subdivision (a) of Section 3702.5.
>
> You note that LVN students are "certified" in ventilator management. "Certified" implies official recognition, possessing certain qualifications, or meeting certain standards. Given that the health care industry is highly regulated, implying a person is certified to perform a health care task also implies a legislative or regulatory process has been established to authorize such certification. Please be advised that no such government authority exists to permit anyone to "certify" a person to legally perform "ventilatory management." The only authority that exists to provide respiratory care resides within the Act (including exemptions for other health care personnel such as RNs or physicians to perform respiratory care).
>
> You also mention the respiratory care tasks of tracheostomy care and suctioning the [LVN] instructor and ask if this will "allow these students to provide those kinds of treatments to patients." The proposed regulations for "Basic Respiratory Tasks and Services," to which the RCB believes are being referenced in this comment, if passed will allow LVNs to perform hygiene care including replacement of tracheostomy ties and gauze and cleaning of the stoma sites. However, it will not allow LVNs to perform tracheal suctioning, cuff inflation/deflation, use or removal of an external speaking valve, or removal and replacement of the tracheostomy tube or inner cannula because those tasks are not basic respiratory tasks and services.
>
> This regulatory proposal does not limit what is taught in an LVN classroom. However, pursuant to sections 3741 and 3742 of the Business and Professions Code, a student must be enrolled in an approved respiratory care training program to render respiratory care

services during the period of any clinical training. Pursuant to 3742, the student shall be under the direct supervision of a licensed RCP. Therefore, a student may not provide these respiratory services to patients. However, once the student obtains their LVN license, they can perform the hygiene care including replacement of tracheostomy ties and gauze and cleaning of the stoma sites upon demonstrated competency satisfactory to their employer and when directed by a physician and surgeon pursuant to subdivision (b) of Section 2860 of the Business and Professions Code and the Vocational Nursing Practice Act.

I trust this responds to your inquiry. If you have any further questions, please reach out to us at rcbinfo@dca.ca.gov.

COMMENTERS D: **MARY ADORNO**
Legislative Specialist
California Association for Health Services at Home (CAHSAH)

DEAN CHALIOS
President and CEO
California Association for Health Services at Home (CAHSAH)

via: Email Dated August 5, 2024, with Letter Dated July 31, 2024 Attached

The California Association for Health Services at Home (CAHSAH) representing licensed, and Medicare certified home health agencies, hospices, and home care agencies appreciates the opportunity to comment on the proposed regulations for the scope of practice of licensed vocational nurses who provide respiratory care.

1) We are especially focused on ensuring continuity of care for patients who are ventilator-dependent and receive care from LVNs in the home and school setting.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. Effective January 1, 2023, SB 1436 *(statutes of 2022*, underlying data Item 1 in the ISOR*)* made it legal for patients in home care settings to receive respiratory care from LVNs employed by a home health agency licensed by the State Department of Public Health as follows:

Respiratory Care Practice Act, Business and Professions Code

3765.
This act does not prohibit any of the following activities:
…
(i) The performance, by a vocational nurse licensed by the Board of Vocational Nursing and Psychiatric Technicians of the State of California who is employed by a home health agency licensed by the State Department of Public Health, of respiratory tasks and services identified by the board, if the licensed vocational nurse complies with the following:

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

(2) 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 (*statutes of 2024)* changed the dates in subdivision (i) above from January 1, 2025, to January 1, 2028, to align with other changes needed with training due to the new exemptions

sought for other home and community-based settings that are also carried in SB 1451. Subdivision (i)(1) allows LVNs who are employed by a licensed home health agency to continue to practice respiratory care if the LVN has completed patient-specific training to the satisfaction of the employer. While the RCB has not yet identified those "respiratory tasks and services," at this time, the law leans in favor of giving home health agencies enough authority to continue performing the same tasks and services that most have done for years with patient-specific training. It is the RCB's position that the RCB must specify those "respiratory tasks and services" before it can pursue any form of disciplinary or administrative action against an LVN employed by a home health agency or an LVN employed by a home health agency, with the exception of cases where gross negligence, gross incompetence, or inadequate training, as determined by a reasonable person, causes patient harm or death. It is incumbent upon home health agencies to consult with their legal counsel to determine any liability issues.

As it pertains to LVNs who accompany patients to school, there is currently no legal authorization for an LVN to provide respiratory care if they are not employed by a home health agency. These proposed regulations will allow specific respiratory tasks to be performed if, and when, they become effective. In addition, SB 1451 *(statutes of 2024)* also provides a legal exemption for LVNs to perform tasks beyond basic respiratory care tasks and services, who accompany patients to school, but it will not be in effect until 2028.

However, given the legislative and regulatory transition that is currently underway, the RCB has no plans to impose disciplinary measures or administrative sanctions contrary to the intended and final legislative and regulatory plan, with the exception of cases where gross negligence, gross incompetence, or inadequate training, as determined by a reasonable person, causes patient harm or death. It is incumbent upon LVNs and facilities to consult with their legal counsel to determine any liability issues. The RCB expects the legislative and regulatory transition to be complete by January 1, 2028.

2) We also want to ensure that LVNs are not unjustly forced to leave their current jobs.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. It is the RCB's position that LVNs have never been legally authorized to practice respiratory care, and which is what prompted the RCB to seek a legal remedy through the California Legislature to amend the VN Act to codify existing law. As noted in the Response to Comment B-1, SB 1436 *(statutes of 2022)* amended the VN Act at B&P 2860(a) to state that LVNs have "no authority" to "provide respiratory care services and treatment." Subdivision (b) was also added to B&P 2860, providing that an LVN who has received training and who demonstrates competency satisfactory to their employer may, when directed by a physician and surgeon, perform respiratory tasks and services expressly identified by the RCB pursuant to B&P section 3702.5(a). This regulatory proposal, if approved, would set forth those basic respiratory tasks and services LVNs can perform.

3) CAHSAH has been very active in several stakeholder meetings that were held by the BVNPT and the RCB on the practice of LVNs performing respiratory care. During those stakeholder meetings many families of ventilator-dependent patients spoke out in support of continuity of care by the LVNs who are currently caring for their family members and urged the RCB to consider the detrimental impact that could occur if LVNs were not permitted to continue their scope of practice.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. These regulations would not be the catalyst to disrupting the continuity of care. These regulations actually provide a legal pathway for LVNs to provide basic respiratory care tasks and services.

As noted in the Response to Comment D-2, it is the RCB's position that LVNs have never been legally authorized to practice respiratory care, which is what prompted the RCB to seek a legal remedy through the California Legislature to amend the VN Act to codify existing law. SB 1436 *(statutes of 2022)* amended the VN Act at B&P 2860(a) to state that LVNs have "no authority" to "provide respiratory care services and treatment." This same bill, effective January 1, 2023, also gave home health agencies even greater leeway to allow LVNs employed by them to perform respiratory care beyond basic tasks provided patient-specific training is provided by the employer as described in the Response to Comment D-1.

4) As your Board prepares to address the tasks that fall within basic respiratory care performed by an LVN, we ask that you consider all the facts presented by the during the [sic] BVNPT during the state's legislative committee hearing that were conducted when SB 1436 was enacted.

Response: The RCB acknowledges this comment but declines to make any amendments to the proposed regulatory text because these regulations were drafted after careful consideration of all the comments and facts that were presented at numerous meetings and hearings, as well as those that resulted in the Joint Resolution (item 3 of underlying data in ISOR) established in 2019 (discussed in greater detail in the Response to Comment D-5).

5) First and foremost, the BVNPT issued guidance to licensees permitting LVNs to adjust ventilator settings. BVNPT cited CCR 2518.5 for the basis of allowing LVNs to manage ventilator patients. CCR 2518.5 specifies LVNs can use and practice basic assessment, participate in planning, execute interventions in accordance with the care plan or treatment plan, and contribute to evaluation of individualized interventions related to the care plan or treatment plan. An LVN may also administer medications.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. As detailed in the *RCB 2022 Sunset Oversight Review* report, at page 87, in 1996, the BVNPT drafted and disseminated to multiple healthcare agencies and education programs a "policy" that provided LVNs are permitted to adjust ventilator settings.

