

Date of Hearing: June 30, 2026

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS

Marc Berman, Chair

SB 1304 (Wahab) – As Amended April 15, 2026

SENATE VOTE: 38-0

SUBJECT: Respiratory Care Practice Act

SUMMARY: Makes various changes to the regulation of licensed respiratory care practitioners (RCPs) and the practice of respiratory care by licensed vocational nurses (LVNs) recommended as part of the joint sunset review oversight of the Respiratory Care Board of California (RCB).

EXISTING LAW:

- 1) Regulates the practice of respiratory care through the licensure of RCPs under the Respiratory Care Practice Act (RC Act). (Business and Professions Code (BPC) §§ 3700-3779)
- 2) Establishes the RCB, until January 1, 2027, to administer and enforce the RC Act. (BPC §§ 3710, 3716).
- 3) Declares that protection of the public shall be the highest priority for the RCB in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. (BPC § 3710.1)
- 4) Defines the practice of respiratory care as a health care profession employed under the supervision of a medical director in the therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the pulmonary system and associated aspects of cardiopulmonary and other systems functions, as specified. (BPC § 3702)
- 5) Prohibits the practice of respiratory care unless licensed under the RC Act or otherwise authorized. (BPC § 3760)
- 6) Specifies that the RC Act is not intended to limit, preclude, or otherwise interfere with the practices of other licensed personnel in carrying out authorized and customary duties and functions. (BPC § 3762)
- 7) Specifies that the RCB is the only state agency that may define or interpret the practice of respiratory care for RCPs or develop standardized procedures or protocols pursuant to the RC Act unless authorized by the act or specifically required by state or federal statute. (BPC § 3702.5)
- 8) Authorizes the RCB to adopt regulations to define, interpret, or identify all of the following:
 - a) Basic respiratory tasks and services that do not require a respiratory assessment and only require manual, technical skills, or data collection. (BPC § 3702.5(a))

- b) Intermediate respiratory tasks, services, and procedures that require formal respiratory education and training. (BPC § 3702.5(b))
 - c) Advanced respiratory tasks, services, and procedures that require supplemental education, training, or additional credentialing consistent with national standards, as applicable. (BPC § 3702.5(c))
- 9) Establishes a list of basic respiratory tasks and services and exclusions identified by the RCB. (California Code of Regulations (CCR) Title 16, § 1399.365)
- 10) Defines “assessment,” for purposes of basic respiratory tasks and services, 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 that is beyond documenting observations, and gathering and reporting data to a licensed respiratory care practitioner, registered nurse, or physician. (CCR tit. 16, § 1399.365(a))
- 11) Specifies that basic respiratory tasks and services do not require a respiratory assessment. (CCR tit. 16, § 1399.365(b))
- 12) Specifies that basic respiratory tasks and services include the following:
- a) Patient data collection. (CCR tit. 16, § 1399.365(b)(1))
 - b) Application and monitoring of a pulse oximeter. (CCR tit. 16, § 1399.365(b)(2))
 - c) Medication administration by aerosol that does not require manipulation of an invasive or non-invasive mechanical ventilator. (CCR tit. 16, § 1399.365(b)(3))
 - d) Heat moisture exchanger (HME) and oxygen tank replacement for patients who are using non-invasive mechanical ventilation. (CCR tit. 16, § 1399.365(b)(4))
 - e) Hygiene care, including replacement of tracheostomy ties and gauze and cleaning of the stoma sites. (CCR tit. 16, § 1399.365(b)(5))
 - f) Use of a manual resuscitation device and other cardio-pulmonary resuscitation technical skills (basic life support level) in the event of an emergency. (CCR tit. 16, § 1399.365(b)(6))
 - 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. (CCR tit. 16, § 1399.365(b)(7))
 - h) Observing and gathering data from chest auscultation, palpation, and percussion. (CCR tit. 16, § 1399.365(b)(8))
- 13) Excludes the following tasks and services from the list of basic respiratory tasks and services:
- a) Manipulation of an invasive or non-invasive ventilator. (CCR tit. 16, § 1399.365(c)(1))