However, it is the position of the RCB that the guidance issued by the BVNPT allowing LVNs to adjust ventilator settings is an underground regulation carrying no legal authority because such a reading of CCR Section 2518.5 exceeds the scope of that regulation. Adjusting ventilator settings is a complex respiratory task. It includes setting the mode of ventilation, tidal volume, respiratory rate, oxygen concentration and positive end-expiratory pressure. Adjustment of one setting can throw off other settings. It requires regular assessment including the synthesis of data, of the patient's lung function, blood gases and overall response to ensure optimal oxygenation and ventilation while minimizing risks such as lung injury or infection. Results of changing a ventilator can be instant and dire if not performed correctly. The language of CCR Section 2518.5 provides in part, "The licensed vocational nurse performs services requiring *technical and manual skills*" (emphasis added). As noted in the ISOR at page 3, in the RCB's experience, ventilator manipulation requires a respiratory assessment that is informed by formal respiratory care education and training to ensure patient health care is not compromised. Such a task exceeds the technical and manual skills limited to LVNs.

Further, the BVNPT's guidance that LVN's are permitted to adjust ventilator settings does not align with current statutory law. Subdivision (a) of section 2860 of the VN Act states that LVNs have no authority to "provide respiratory care services and treatment." Further, section 3702.5 of the Act provides that no other state agency except the RCB may define or interpret the practice of respiratory care. Adjustment of ventilator settings falls within what constitutes the practice of respiratory care as set forth in B&P section 3702 because it is a direct pulmonary care service that

requires assessment, including the synthesis of data and evaluation, and as such within the RCB's express authority to define and interpret.

6) The following are specific text edits for the Board's current proposed regulations [Comments D-6 to D-9]:

1399.365 Basic Respiratory Tasks and Services Pursuant to subdivision (a) of section 3702.5 of the Business and Professions code, basic respiratory tasks and services ~~("tasks"), described more specifically below, do not require a respiratory assessment, and only require manual, technical skills, or data collection. Basic respiratory tasks do not include manipulation of an invasive or non-invasive ventilator and do not include assessment or evaluation of chest auscultation. Basic respiratory tasks~~ include:
(a) Data collection.
(b) Application and monitoring of the pulse oximeter.

Response: The RCB accepts in part and rejects in part this comment.

In light of this comment, generally, and upon further RCB staff review, the RCB proposes amending the text of CCR section 1399.365 to delete the term "task" as a shorthand for "basic respiratory tasks and services," and deleting the statutory language found in B&P section 3702.5(a), stating that basic respiratory tasks and services "only require manual, technical skills, or data collection." By removing this language, the RCB aims to increase readability and be more succinct.

The RCB rejects the comment regarding other text deletion to the preamble, although for the reasons discussed in the Response to Comment D-10, the RCB proposes rearranging the content found in the preamble to increase clarity and readability. As stated in the ISOR at pages 3-4, the preamble makes it easier for a reader to understand the context of the following subdivisions. B&P section 3702.5 expressly authorizes the RCB to adopt regulations further defining, interpreting, and identifying basic respiratory tasks. By including a reference to B&P section 3702.5(a), the proposed preamble directs readers to the statutory basis for clarifying what constitutes basic respiratory tasks. By including from the definition of basic respiratory tasks taken from B&P section 3702.5(a) that basic respiratory tasks "do not require a respiratory assessment" helps a reader understand not only what the definition is, but it shows the reader that the following subdivisions are examples of that definition.

The proposed regulatory text specifies that manipulation of an invasive or non-invasive ventilator is not a basic respiratory task. Basic respiratory tasks do not include manipulation of a ventilator in any form because, in the RCB's experience, ventilator manipulation requires a respiratory assessment that is informed by formal respiratory care education and training to ensure patient health care is not compromised, which is beyond the scope of basic respiratory tasks.

Further, assessment and evaluation of chest auscultation is not a basic respiratory task because, in the RCB's experience and in the common practice of the field, it requires pulmonary and cardiopulmonary education and training specific to numerous respiratory conditions and contraindications to which requires a comprehensive analysis to achieve the best intended patient outcomes. Pursuant to B&P section 3740, to become licensed as an RCP, an applicant must complete an education program that is accredited by the nationally recognized Commission on Accreditation for Respiratory Care (CoARC).

There are both associate degree and baccalaureate degree programs in California. However, even the RCP associate degree programs take a minimum of three years to complete with full-time attendance, and the programs are weighted heavily with courses specific to respiratory care. While other health care disciplines will include a high-level review of respiratory care in their education

programs, respiratory care students delve into the intricacies of the practice that also requires advanced math and science.

Respiratory care is considered a health care specialty that takes thousands of hours of education to be prepared to pass the national competency exam and begin practicing at the minimum competency level.

7) (c) Medication administration by aerosol, ~~that does not require manipulation of an invasive or non-invasive mechanical ventilator. Basic respiratory tasks do not include~~ pre-treatment assessment, use of medical gas mixtures ~~other than oxygen~~, preoxygenation, *oral suctioning*, endotracheal or nasal suctioning, or post-treatment assessment *when there is a specific written medical order by an authorized practitioner.*

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. As stated in the ISOR at page 5, adoption of this regulatory language maximizes resources of the health care teams to perform duties at their skill levels without interruption to health care delivery or reducing the quality of care delivered. It is necessary to enumerate regulatory standards about the administration of medication via aerosol because, in the RCB's experience and in the common practice of the field, the actual task of delivering aerosol medication to a patient that does not require ventilator manipulation consists of waving aerosol medication around the patient's mouth and nose area and takes an average of 20 minutes to give. As such, this task is one that, in the language of B&P section 3702.5(a), only requires manual skills to accomplish and does not require formal education. This frees physicians, RNs, and RCPs to perform intermediate and advance level of respiratory care for all patients, maximizing resources.

Following from this, it is appropriate to exclude administration requiring the manipulation of an invasive or non-invasive mechanical ventilator because there are many more possible adverse outcomes that require advanced skills to mediate problems; thus, ensuring patients are receiving expected quality of care. There are a host of considerations when delivering medication via aerosol to a ventilator patient such as blockages in the ventilator circuit, ventilator settings, endotracheal tube size, heat and moisture exchange, gas density, obstruction in major airways, aerosol particle size, and delivery methods, to name just a few. With each delivery of an aerosol medication, the ventilator patient is at greater risk for possible adverse outcomes, thereby making it necessary to have the most qualified health care provider delivering the medication.

Further, excluded from this category of basic respiratory tasks are pre-treatment assessments, the use of medical gas mixtures other than oxygen, preoxygenation, endotracheal or nasal suctioning, and post-treatment assessment. These tasks have been excluded because they are often performed when providing medication by aerosol, especially for patients on ventilators. These tasks require assessment, evaluation, or both based on complete respiratory education and training and the Board believes it is important to make the distinction to ensure patient health care is not compromised.

8) (d) Heat moisture exchanger (HME) and oxygen tank replacement, ~~for patients who are using non-invasive mechanical ventilation. Basic respiratory tasks do not include the initial setup,~~ change out, or replacement of the breathing circuit or adjustment of oxygen liter flow or oxygen concentration *when there is a specific written medical order by an authorized practitioner*.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. As stated in the ISOR at page 6, it is necessary to specify that HME and oxygen tank replacement are basic respiratory tasks because, in the RCB's experience and in the common practice of the field, these tasks are not invasive–that is they do not involve a puncture or incision of the skin, insertion of an instrument or foreign material into the

body, and do not require extensive education and training. However, it is necessary to specify that these tasks are only basic respiratory tasks if they relate to patients who are using non-invasive mechanical ventilation because there are many more common contraindications with patients using invasive mechanical ventilation that requires advanced skills to mediate adverse reactions, thereby ensuring patients are receiving expected quality of care.

Further, it is necessary to specify that related tasks that are not basic respiratory tasks include "the initial setup, change out, or replacement of the breathing circuit or adjustment of oxygen liter flow or oxygen concentration" because these tasks require assessment, evaluation, or both based on complete respiratory education and training, and making the distinction helps ensure patient health care is not compromised.

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

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

   (g) Documentation of care provided, which includes data retrieved from performing a breath count or transcribing data from an invasive or non-invasive ventilator interface.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. As stated in the ISOR at page 6, the rationale for specifying hygiene care that includes replacement of tracheostomy tie and gauze, and the cleaning of stoma sites are basic respiratory tasks because, in the RCB's experience and in the common practice of the field, these tasks are not invasive and do not require in-depth respiratory education or training. On the other hand, tracheal suctioning, cuff inflation/deflation, the use or removal of an external speaking valve or removal and replacement of the tracheostomy tube or inner cannula are not basic respiratory tasks because these tasks may require assessment, evaluation, or both based on complete respiratory education and training. Further, there are numerous contraindications that can occur requiring extensive respiratory care education and training to properly mediate adverse reactions. Each licensed RCP must pass both written and clinical simulation exams that both test the competency in all these tasks. Making the distinction helps ensure patient health care is not compromised.

10) All the above recommended text edits made to the proposed regulations remove wording that states "does not include." The regulations should focus on outlining what is allowed not what is not allowable. This will ensure the reader is not confused because they missed reading the word "not."

Response: The RCB rejects in part and accepts in part this comment.

The RCB rejects this comment with respect to removing from the proposed regulatory text the words "does not include" or what is not allowed as a basic respiratory care task or service. The RCB finds it imperative to identify the tasks associated with respiratory services that are not considered manual and technical tasks so that there is no confusion. As stated in the ISOR at page 2 to 3, the RCB's highest priority is protection of the public in exercising its licensing, regulatory, and disciplinary functions. The RCB is mandated to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care. To continue performing these functions in support of its mandate, the RCB must ensure only qualified personnel are providing respiratory care beyond tasks and services that only require manual, technical skills, or data collection. In addition, all

stakeholders (i.e., health care practitioners, facilities, employers, and patients) benefit by having a clear and precise understanding of which respiratory tasks and services may be performed by LVNs. Clarity will overall enhance the timely delivery of health care monitoring and attention by maximizing resources of the health care teams to perform duties and functions at their skill levels without interruption to health care delivery or planning or reducing the quality of care delivered.

In light of this comment, generally, and upon further RCB staff review, the RCB proposes amending the text of CCR section 1399.365 by reorganizing the content of the preamble into two separate subdivisions. One subdivision sets forth what is included as basic respiratory tasks and services followed by a list of such tasks, and one subdivision sets forth what is not included as basic respiratory tasks and services followed by a list of such tasks. By reframing the subdivisions, the RCB aims to promote further clarity and readability.

11) We are recommending the inclusion of several tasks that were not presented as allowable basic respiratory tasks; hence, you will see the removal of the word "not allowed." These changes were made to align with the current scope of practice that the BVNPT issued guidance upon to its licensees. The Respiratory Care Board must ensure that it does not alter the continued scope of practice which an LVN learns to perform during their basic pre-licensure training, both in the classroom setting and in clinical rotations.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. These regulations were drafted after careful consideration of public input and after several meetings between the BVNPT and the RCB. It is the position of the RCB that the guidance issued by the BVNPT does not align with current law, including subdivision (a) of section 2860 of the VN Act, which states that LVNs have no authority to "provide respiratory care services and treatment." Further, section 3702.5 of the Act provides that no other state agency except the RCB may define or interpret the practice of respiratory care.

These regulations do not alter the education or classroom training of LVNs. Rather, these regulations interpret and clarify subdivision (a) of Section 3702.5 of the Act as referenced in subdivision (b) of Section 2860 of the VN Act by identifying the basic respiratory care tasks and services that LVNs are legally authorized to perform.

12) Respiratory assessment is a technical skill to assist with data collection. Specifically, chest auscultation, endotracheal or nasal suctioning, removal and replacement of inner cannula, and removal of external speaking valves are all within the LVN scope of practice and part of the basic respiratory assessment performed by LVNs. Patient assessment is essential to ensuring that the patient's conditions are not changing or worsening. Assessment does not entail an LVN changing the directed treatment without consultation and direction from the physician or RN supervising the LVN. It does entail basic tasks like suctioning to keep a patient safe and comfortable.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. According to subdivision (a) of B&P section 2860, the VN Act provides "no authority" for LVNs to "provide respiratory care services and treatment…" Evaluation or assessment of chest auscultation, endotracheal or nasal suctioning, removal and replacement of inner cannula and removal of external speaking valves are all the practice of respiratory care. Section 3702.5 of the Act provides that no other state agency except the RCB may define or interpret the practice of respiratory care.

However, to increase clarity, the RCB proposes to amend the text of CCR section 1399.365 to include a definition of "assessment," as detailed in the Response to Comment F-1.

13) California B&P section 2859 specifies “The practice of vocational nursing within the meaning of this chapter is the performance of services requiring those technical, manual skills acquired by means of a course in an approved school of vocational nursing, or its equivalent, practiced under the direction of a licensed physician and surgeon, or registered nurse, as defined in Section 2725.”

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. It appears the commenter is inferring that if an LVN school teaches a skill, that skill is within the LVN scope of practice. On the contrary, the RCB contends the LVN scope of practice is not solely set by B&P section 2859, and when LVN education programs teach skills that are inconsistent with the law, the law prevails, and the curriculum of the school should be reconsidered.

As noted previously, subdivision (a) of section 2860 of the VN Act provides that LVNs have no authority to “provide respiratory care services and treatment.” B&P section 2860(a) also provides that LVNs have no authority to practice medicine or surgery. Within a physician’s and surgeon’s practice there are many tasks that may appear as “manual, technical tasks” without the proper education and training of a physician or surgeon. For example, if an LVN school taught students how to perform a minor surgery, perhaps the removal of a small lipoma, doing so would not make minor surgeries part of the LVN scope of practice. Removal of a lipoma is done by 1) washing the area, 2) injecting a local anesthetic, 3) making a small cut in the skin, 4) removing the lipoma, and 5) placing one or two stitches. Those without a medical background could learn how to do this and some may categorize this as manual, technical tasks. However, a lay person risks an improper diagnosis as well as damage to surrounding structures (e.g. nerves, muscles, blood vessels). The same is true for the practice of respiratory care. This is what prompted the California Legislature to establish in law section 3702.5 of the Act, which expressly authorizes the RCB, and no other state agency, to define or interpret the practice of respiratory care. Because the RCB currently has no existing regulations further defining, interpreting, or identifying “basic respiratory tasks and services,” the RCB proposes this rulemaking to implement SB 1436 in part by identifying, through enumerating tasks, what is and is not meant by “basic respiratory tasks and services.”

14) Furthermore, as indicated by the BVNPT “The licensed vocational nurse performs services requiring technical and manual skills which include the following: (a) Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan. (b) Provides direct patient/client care by which the licensee: (1) Performs basic nursing services as defined in subdivision (a); (2) Administers medications; (3) Applies communication skills for the purpose of patient/client care and education; and (4) Contributes to the development and implementation of a teaching plan related to self-care for the patient/client.”

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. The commenter appears to be citing to CCR section 2518.5: Scope of Vocational Nursing Practice.

CCR section 2518.5 defining the scope of the vocational nursing practice is not the subject of these regulations. This regulatory action proposes to interpret and make specific subdivision (a) of section 3702.5 of the Act. As stated in the ISOR on page 2, this regulatory proposal benefits the health and welfare of California residents by further defining, interpreting, and identifying basic respiratory tasks and services that may be safely performed by LVNs or other properly trained health care personnel consistent with the underlying statutory requirements. This will help ensure the most up-to-date standards and practices are met and will help protect patients in need of respiratory care.

15) The BVNPT has indicated that “endotracheal or nasal suctioning is a manual, technical skill, and part of the LVN prelicensure training, and practiced in the LVN clinical rotation. The proposed text lists pre-treatment assessment and post treatment assessment but does not clarify the specific treatment this is in reference to. Basic respiratory assessment is a manual, technical skill and part of the LVN prelicensure training, and practiced in the LVN clinical rotation."

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. The guidance issued by the BVNPT does not align with existing law. Subdivision (a) of section 2860 of the VN Act states that LVNs have no authority to “provide respiratory care services and treatment.” Further, section 3702.5 of the Act provides that no other state agency except for the RCB may define or interpret the practice of respiratory care. Pre- and post-treatments assessments require synthesis of data or evaluation, far beyond data collection, and are therefore not considered a basic respiratory care task or service. Endotracheal and nasal suctioning when improperly done can lead to bleeding disorders, severe bronchospasm, laryngeal stridor, severe hemodynamic instability, hemoptysis, severe coagulopathies. Even when properly performed complications may arise including blood pressure instability, mucosal trauma, or hypoxemia. It is imperative that the care provider have a wholly rounded education to provide a real-time assessment and synthesis of data while performing the task as well as have the education and training to immediately respond to complications that may arise. Each licensed RCP must pass both written and clinical simulation exams that test the competency in all these tasks. Making the distinction helps ensure patient health care is not compromised.