- b) Assessment or evaluation of observed and gathered data from chest auscultation, palpation, and percussion. (CCR tit. 16, § 1399.365(c)(2))
 - c) Pre-treatment or post-treatment assessment. (CCR tit. 16, § 1399.365(c)(3))
 - d) Use of medical gas mixtures other than oxygen. (CCR tit. 16, § 1399.365(c)(4))
 - e) Preoxygenation, or endotracheal or nasal suctioning. (CCR tit. 16, § 1399.365(c)(5))
 - f) Initial setup, change out, or replacement of a breathing circuit or adjustment of oxygen liter flow or oxygen concentration. (CCR tit. 16, § 1399.365(c)(6))
 - g) Tracheal suctioning, cuff inflation or deflation, use or removal of an external speaking valve, or removal and replacement of the tracheostomy tube or inner cannula. (CCR tit. 16, § 1399.365(c)(7))
- 14) Specifies that the definitions and lists regarding basic respiratory tasks and services do not apply to LVNs performing respiratory care services identified by the RCB while providing specified home and community-based care exempt from the RC Act, as specified. (CCR tit. 16, § 1399.365(d))
- 15) Exempts an LVN from the licensing requirements of the RC Act when providing home and community-based care under two pathways:
- a) Performing respiratory care tasks identified by the RCB while employed by a licensed home health agency if the LVN completes specified patient-specific training provided by the employer. (BPC § 3765(i))
 - b) Performing respiratory care tasks identified by the RCB in specified congregate, day center, and home health settings if the LVN completes patient-specific training satisfactory to their employer and holds a current and valid certification of competency for each respiratory task to be performed from the California Association of Medical Product Suppliers, the California Society for Respiratory Care, or another organization identified by the RCB. (BPC § 3765(j))
- 16) Regulates the practice of vocational nursing under the Vocational Nursing Practice Act (VN Act). (BPC §§ 2840-2895.5)
- 17) Establishes the Board of Vocational Nursing and Psychiatric Technicians (BVNPT) to administer and enforce the VN Act. (BPC §§ 2840-2858)
- 18) Declares that protection of the public shall be the highest priority for the BVNPT in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. (BPC § 2841.1)
- 19) Defines the practice of vocational nursing within the meaning of the VN Act 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, or naturopathic doctor, as specified. (BPC § 2859(a))

- 20) Specifies that the VN Act 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. (BPC § 2860(a))
- 21) Specifies that, notwithstanding the prohibition against practicing respiratory care, an LVN who has received training and who demonstrates competency satisfactory to their employer may, when directed by a physician and surgeon, perform respiratory care tasks identified by the RCB as basic. (BPC § 2860(b))

THIS BILL:

- 1) Extends the operation of the RCB until January 1, 2031.
- 2) Updates title of the national examination and makes a conforming change to the cut-off level.
- 3) Authorizes the RCB to automatically suspend and revoke licenses for specified serious felony convictions.
- 4) Makes the following changes to the exempted congregate, day center, and home health settings where LVNs may practice respiratory care:
 - a) Changes the required training from patient-specific to task-specific.
 - b) Combines the employer-provided training and the organization-based training into one list of options.
 - c) Increases the bed limit for intermediate care facilities to 15 and removes the 6-bed limit for others.
 - d) Deletes the home health employment pathway and instead adds home health agency to the list of settings licensed by the California Department of Public Health (CDPH) along with hospice agencies and hospice facilities.
 - e) Expands the facilities licensed by the Department of Social Services to include adult residential facilities, adult residential facilities for persons with special health care needs, group homes, group homes for children with special health care needs, enhanced behavioral supports homes, community crisis homes, residential care facilities for the elderly, residential care facilities for the chronically ill, adult day programs, and therapeutic day services facilities.
 - f) Adds medical foster homes for veterans approved by the United States Department of Veterans Affairs.
 - g) Adds family home agencies and regional centers.
- 5) Defines, for purposes of all respiratory care exempted from the RC Act, “employer” as:
 - a) A person, agency, facility, organization, or entity responsible for assigning, directing, or coordinating the care provided by the licensed vocational nurse.

- b) When applicable, a family member or legal guardian authorized under the patient's plan of care to perform that function.
- 6) Deletes the exemption to the RC Act for performance of pulmonary function testing by persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.
- 7) Deletes the \$300 fee for issuance of an initial license.
- 8) Increases the license renewal fee from \$230 to \$330 and authorizes the RCB to increase the fee to \$375 through rulemaking.