16) Because the BVNPT has indicated that it is within an LVN’s scope to perform respiratory assessment, we believe an LVN with the appropriate training and education can perform the following interventions: replacement of HME and oxygen tank as well as setup, change out and replace breathing circuits. These tasks fall within manual/technical skills.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. Subdivision (a) of section 2860 of the VN Act provides that LVNs have no authority to “provide respiratory care services and treatment.” Section 3702.5 of the Act provides that no other state agency except for the RCB may define or interpret the practice of respiratory care. Heat moisture exchanger (HME) and oxygen tank replacement for patients who are using non-invasive mechanical ventilation are considered basic respiratory tasks. As noted in the ISOR at page 6, the initial setup, change out, or replacement of the breathing circuit or adjustment of oxygen liter flow or oxygen concentration are respiratory tasks and services that require assessment, evaluation, or both based on complete respiratory education and training, and, thus, are not considered basic respiratory tasks or services.

17) Additionally, an LVN should be able to adjust oxygen liter flow, or oxygen concentration on ventilated and non-ventilated patient when there is a specific MD order. These tasks are essential interventions that have been provided by LVNs for many years to thousands of ventilator-dependent patients under the Medi-Cal program.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. Subdivision (a) of section 2860 of the VN Act provides that LVNs have no authority to “provide respiratory care services and treatment.” Section 3702.5 of the Act provides that no other state agency except for the RCB may define or interpret the practice of respiratory care. Adjusting ventilator settings is a respiratory task that requires assessment, including the synthesis of data and evaluation. The RCB thanks the commenter for bringing to the RCB’s attention that Medi-Cal may be reimbursing LVNs improperly. Upon implementation, the RCB will reach out to the Department of Health Care Services to ensure reimbursement is being made in accordance with established laws and regulations.

18) The BVNPT has indicated that removal, cleaning, and replacement of an inner cannula, tracheal suctioning and removal of an external speaking valve is within an LVNs scope of practice. Considering that determination by the BVNPT, we also believe that cuff/inflation and deflation should be included as well.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. The guidance issued by the BVNPT does not align with existing law. Subdivision (a) of section 2860 of the VN Act provides that LVNs have no authority to "provide respiratory care services and treatment." Section 3702.5 of the Act provides that no other state agency except for the RCB may define or interpret the practice of respiratory care. Removal and replacement of an inner cannula, tracheal suctioning, removal of an external speaking valve and cuff inflation/deflation are respiratory tasks and services that require assessment, including the synthesis of data and evaluation, and, thus, are not considered basic respiratory tasks or services. Further, there are numerous contraindications that can occur requiring extensive respiratory care education and training to properly mediate adverse reactions. Each licensed RCP must pass both written and clinical simulation exams that both test the competency in all these tasks. Making the distinction helps ensure patient health care is not compromised.

19) Lastly, we would like to ensure the board understands and considers the fiscal impact of these proposed regulations. Costs will be incurred to recruit staff, change policies and procedures, and orient staff on any new necessary protocols to ensure compliance. Those costs can vary for the small employer to the large employer. If LVNs are displaced from their current roles, the resulting impact will be catastrophic costs to the State and to families as many of these individuals will be forced into institutional care because there are not enough LVNs or Respiratory Care Therapists.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. Subdivision (a) of section 2860 of the VN Act provides that LVNs have no authority to "provide respiratory care services and treatment." Section 3702.5 of the Act provides that no other state agency except for the RCB may define or interpret the practice of respiratory care.

These regulations do not remove authority for LVNs to practice respiratory care. These regulations clarify those basic respiratory care tasks and services LVNs can legally perform.

Moreover, effective January 1, 2023, SB 1436 *(statutes of 2022)* made it legal for patients in home care settings to receive respiratory care from LVNs employed by a home health agency licensed by the State Department of Public Health (B&P section 3765).

It is the RCB's position that the RCB must specify those "respiratory tasks and services" referred to in B&P section 3765(i) before it can pursue any form of disciplinary or administrative action against an LVN employed by a home health agency or an LVN employed by a home health agency, with the exception of cases where gross negligence, gross incompetence, or inadequate training, as determined by a reasonable person causes patient harm or death. While it is incumbent upon each home health agency to discuss liability issues with their legal counsel, legislative authority exists for LVNs employed by a home health agency to continue to practice respiratory care with appropriate patient-specific training.

COMMENTER E: **ELAINE YAMAGUCHI**
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
via: E-Mail Dated August 5, 2024, with Two Letters Attached Dated August 2, 2024, and December 13, 2022

Letter Dated August 2, 2024

1) The BVNPT submits the attached comment that incorporates a letter including attachments. Since the text that has been noticed is the same as previously noticed in 2022, the BVNPT hereby resubmits the same document filed in December 2022 and raises the same points of concern.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. The text of this proposed regulation is not identical to text that was publicly noticed in 2022.

2) BVNPT wants to express our appreciation for the opportunity to address concerns raised in establishing standards regarding these important services and hope that this Board appreciates the BVNPT's commitment to achieving an outcome which best serves the public. Consistent with the Board's previous position on this issue, I wanted to reiterate an important concern. The LVN scope of practice has always been the same in any setting and consistent with the pre-licensure training and scope of practice recognized by this Board pursuant to B&P section 2859. All licensees currently have the same opportunity for training and Continuing Education courses acknowledged by the BVNPT. We absolutely support the need for consistent, expert training in this vital patient care area, but we are against specifying standards that are inconsistent with the training received at BVNPT approved schools.

Response: The RCB acknowledges the supporting comments and appreciates the support in achieving an outcome that best serves the public. The RCB reviewed and rejects the opposing comments and declines to make any amendments to the proposed regulatory text based thereon. These regulations enumerate specific basic respiratory tasks and services LVNs are permitted to practice in any location. Moreover, any legislation such as SB 1451 (*statutes of 2024*) that specifies a specific type of facility where LVNs may practice respiratory care beyond basic respiratory tasks and services, overrides the BVNPT's position or policy as a legal matter.

COMMENTER F: ELAINE YAMAGUCHI
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians

Letter Dated December 13, 2022

The BVNPT met on Friday,
December 9, 2022, to discuss the RCB's proposed regulatory action concerning Basic Respiratory Tasks and Services. The BVNPT voted unanimously to file an official comment recommending amendments to the RCB's proposed Title 16 Division 13.6, Article 6, section 1399.365 that reflect the current LVN's prelicensure training and scope of practice. Specifically, the BVNPT respectfully requests the following amendments, which are highlighted in yellow. Suggested added text is indicated by double underline. Deleted text by ~~double strikethrough~~.

1) Amendment 1

1399.365 Basic Respiratory Tasks and Services

Pursuant to subdivision (a) of section 3702.5 of the B&P, basic respiratory tasks and services ("basic respiratory tasks") ~~do not require a respiratory assessment, and only~~ require manual, technical skills, or data collection. Basic respiratory tasks do not include manipulation of an invasive or non-invasive ventilator. Basic respiratory tasks include:

Rationale for suggested change: Basic respiratory assessment is within the scope of the licensed vocational nurse (LVN). The LVN learns how to perform this task during the fundamentals section of their LVN prelicensure program and it is performed throughout the remainder of the program when assessing assigned patients. Basic respiratory assessment is a technical skill to assist with data collection. The term "data collection" is commonly used when assessing a patient, collecting data from any type of assessment or from patient verbally. The term is also within BVNPT's existing regulations:

2518.5. Scope of Vocational Nursing Practice.
The licensed vocational nurse performs services requiring technical and manual skills which include the following:
(a) Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan.
(b) Provides direct patient/client care by which the licensee:
(1) Performs basic nursing services as defined in subdivision (a);
(2) Administers medications;
(3) Applies communication skills for the purpose of patient/client care and education; and
(4) Contributes to the development and implementation of a teaching plan related to self-care for the patient/client.

Response: The RCB accepts this comment. The RCB modified the proposed regulatory text to define assessment as used in this proposed regulatory action to clearly delineate that assessment goes beyond gathering data, specifically as follows:

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

2) Amendment 2

(a) Basic respiratory assessment and data collection ~~Basic respiratory tasks do not include assessment and/or evaluation of chest auscultation~~.

Rationale for suggested change: Chest auscultation is within the LVN scope of practice and is part of the basic respiratory assessment. This is a part of their LVN prelicensure training and practiced in the LVN clinical rotations.

Frequency. Is the sound high or low pitched?
Intensity. How loud is the sound?
Duration. How long does the sound last?
Number. Is the sound repeated?
Quality. How would you describe the sound?
Auscultation is a valuable diagnostic tool because it is safe and noninvasive. It can also be done at a moment's notice, since most healthcare providers have their stethoscopes close at hand.

Response: The RCB accepts in part and rejects in part this comment.

The RCB accepts this comment with respect to acknowledging that some tasks involving chest auscultation are basic respiratory tasks and services, including reporting on or gathering data from chest auscultation. To increase clarity of which tasks related to chest auscultation are and are not basic respiratory tasks, the RCB proposes amending the regulatory text to include in the list of basic respiratory task and service, "Observe and gather data from chest auscultation, palpation and percussion." Further, the RCB proposes amending the regulatory text to include in the list of what is not basic respiratory task and service, "Assessment or evaluation of observation and gathered data from chest auscultation, palpation and percussion."

The RCB rejects this comment to the extent it suggests that tasks and services involving chest auscultation beyond observing, reporting on, or gathering data fall within basic respiratory tasks. In December 2006, the BVNPT president responded and provided that LVNs "should most certainly have the ability to decide, for example, whether or not to listen to breath sounds in a patient previously diagnosed with pneumonia and then report it to the R.N. or physician directing the LVN." As detailed in the *RCB 2022 Sunset Oversight Review* report, beginning at page 88, in response to this specific claim, the RCB sought a legal opinion from its liaison at the Office of the Attorney General. Mara Faust, DAG, who provided the following:

> "'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 care 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."

As stated in the ISOR at pages 3-4, and discussed in the Response to Comment D-6, assessment or evaluation of chest auscultation is not a basic respiratory task because, in the RCB's experience and in the common practice of the field, it requires pulmonary and cardiopulmonary education and training specific to numerous respiratory conditions and contraindications to which requires a comprehensive analysis to achieve the best intended patient outcomes. Pursuant to B&P section 3740 to become licensed as an RCP, an applicant must complete an education program that is accredited by the nationally recognized CoARC. There are both associate degree and baccalaureate degree programs in California. However, even the RCP associate degree programs take a minimum of three years to complete with full-time attendance and the programs are weighted heavily with courses specific to respiratory care. While other health care disciplines will include a high-level review of respiratory care in their education programs, respiratory care students delve into the intricacies of the practice that also requires advanced math and science. Respiratory care is considered a health care specialty that takes thousands of hours of education to be prepared to pass the national competency exam and begin practicing at the minimum competency level.

Subdivision (a) of section 2860 of the VN Act provides that LVNs have no authority to "provide respiratory care services and treatment." Section 3702.5 of the Act provides that no other state agency except for the RCB may define or interpret the practice of respiratory care.

3) Amendment 3

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

Rationale for suggested change: Endotracheal or nasal suctioning is a manual, technical skill and part of the LVN prelicensure training, and practiced in the LVN clinical rotation.

The proposed text lists pre-treatment assessment and post treatment assessment but does not clarify the specific treatment this is in reference to. Basic respiratory assessment is a manual, technical skill and part of the LVN prelicensure training, and practiced in the LVN clinical rotation. Staff should work with RCB to develop a mutually acceptable definition of pre and post treatment assessment. These definitions may need to list specific treatments

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. The guidance issued by the BVNPT does not align with existing law. Subdivision (a) of section 2860 of the VN Act states that LVNs have no authority to "provide respiratory care services and treatment." Further, section 3702.5 of the Act provides that no other state agency except for the RCB may define or interpret the practice of respiratory care. Pre- and post-treatments assessments require synthesis of data or evaluation, far beyond data collection, and are therefore not considered a basic respiratory care task or service. Endotracheal and nasal suctioning when improperly done can lead to bleeding disorders, severe bronchospasm, laryngeal stridor, severe hemodynamic instability, hemoptysis, severe coagulopathies. Even when properly performed, complications may arise including blood pressure instability, mucosal trauma or hypoxemia. It is imperative that the care provider have a wholly rounded education to provide a real-time assessment and synthesis of data while performing the task as well as have the education and training to immediately respond to complications that may arise. Each licensed RCP must pass both written and clinical simulation exams that test the competency in all these tasks. Making the distinction helps ensure patient health care is not compromised.

4) Amendment 4

(d) Heat moisture exchanger (HME) and oxygen tank replacement for patients who are using non-invasive mechanical ventilation. Basic respiratory tasks do not include the initial setup, change out, or replacement of the breathing circuit or adjustment of oxygen liter flow or oxygen concentration <u>on ventilated patients</u>.

Rationale for suggested change: "On ventilated patients" was added to clarify the task of oxygen therapy and to make it clear this statement is only referring to mechanical ventilation.

Response: The RCB rejects this comment. However, to increase clarity, the RCB proposes amending the regulatory text to state that initial setup, change out, or replacement of the breathing circuit or adjustment of oxygen liter flow or oxygen concentration are not basic respiratory tasks. These tasks require assessment, evaluation, or both based on complete respiratory education and training. Making the distinction helps ensure patient health care is not compromised.

5) Amendment 5

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

Rationale for suggested change: Removal and replacement of inner cannula is a manual, technical skill and part of the LVN prelicensure training, and practiced in the LVN clinical rotation.

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon. As noted in the ISOR at page 6, in the RCB's experience and in the common practice of the field, tracheal suctioning, cuff inflation/deflation, the use or

removal of an external, speaking valve or removal and replacement of the tracheostomy tube or inner cannula are not basic respiratory tasks because these tasks may require assessment, evaluation, or both based on complete respiratory education and training. Further, there are numerous contraindications that can occur requiring extensive respiratory care education and training to properly mediate adverse reactions. Each licensed RCP must pass both written and clinical simulation exams that both test the competency in all these tasks. Making the distinction helps ensure patient health care is not compromised.

Subdivision (a) of section 2860 of the VN Act provides that LVNs have no authority to "provide respiratory care services and treatment." Section 3702.5 of the Act provides that no other state agency except for the RCB may define or interpret the practice of respiratory care.

6) Amendment 6

g) Documentation of care provided, which includes documentation of data retrieved from performing a breath count~~.~~, chest auscultation, or transcribing data from an invasive or non-invasive ventilator interface.

Rationale for suggested change: Chest auscultation is a manual, technical skill and part of the LVN prelicensure training, and practiced in the LVN clinical rotation.

Response: The RCB accepts this comment. The RCB modified the proposed regulatory text to include "Observe and gather data from chest auscultation, palpation and percussion" as basic respiratory care tasks and services, which is also discussed in Response to Comment F-2.

7) These six amendments will bring the RCB's proposed regulations into conformity with the Vocational Nursing Practice Act and enable our licensees to continue providing essential patient care. Coupled with other provisions in SB 1436 *(Roth, Chapter 624 of the Statutes of 2022)*, these suggested amendments will allow both Boards to regulate and enforce safe and trained nursing care. [Attachments include: 1) *Memo from the Board of Vocational Nursing and Psychiatric Technicians (BVNPT) office to BVNPT members, December 9. 2022*; and 2) BVNPT Suggested Amendments to RCB Proposed Text.]

Response: The RCB rejects this comment and declines to make any amendments to the proposed regulatory text based thereon, except with respect to Comments F-1, F-2, F-4, and F-6. Since 1996, the RCB has contended that LVNs have never been legally authorized to practice respiratory care beyond manual, technical tasks. The misinterpretation and misinformation are what prompted the RCB to seek a legal remedy through the California Legislature to amend the VN Act to codify existing law. SB 1436 *(statutes of 2022)* amended the VN Act to state that LVNs have "no authority" to "provide respiratory care services and treatment:"

These regulations were drafted after careful consideration of public input and after several meetings between the BVNPT and the RCB. The guidance issued by the BVNPT permitting LVNs to adjust ventilator settings does not align with existing law. Subdivision (a) of section 2860 of the VN Act provides that LVNs have no authority to "provide respiratory care services and treatment." Section 3702.5 of the Act provides that no other state agency except for the RCB may define or interpret the practice of respiratory care.

These regulations do not prohibit LVNs from practicing respiratory care. These regulations clarify those basic respiratory care tasks and services LVNs can legally perform. These regulations interpret and make specific subdivision (a) of section 3702.5 of the Act as referenced in subdivision (b) of section 2860 of the VN Act.