FISCAL EFFECT: According to the Senate Appropriations Committee, the 2026-27 Governor's Budget provides:

- Approximately \$4.15 million (Respiratory Care Fund) and 16.4 positions to support the continued operation of the RCB's licensing and enforcement activities.

The RCB anticipates:

- An increase in annual fee revenue of approximately \$450,000 resulting from the raised renewal fee cap.
- Unknown costs to promulgate regulations to increase fees within the new statutory limit.
- Minor annual cost savings of approximately \$15,000 in Attorney General enforcement costs due to RCB's new authority to automatically suspend or revoke licenses for certain felony convictions.

COMMENTS:

Purpose. This bill is sponsored by the author. According to the author, "This bill is necessary to make changes to the Board of Respiratory Care to improve oversight of the regulated professions under the jurisdiction of the Board."

Background. Each year, the Assembly Committee on Business and Professions and the Senate Committee on Business, Professions, and Economic Development hold joint sunset review oversight hearings to review the licensing entities under the Department of Consumer Affairs (DCA). The DCA boards, bureaus, and other entities are responsible for protecting consumers and the public and regulating the professionals they license. The sunset review process provides an opportunity for the legislature, DCA, licensing entities, and stakeholders to discuss the entities' performance and make recommendations for improvements.

Each licensing entity subject to review has an enacting statute with a repeal date, meaning their authority must be extended by the legislature before the repeal date, otherwise the entity will lose its statutory mandate. This bill is a "sunset" bill, intended to extend the repeal date of the RCB, as well as incorporate the recommendations from the sunset review oversight hearings. This year there are ten boards up for review, each with their own sunset bill. This year, five of the sunset review bills are authored by the chair of the Assembly Committee on Business and Professions and the other five are authored by the chair of the Senate Committee on Business, Professions, and Economic Development.

RCB. The RCB is responsible for administering and enforcing the RC Act, which establishes the board and contains the regulatory framework for the practice of respiratory care. According to the RCB:

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

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

The RCB's primary function is to run the licensing, education, and disciplinary programs for RCPs. At the end of fiscal year (FY) 2024-25, the RCB reported a total of 21,390 active, in-state licensees. It also reported 36 respiratory care education programs in California that are approved by the RCB by virtue of their accreditation status.

The RCB's mission statement, as stated in its *2023-2027 Strategic Plan*, is: "To protect and serve consumers by licensing qualified respiratory care practitioners, enforcing the provisions of the Respiratory Care Practice Act, expanding the availability of respiratory care services, increasing public awareness of the profession, and supporting the development and education of respiratory care practitioners."

Current Related Legislation. AB 2771 (Committee on Business and Professions) is the sunset review bill for the Bureau of Private Postsecondary Education. *AB 2771 is pending in the Senate.*

AB 2772 (Committee on Business and Professions) is the sunset review bill for the California Council for Interior Design Certification. *AB 2772 is pending in the Senate.*

AB 2773 (Committee on Business and Professions) is the sunset review bill for the California Board of Occupational Therapy. *AB 2773 is pending in the Senate.*

AB 2774 (Committee on Business and Professions) is the sunset review bill for the Physical Therapy Board of California. *AB 2774 is pending in the Senate.*

AB 2775 (Committee on Business and Professions) is the sunset review bill for the State Board of Chiropractic Examiners (BCE). *AB 2775 is pending in the Senate.*

SB 1302 (Wahab) is the sunset review bill for the California Board of Registered Nursing. *SB 1302 is pending in this Committee.*

SB 1303 (Wahab) is the sunset review bill for the California Board of Naturopathic Medicine. *SB 1303 is pending in this Committee.*

SB 1363 (Wahab) is the sunset review bill for the California Board of Barbering and Cosmetology. *SB 1363 is pending in this Committee.*

SB 1368 (Wahab) is the sunset review bill for the California Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board. *SB 1368 is pending in this Committee.*

Prior Related Legislation. SB 389 (Ochoa Bogh), Chapter 389, Statutes of 2025, authorized LVNs to perform suctioning and other basic respiratory tasks and services under the supervision of a credentialed school nurse.