Untimely Letters and Emails Received Outside the Official Comment Period Regarding the

Originally Published Text (45-Day)

The RCB received two (2) additional untimely letters/emails that were received outside the official comment period, and those letters/emails were included in the agenda materials for the RCB's October 14, 2024, meeting as follows:

- Letter from Elaine Yamaguchi, BVNPT dated September 17, 2024 [Received September 20, 2024] with attachments:
  - Attachment 1: The National Council of State Boards of Nursing 2023 Test Plan for the National Council Licensing Examination for Practical Nursing (NCLEX-PN)
  - Attachment 2: An excerpt from the 2023 Community Colleges' Model Curriculum. Development of this project was supported by Strong Workforce Funds through the Inland Empire/Desert Regional Consortium.
  - Attachment 3: Unitek Curriculum
- Letter from the California School Nurses Organization dated September 17, 2024 [Received September 18, 2024]

The RCB received 13 additional untimely letters/emails outside the official comment period and after agenda materials were prepared, so those items were provided to RCB members at its October 14, 2024, meeting as follows:

1: Letter from Aleta Carpenter, BVNPT, dated October 11, 2024
2: Letter from Amanda Wright, Aveanna healthcare, dated October 11, 2024
3: Letter from Melissa Malone Team Select Home Care, dated October 7 2024
4: Email from Brina Slater dated October 2, 2024
5: Email from Dorothy Daniels dated October /2, 2024
6: Email from Clare Bello, dated October 4, 2024
7: Email from Yvette Mount, dated October 3, 2024
8: Email from Ryan Freeman, dated October 8, 2024
9: Email from Shamara Terlaje, dated October 8, 2024
10: Email from Rosario Barreto, dated October 8, 2024
11: Email from "MS. P87," dated October 8, 2024
12: Email from Jay Joo, dated October 8, 2024
13: Email from Lawren Moss, dated October 10, 2024

The RCB received one (1) additional untimely letter directed at the originally proposed text after the RCB's October 14, 2024, meeting, which was provided to RCB members at its March 13, 2025, meeting:

- Letter from Barbara Hanna, Home & Health Care Management, dated October 7, 2024 [received by the RCB October 15, 2024]

The Administrative Procedure Act (APA) does not require the Board to review or respond to written comments in support of this regulatory action during the final rulemaking process. Further, the Board is not required to review or respond to comments that are untimely.

Modified Text 15-Day Comment Period: Summary of Comments and Board Responses

The Board received 44 timely letters, emails, or facsimiles during the 15-day comment period from October 15, 2024 through October 31, 2024. Comments received were from those representing three broad areas of interest that were grouped into a total of 20 issues regarding the modified proposal of section 1399.365 of Division 13.6 of the CCR as follows:

1) K-12 Schools:
Issues numbered 1- 5 are from those representing the interest of Licensed Vocational

Nurses (LVNs) working in or affiliated with K-12 schools.

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

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

The Board considered these comments at its March 13, 2025, meeting and did not recommend making any additional changes to the text. Below are summaries of the comments received, followed by the Board's response to comments.

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

ISSUE NO. 1 – Need for LVNs in K-12 Schools (Submitted by commenters: S1, S3, S4, S5, S6, S7, S8, S9, S10, S11, S12, S13, S14, S15, S16, S17, S18, S22, S23, S25, S26, S31, S32)

Comments received were in opposition from employees of K-12 schools or school districts, throughout California, some in rural areas, describing the need for unlicensed and licensed personnel, such as LVNs, to provide health services to students attending K-12 schools in California. Commenters suggested that there are 17,400-20,880 students who rely on respiratory care throughout the school day throughout 1,000+ California school districts.

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

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

- Though not often in commenter's rural school district of Pollock Pines Elementary School District, they do sometimes encounter students on ventilators, with tracheostomies, or with oxygen needs.
- The Anaheim Elementary School District school nurses, as supervisors of health, provide health services to district's 15,000 students daily. The district currently has 7 students at various school sites that require suctioning support to ensure the maintenance of their airway and allow them to receive their education alongside peers.
- School nurse and nursing coordinator for El Dorado County Office of Education supports six school districts with multiple LVNs and medical assistants (MAs) that keep the county's health offices running in these rural districts. These districts have only a handful of students who have respiratory needs including oxygen and tracheal care (including suctioning), but these are within some of their most remote districts.
- Santa Clara County Office of Education (SCCOE) school nurse's cohort serves the county's most critical students including those who require respiratory care along with 1:1 attention and in-class/on bus care. SCCOE students are located in classrooms in separate schools as well as integrated sites throughout Santa Clara County. SCCOE has 13 school nurses who serve a number of students at 55+ sites. Following are the current

numbers of students receiving suctioning, tracheostomy and ventilator care and includes designated staff providing Specialized Physical Healthcare Services:

Suctioning: 33	Tracheostomies: 14	UAPs providing care: 32
Ventilators: 3	Cough assist/ other: 6	Licensed Nurses providing care: 31

- Currently in Special Education Programs operated by the San Joaquin County Office of Education (SJCOE), there are 15 LVNs either hired or contracted for student care including suctioning under the supervision of the credentialed school nurses.

RESPONSE TO ISSUE NO. 1[2]

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

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

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

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

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

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

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

basic respiratory task because such task may require assessment, evaluation, or both based on complete respiratory education and training.

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

While the RCB acknowledges concerns about efficiency, it also recognizes the risks associated with unlicensed personnel, which may include LVNs, performing respiratory care. Despite this, the RCB believes that families and individuals should retain the right to choose the care that best aligns with their needs and priorities. At present, it is not feasible to place an RCP in every home or community-based setting, even if this would provide the highest quality care.

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

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

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

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

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

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

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

However, at this point, the RCB believes that it is the responsibility of K-12 school advocates to

pursue a legislative remedy.[3] Further amendments to the proposed regulations to accommodate K-12 schools would be unfeasible, would delay compliance with legislative and regulatory timelines, and is not the appropriate avenue to remedy their concerns.

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

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

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

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

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

Commenters urge the RCB to modify CCR §1399.365 related to basic respiratory tasks and services. Commenters indicate that unlike in years past, students with special educational needs are mainstreamed with general education students and are not necessarily segregated to special education sites. Further, schools are required to provide healthcare services so students can attend and remain in school. Commenters cite to the requirement under section 504 of the Federal Rehabilitation Act for schools to provide a Free Appropriate Public Education (FAPE), arguing that LVNs are essential to delivering respiratory services to students with special needs. Commenters

[3] After submitting comments, the Board was advised that K-12 advocates are pursuing a legislative remedy, and on February 14, 2025, SB 389 was introduced to add "notwithstanding" language to EDC section 49423.5.

wrote many outside the school setting fail to understand that FAPE requires even those students with ventilators, tracheostomies and/or oxygen needs to be provided FAPE. Thus, for these students to attend school in a safe environment LVNs play a key role in commenter's school setting to care for the needs of these students. Commenters state schools have developed appropriate staffing structures using registered credentialed school nurses, RNs, LVNs, and unlicensed staff to meet the healthcare needs of students during the school day. Commenters state most school districts staff LVNs to care for their students with trachs and suctioning needs, as this level of care is safest for students. Per commenters, there are a very limited number of students with trachs who can be appropriately cared for by qualified designated school personnel. Commenters assert the proposed modifications will mean students are not able to get the care needed to attend school.

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

RESPONSE TO ISSUE NO. 2

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

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

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

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

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

create unnecessary barriers to providing care.

Commenters indicate unlike other specialized healthcare that is performed on a schedule, the procedure of suctioning is typically done on an "as needed" basis, which would require the RCP to remain with a student all day, just in case they required suctioning. Commenters state expecting nearly 1,000 school districts to hire multiple RCPs to provide exclusive suctioning services on a standby basis when an LVN or trained unlicensed assistive personnel can provide these and other services would be unrealistic, cost-prohibitive, and unnecessary. Commenters note that unlicensed personnel and LVNs in school districts can typically support and provide specialized physical health care services to support the whole student's medical needs for multiple students within their day, whereas an RCP would only be able to provide respiratory support, which may not be required daily. Commenters noted it is unclear whether RCPs would be willing to be 'trained' to provide other specialized health care services.

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

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

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

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

Commenters claim that the demand for healthcare services continues to rise, and the availability of qualified nursing personnel is a pressing issue. By enabling LVNs to carry out tracheostomy care, healthcare facilities and school districts can maximize their workforce efficiency. LVNs are already trained in essential nursing skills and can be quickly oriented to tracheostomy care protocols, allowing for a more responsive healthcare environment.