SB 1451 (Ashby), Chapter 480, Statutes of 2024, among other things unrelated to respiratory care, extended the dates by which LVNs employed by home health agencies would need to meet additional training specified by the RCB in collaboration with the BVNPT from January 1, 2025, to January 1, 2028, and established the settings-specific exemptions for congregate, day center, and home health settings that will take effect January 1, 2028.

SB 1436 (Roth), Chapter 624, Statutes of 2022, was the RCB's prior sunset bill which, among other things: established the initial RC Act exemption for LVNs employed by home health agencies if, prior to January 1, 2025, patient-specific training satisfactory to their employer and, after January 1, 2025, patient-specific training by the employer in accordance with guidelines promulgated by the RCB in collaboration with the BVNPT; amended the VN Act to specifically restrict the practice of respiratory care by LVNs; and made other conforming or otherwise related changes.

ARGUMENTS IN SUPPORT:

The *California Assisted Living Association* writes in support:

The California Assisted Living Association (CALA), representing Residential Care Facilities for the Elderly (RCFEs) and Continuing Care Retirement Communities (CCRCs) throughout the state, is pleased to support [this bill].

Prior to implementation on October 1, 2025 of the Respiratory Care Board's regulations defining basic respiratory tasks, Licensed Vocational Nurses (LVNs) had been safely providing care in Assisted Living communities, among other settings, that generally included assisting residents with CPAP and BiPAP machines and with oxygen. While RCFEs are not required to provide nurses, many choose to employ nurses for these types of basic services and for medication administration so that residents don't have to live in a skilled nursing facility simply due to the need for assistance with these basic tasks. The updated regulations created challenges for existing residents and prospective residents not capable of managing these systems on their own.

We appreciate the amendments to [this bill] that allow current staff working in RCFEs to resume providing these basic tasks, for which they have been adequately trained, and allow residents to remain in the least restrictive setting.

The *California Association of Medical Product Suppliers* writes in support:

We appreciate that [this bill], as amended on April 15, 2026, includes clear authorization for LVNs who have received training from their employer to continue performing intermediate tasks & services so as not to disrupt the continuity of care for medically fragile children and adults who choose to receive respiratory care services and the normalcy of life at home and in community-based settings with their families instead of in a hospital or other institutional setting.

With regard to the requirements that take effect on or after January 1, 2028, we ask that the Committee consider an amendment to give employers a 12 month “training and compliance window” after the release of the RCB’s guidelines. This will allow a sufficient amount of time for LVNs to complete the required training, and for facility administrators to ensure full compliance and a smooth transition before implementation deadlines take effect. Establishing a “training and compliance window” will also enable facility administrators to coordinate schedules, maintain staffing levels, and minimize disruption to daily operations while LVNs under their employ work toward meeting the new training requirements.

To this end, we request that the date in B & P §3765 (a)(9)(B) be removed as we cannot be sure if the guidelines will be completed sooner or later than the data specified.

We note that Sections (C) (iv) and (iiv) allow for LVNs to provide respiratory care tasks and services for adults with developmental disabilities as part of services provided through a family home agency, as defined in Section 4689.1 of the Welfare and Institutions Code, and as part of supported living services provided pursuant to Section 4689 of the Welfare and Institutions Code.

The Legislature and Governor have consistently supported the expansion of home and community-based services which allow patients with complex medical conditions to remain in familiar environments with family and community members, promoting emotional well-being and stability alongside their medical treatment. Some examples include:

- The California Program of All-Inclusive Care for the Elderly (PACE) program serves individuals with significant health needs with the intent to provide preventive, primary, acute, and LTC services so older individuals can continue living in the community and avoid hospitalization and skilled nursing facility (SNF) services. PACE organizations provide care for dually enrolled Medi-Cal and Medicare beneficiaries.
- The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program provides care for critically ill children in California suffering from complex medical conditions, such as spastic quadriplegic cerebral palsy, muscular dystrophy, and anoxic brain injury.

- The “Home- and Community-Based Services” (HCBA) Waiver allows individuals who would medically qualify to receive hospital or skilled nursing facility care to instead receive similar services at home or in community settings.

It is unclear whether [this bill] allows for LVNs to provide respiratory care tasks and services under these programs. Therefore we are requesting clarification to ensure the provisions of [this bill] cover the services provided in these programs in addition to the supported living services provided pursuant to Section 4689 and 4689.1 of the Welfare and Institutions Code.