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

RESPONSE TO ISSUE NO. 3

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

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

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

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

Commenters claim that LVNs receive comprehensive education regarding suctioning and tracheostomy care, which are an integral part of their educational programs. Comments suggest that the proposed regulation prevents the LVN from having the opportunity to work in their full capacity in which they were trained. Comments state the B&P empowers trained LVNs to provide airway support, encompassing suctioning procedures. Commenter finds LVNs to consistently demonstrate excellence in licensed care nursing procedures, such as tracheal suctioning.

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

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

RESPONSE TO ISSUE NO. 4

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

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

Further, the RCB disagrees with the premise that the B&P authorizes LVNs to practice respiratory care. The RCB maintains that LVNs have never been authorized to practice respiratory care, which led to the RCB seeking legislative clarification. As detailed on pages 1 and 2 of the ISOR and as noted in Response to Issue No. 1, SB 1436 amended the VN Act, explicitly stating that the VN Act confers "no authority" to provide respiratory care services and treatment (B&P §2860(a)). However, LVNs who have received training and demonstrate competency satisfactory to their employer, when directed by a physician and surgeon, may perform certain basic respiratory tasks expressly identified by the RCB pursuant to B&P §3702.5(a) (B&P §2860(b)).The RCB is the only state agency statutorily authorized to define or interpret the practice of respiratory care in California, as outlined in B&P §3702.5 of the Act. The tasks identified in this regulatory proposal are those deemed by the RCB to be basic respiratory tasks that do not require a respiratory assessment and only require manual, technical skills, or data collection, consistent with the RCB's experience and understanding of the practice of respiratory care in California.

Claims that LVNs' ability to provide respiratory care is rooted in LVN training standards or evidence-based nursing care are unsupported. No commenter has provided substantive evidence, and the RCB has not found evidence to substantiate the claim that respiratory care is part of every

LVN training program. Additionally, the required curriculum content under CCR §§ 2533 and 2534 do not include respiratory care or related tasks.

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

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

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

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

The RCB received comments in opposition, many of which expressed concerns that requiring K-12 schools or school districts – particularly those in rural areas – to hire RCPs or RNs would strain or even cripple school budgets. Commenters noted that these positions would be difficult to fill, inefficient for the as-needed nature of the tasks, and divert resources from other critical educational and health services. Several commenters argued that the regulations would impose a substantial fiscal burden on the state. Instead, commenters strongly advocate for allowing LVNs, to continue providing respiratory care, emphasizing that this approach is cost-effective, feasible, and maintains student safety.

Specifically, commenters provided an estimate of cost, stating that given the similar amount of education required, RCPs would make monthly schedule amounts similar to that of an LVN, which is approximately $5,175-$6,278 monthly. In calculating a mean salary $5,727 x 12 months=$68,724 annually X 10,000 RCPs=$687,240,000.00 additional educational costs in salaries. The RCPs would be placed on the PERS salary schedule @ .45% of salary cost=$309,258,000. Salary and benefits cost would total $996,498,000 or nearly $1 billion dollars. Commenters note this does not include charter schools. Commenter states they fundamentally believe that RNs and RCPs, who are in high demand in medical settings, will not leave their high paying hospital jobs (at $47/hour for RCPs) for school district salaries to simply stand-by to suction students, or it is unlikely that enough would be available or willing to take on school-based

positions for the salaries typically offered. Commenters add that the average RCP salary in CA is $59,878 and $103,060 according to the BLS. With consideration of the shortage of RCPs in the healthcare industry and higher salaries expected, it would be prohibitive for students to receive the suctioning and other higher level respiratory care needed if the provider is restricted to an RCP. Commenter states the current nationwide shortage of RCPs will result in districts being likely unable to hire and retain RCPs due to the competitive salaries paid by hospitals.

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

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

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

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

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

Comments from rural school districts provide that it would be a financial struggle to hire RCPs and that such an expectation is unrealistic. One comment specifically notes that the rural location,

inclement winter weather, and competing wages with larger cities/districts, makes it difficult to maintain medical personnel. Commenter claims this regulation would cause a hardship for their district with the financial burden or would negatively impact their current staffing situation pulling already scarce resources from their existing programs and students.

RESPONSE TO ISSUE NO. 5

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

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

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

At this stage, amendments to the proposed regulatory action to accommodate the comments from K-12 schools would not align with current legislative intent, would delay compliance with legislative and regulatory timelines, and is not the appropriate avenue to remedy their concerns. The RCB believes that it is the responsibility of K-12 school advocates to pursue a legislative remedy if so desired.

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

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

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

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

The RCB received comments in opposition, highlighting concerns about the proposed regulation's impact on LVNs and their ability to perform respiratory care tasks, arguing that it would narrow their scope of practice and put patients at risk. Commenters note the BVNPT provides that preoxygenation or nasal suctioning; tracheal suctioning, cuff inflation/deflation, use or removal of an external speaking valve, or removal and replacement of the tracheostomy tube or inner cannula, and adjusting oxygen (O2) are tasks specifically included in their licensure training, and are part of the National Licensing Examination-PN (NCLEX-PN), which is the vocational nursing competency exam.[4]

Commenters state that LVNs are trained and licensed to perform respiratory care, including tracheostomy care, suctioning, and oxygen adjustment, and that these skills are essential for continuity of care, particularly in home health, long-term care, and pediatric settings. They argue that restricting LVNs' roles would create workforce shortages, increase workloads for RNs and RCPs, and ultimately compromise patient outcomes. Commenters expresses concern that this proposed regulatory package omits certain tasks that are within the scope of practice of an LVN, specifically they do not represent assessment-related tasks. Commenter states, "we certainly don't want to erode current LVN scope of practice in regulations."

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

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

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

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

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

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

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

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

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

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

RESPONSE TO ISSUE NO. 6

The RCB reviewed and considered the opposing comments and suggested amendments and

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

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

The RCB is the only state agency statutorily authorized to define or interpret the practice of respiratory care in California (B&P §3702.5). The tasks identified in this regulatory proposal represent basic respiratory tasks that do not require a respiratory assessment and require only manual, technical skills, or data collection, consistent with the RCB's experience and understanding of the practice of respiratory care in California.

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

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

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

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

It is also important to note that regulations expanding LVN training and the respiratory services they may provide in home and community-based settings are forthcoming, with an expected

implementation date of January 2028. For skilled nursing facilities, compliance with the law may necessitate hiring additional RCPs or RNs. However, LVNs continue to play a vital role in delivering a wide range of patient care services and will remain in high demand despite the nursing shortage. Laws are in place to prevent increased workloads for healthcare staff in ways that could compromise patient safety. Additionally, respiratory patients cared for at some skilled nursing facilities are reimbursed at significantly higher rates to offset the costs of employing more highly trained and qualified RCPs.

Lastly, the proposed regulation does not limit LVN classroom instruction, nor does LVN curriculum content influence the RCB's definition of basic respiratory tasks. It is critical to note that respiratory care is not classified as a "skilled nursing service" for the purpose of determining patient-to-nurse ratios. The RCB affirms that the proposed regulatory language appropriately delineates basic respiratory tasks within its statutory authority, ensuring the safety and efficacy of respiratory care services.

ISSUE NO. 7 – Creates Confusion (Submitted by commenters: L33, L35)

The RCB received comments in opposition stating the proposed changes may cause confusion and inefficiency in patient care.

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

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

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

> 1399.365. Basic Respiratory Tasks and Services.
> (a) For purposes of this section, "respiratory assessment" includes ~~means~~ making an analysis or judgment of a patient's breathing and making recommendations to a medical doctor concerning the management, ~~diagnosis,~~ treatment, or care of a patient ~~or as a means to perform any task in regard to the care of a patient. Assessment as used in this section is beyond documenting observations, and gathering and reporting data to a licensed respiratory care practitioner, registered nurse, or physician.~~

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

RESPONSE TO ISSUE NO. 7

The RCB reviewed and considered the opposing comments and suggested amendments and declines to make any amendments to the proposed text based thereon, for the same reasons detailed in Response to Issue Nos. 1, 4, 5, and 6 above. Further, the RCB disagrees with the assertion that the language creates confusion, as it is precise and consistent with the terminology commonly used in the health care industry.