The *California Society for Respiratory Care* writes in support:

CSRC supports the RCB’s efforts to clarify a pathway for LVNs to provide basic respiratory tasks for nonacute patients in certain settings. We look forward to working with the committee to resolve any outstanding issues on that topic.

CSRC supports the New Issues outlined in RCB’s report. Particularly item #5 to create a cardiopulmonary specific graduate level practitioner, the Advanced Practice Respiratory Therapist (APRT).

The APRT continues to advance nationally. CoARC, the Commission on Accreditation of Respiratory Care, has already approved curriculum. Ohio State has a formal APRT program. The APRT would add a much-needed advanced practice provider already specialized in cardiopulmonology to care for patients with cardiopulmonary disease, and a new option within the respiratory care profession for those therapists and students who are already interested in a graduate position.

Respiratory care practitioners, already trained to manage complex cardiopulmonary conditions such as COPD, asthma, and respiratory failure, are uniquely positioned to help close critical gaps in care. Establishing the APRT role will create a pathway for graduate-level trained RCPs to serve as physician extenders, deliver advanced assessments, ordering and interpreting diagnostic tests, prescribing medications, managing treatment plans, and supporting patients with complex needs, particularly in critical care, pulmonary medicine, and underserved regions where workforce shortages are most acute.

The *Pediatric Day Health Care Coalition* writes in support:

On behalf of the Pediatric Day Health Care Coalition [PDHCC], we would like to express our support for [this bill], as amended on 04/15/26. These amendments streamline and simplify the process whereby LVNs working for employers in exempted settings may perform specific respiratory care tasks and services ensuring competency through employer-based training.

Pediatric Day Health Care centers have provided skilled nursing, including respiratory care, to children with defined diagnoses that result in medically fragile and/or technology-dependent health conditions. LVNs have safely provided respiratory care for decades. We acknowledge that some respiratory care tasks

should only be performed by a respiratory care professional as indicated by the Respiratory Care Board of California [RCB].

The bill also requires the RCB to develop Training Guidelines for employers and other entities to use when training LVNs on task-specific and patient specific respiratory care. Under the current version of [this bill], the Board has until January 1, 2028, to release those Guidelines. However, the bill does not allow for time between this release and the effective date by which employers must review their curriculum, revise if necessary, and train nursing staff according to the Guidelines. We do have one suggestion to ensure smooth implementation. We also suggest that employers, in exempt settings, have six months after the release of the guidelines to review their curriculum using the guidelines, revise the curriculum and complete the training.

ARGUMENTS IN OPPOSITION:

A coalition comprised of the *California Association of Health Facilities*, *LeadingAge California*, the *California Hospital Association*, the *Association of California Healthcare Districts*, and the *American Nurses Association\California* is opposed to this bill unless it is amended to:

- Delete the setting-specific framework in the [existing law] that establishes different tasks that LVNs can do in different settings or include additional settings where an LVN may perform respiratory care tasks to include skilled nursing facilities (SNFs), intermediate care facilities for the developmentally disabled, pediatric and adult subacute facilities, and hospitals.
- Clarify that LVNs can perform respiratory tasks as part of their formal training and education program and under the supervision of the training program in any setting, as part of their required training.
- Specify the basic respiratory tasks that are within the data collection and observation roles of their scope and can be performed by LVNs in any setting based on their existing licensure and without additional training.

Specifically, the coalition writes:

[This bill] does not authorize LVNs working in non-exempted settings, to perform respiratory care tasks in those settings even if they were to obtain the same training provided to LVNs practicing in exempted settings. Establishing a different scope of practice for LVNs based on the setting in which they are practicing is inconsistent with how scope of practice has been historically determined for other licensed health professionals....

The LVN scope of practice is defined in state law and oversight for LVN licensing is under the oversight of the [BVNPT]. LVNs are trained and licensed to perform a range of practical nursing tasks as part of a health care team under the direct supervision of registered nurses and physicians, regardless of setting type. As part of their scope of practice to provide direct patient care, basic nursing care, and administer medications, LVNs are trained and have historically provided basic respiratory services related to oxygen delivery and tracheostomy care

(suctioning, cleaning, etc.) consistent with their training. LVNs have been trained in and evaluated on all tasks, including basic respiratory care, in their scope of practice and have performed these tasks for decades.