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

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

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

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

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

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

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

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

The RCB believes the proposed text provides essential clarity regarding the roles of LVNs and

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

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

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

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

In conclusion, proposed subsection (c) of CCR §1399.365 is necessary for providing clear guidance on prohibited tasks, offering clarity for practitioners and regulatory bodies alike, and maintaining a robust regulatory framework that protects the public and the profession.

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

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

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

groups. Commenter states that eventually, if one exception exists, others will follow if public policy dictates the need, e.g., schools, retirement communities, state department facilities.

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

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

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

RESPONSE TO ISSUE NO. 9

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

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

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

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

RESPONSE TO ISSUE NO. 10

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

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

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

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

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

RESPONSE TO ISSUE NO. 11

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

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

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

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

RESPONSE TO ISSUE NO. 12

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

COMMENTS FROM PEOPLE REPRESENTING HOME AND COMMUNITY-BASED CARE

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

The RCB received a comment in opposition, from an employee of a home health agency, citing these regulations will create staffing and recruiting challenges. Commenter states the healthcare industry is currently facing significant staffing shortages, particularly among nursing and allied health professions. By restricting LVNs from performing basic respiratory services without additional certification, this regulation will further strain the healthcare workforce. LVNs already

provide critical patient care and could help relieve the growing pressure on RCPs. Restricting LVNs' roles in this way places an undue burden on RCPs, who are also in short supply, and will hinder the ability of healthcare facilities-particularly those in rural or underserved areas-to meet patient care demands.

RESPONSE TO ISSUE NO. 13

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

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

> 3765.
> This act does not prohibit any of the following activities:
> …
> (i) The performance, by a vocational nurse licensed by the Board of Vocational Nursing and Psychiatric Technicians of the State of California who is employed by a home health agency licensed by the State Department of Public Health, of respiratory tasks and services identified by the board, if the licensed vocational nurse complies with the following:
>
> (1) Before January 1, 2028, the licensed vocational nurse has completed patient-specific training satisfactory to their employer.
>
> (2) On or after January 1, 2028, the licensed vocational nurse has completed patient-specific training by the employer in accordance with guidelines that shall be promulgated by the board no later than January 1, 2028, in collaboration with the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

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

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

ISSUE NO. 14 – Financial Implications (Submitted by commenters: H40, H42, H43, H44)

The RCB received comments in opposition from home and community-based employers and organizations, citing significant financial implications of these regulations. Higher costs are attributed to: 1) the lack of financial reimbursement for RCPs in the home, 2) higher wages employers would be forced to pay for RCPs and RNs, and 3) forcing patients to be institutionalized, either from the inability to hire RCPs/RNs due to shortages or financial limitations, which costs significantly more than patients being cared for in the home.

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

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

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

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

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

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

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

expansion of businesses in the State of California.

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

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

Commenter states if LVNs are prohibited from performing certain respiratory tasks, for which they have been determined competent, the increased costs to businesses, the sustainability of businesses who cannot afford to pay these increased costs, and the number of healthcare related businesses that will close is extremely high, thus reducing access to essential healthcare services. Overall, RCPs command a higher salary than LVNs.

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

Occupational Projections [Outlook/Demand] 2020 - 2030

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

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

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

RESPONSE TO ISSUE NO. 14

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

Pointedly, the fiscal impact concerns raised by home health agencies do not exist or are not the result of this proposed rulemaking. Home health agencies were provided an exemption in SB 1436

at B&P §3765(i). There is still a misunderstanding with some home health agencies that mistakenly believe this regulatory proposal is identifying the home care tasks found in B&P §3765(i) and §3765(j)(2)(D).

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

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

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

ISSUE NO. 15 – Task Certification for LVNs (Submitted by commenters: H40, H43)

The RCB received comments in opposition from home and community-based employers and organizations, citing that the training and certification as referred to in B&P §2860(b) is duplicative and unnecessary. Comments also refer to future regulations that are separate from these regulations. Comments in more detail include the following:

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

the requirement that an LVN must have a certificate of competency in specific tasks is new and is one that commenter "wholeheartedly support."

- Citing B&P §3765(j), commenter states LVNs are permitted to perform respiratory services identified by the board if the LVN holds a current license, has received patient specific training satisfactory to their employer, current and valid certification of competency for each respiratory task to be performed from the California Association of Medical Product Suppliers, the California Society for Respiratory Care, or another organization identified by the board. Commenter states that this statutory subsection does not refer to limiting respiratory tasks and services performed by LVNs to those defined as "basic respiratory tasks and services".
- If an LVN obtains certification of competency for specific respiratory tasks from an approved organization, it would appear that the LVN would not be limited to performing only basic tasks and services. However, the proposed regulations do not address this omission.
- Commenter requests that the proposed regulations package for "Basic Respiratory Tasks and Services" be amended to provide for additional tasks beyond the "basic tasks and services" for which the LVN has been determined competent by their employer and holds a valid certificate, as long as the specific task does not violate the LVN scope of practice. The delivery of health care has undergone tremendous change and will continue to change as new technologies and community standards of practice evolve and these proposed regulations are very restrictive which will have detrimental effects on access to care.

RESPONSE TO ISSUE NO. 15

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

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

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

RESPONSE TO ISSUE NO. 16

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

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

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

timely and appropriate care.

RESPONSE TO ISSUE NO. 17

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

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

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

RESPONSE TO ISSUE NO. 18

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

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

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

RESPONSE TO ISSUE NO. 19

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

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

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

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

Given the similar, but different, terminology used in CCR §1399.360 and proposed CCR §1399.365, the RCB agrees with commenter that the language of CCR §1399.360 can be more precise. To reduce possible confusion, the RCB commits to amending the language of §1399.360 in a future regulatory proposal to increase clarity by striking "limited and basic respiratory care."

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

The RCB received a comment in opposition on behalf of a home and community-based organization,

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

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

Modified Text 15-Day Comment Period: Commenter Cross R

COMMENTER S1:	Troy Brown, Ed.D, County Superintendent of Schools San Joaquin County Office of Education Letter dated October 16, 2024 (E-mail from B. Brunni)
Issues:	1, 2, 3, and 5
COMMENTER S2:	Yooni Kim BSN, RN [Typed names in signature block: Kelley Gordon BSN, CSN, RN, Madi Schumann BSN, CSN, RN, Preet Kaur BSN, RN] WPUSD School Nurses E-mail dated October 31, 2024
Issues:	3 and 5
COMMENTER S3:	Christina Mashore, BSN, RN, PHN, CMSRN District Nurse, Liberty Union High School District E-mail dated October 16, 2024
Issues:	1 2, 3, and 5
COMMENTER S4:	Danna dePuglia, LVN, BS HSC Pollock Pines Elementary School District Fax received October 17, 2024
Issues:	1, 2, and 5
COMMENTER S5:	David Tate, District Nurse Rio Bravo-Greeley Union School District E-mail dated October 16, 2024
Issues:	1, 2, 3, and 5
COMMENTER S6**:**	Elizabeth Semmelmann, RN, BSN, PHN, SNSC, District Nurse Santa Rita Union School District

E-mail and letter dated: October 16, 2024
Issues: 1, 2, 3 and 5

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMENTER S26: Grace E. Van Doren, MSN, RN, PHN, RCSN
CSNO Central Coast Section President
San Luis Coastal Unified School District

Hard copy letter received October 28, 2024

Issues: 1, 2, 3, and 5

COMMENTER S27: Katie Rodriguez, RN, PHN, RCSN
Letter dated October 25, 2024

Issues: 2, 3, and 5

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

Issues: 4 and 5

COMMENTER S29: Janene Armas, RN, PHN, RCSN
Letter dated October 25, 2024

Issues: 2, 3, and 4

COMMENTER S30: Jennifer Newsom BSN, RN
HBUHSD Float School Nurse
E-mail dated October 31, 2024

Issues: 2, 4, and 5

COMMENTER S31: GROUP COMMENT (GC-Coburn)
Letter dated 10/24/2024/E-mail (Rachel Scicluna) dated 10/29/2024

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

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

Toni Triguiero, Med, Legislative Consultant, California Teachers Association

Brianna Burns, Director, Policy & Advocacy, California County Superintendents

Serette Kaminski, Legislative Advocate, Association of California School Administrators

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

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

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

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

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

Issues: 6, 7, 8, 9, 10, and 11

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

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

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

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

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

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

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

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

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

COMMENTER H43: Michael Lyman, President
Pediatric Day Health Center Coalition
Letter dated October 28, 2024

Issues: 14, 15, and 19

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