Existing statute and regulations that authorize the RCB to oversee and enforce LVN scope of practice with regard to the performance of respiratory care tasks have resulted in confusion, major care disruptions, and unanticipated cost increases in health care, social service and educational settings. [This bill], through its delineation of expanded settings, does not address these issues. For example, an LVN that works for a hospice agency and provides hospice care to residents in a SNF, they would be able to perform basic respiratory tasks, but if that same LVN works directly for a SNF and receives the same employer-provided training in respiratory care, they would not be allowed to perform respiratory tasks. LVNs in licensed health facilities, such as SNFs and hospitals, practice under the close supervision of physicians and registered nurses in a highly regulated setting. Establishing a different LVN scope of practice that is more restricted than the scope of practice of an LVN working in a non-healthcare facility environment, is contrary to the State's goals for patient safety and public protection.

Existing framework for oversight of LVN respiratory tasks has not improved patient care. There have been serious negative impacts on patient safety and access to care in a wide range of healthcare and non-healthcare settings because of the impact of California Code of Regulations, Title 16, §1399.365, which significantly limited the basic respiratory tasks that LVNs could perform and negatively impacted health care delivery including:

- Delays in addressing immediate breathing issues for vulnerable individuals.
- Unnecessary denied admissions, transfers and discharges of patients from service settings that have not been able to hire additional RNs or RCPs to provide respiratory care previously provided by LVNs.
- Inefficient reallocation of care workload that diverts RNs and other clinical staff to perform tasks that were previously performed by LVNs.
- Increased costs and diversion of limited public funding to hire additional clinical staff to perform respiratory tasks previously performed by LVNs.
- Disruptions in the health care workforce training pipeline for LVNs.
- Confusion among LVNs, employers and other healthcare professionals about the legal scope of practice for LVNs.

We request that [this bill] be amended to allow LVNs in the requested licensed health facility settings to continue to provide critical patient care, including performing respiratory tasks in which they have been trained and evaluated, and across the wide variety of settings in which that they have historically practiced under appropriate clinical supervision.

SUNSET ISSUES FOR CONSIDERATION:

In preparation for the sunset hearings, committee staff publish background papers that identify outstanding issues related to the entity being reviewed. All background papers are available on the committee's website: <https://abp.assembly.ca.gov/hearings/joint-sunset-review-oversight-hearings>. While every issue discussed in the background papers remain available for discussion, the following are being addressed in the amendments to this bill or are being actively discussed.

- 1) *Issue #1: Fees.* The RCB is requesting three changes to its statutory fees. The first request is an increase to the statutory floor and ceiling on its license renewal fee. While the board reports that it “does not anticipate the need for a fee increase in the near future,” it is requesting the increase proactively. It would like the option of increasing its fees in regulation in the event it cannot absorb unanticipated costs, such as legislative or regulatory mandates, fee increases imposed by other agencies, significant enforcement actions, or litigation.

According to the RCB's March 31, 2026, budget update, its reserve has been growing, from approximately \$2,408,000 (7.3 months in reserve) in fiscal year (FY) 2023-24 to a projected \$2,887,000 (8.2 months) by June 30, 2026.¹ However, it projects that it may experience a slight structural imbalance beginning FY 2026-27, with the reserve dropping back down to \$2,622,000 (7.3 months) in 2027-28.

The RCB's renewal fee is currently set to the \$330 statutory maximum in regulation. The RCB is requesting to increase the fee floor from \$230 to match the fee. It is also requesting to increase the statutory limit on the fee from the current \$330 to \$375.

The second request is to delete the requirement that the RCB adjust its fees to maintain no more or less than approximately six months of fund reserve. The RCB believes the six-month reserve is not sustainable and refers to the general requirement that DCA boards and bureaus maintain no more than two-years operating budget in any FY.

The third request is to delete the obsolete initial license fee from the RC Act. The RCB eliminated that fee via regulation in 2012 to reduce the financial burden on new RCPs.

Staff Background Paper Recommendation: The RCB should inform the Committees on the necessity of increasing the renewal ceiling fee. The RCB should update the Committees on whether it believes the reserve limit should be increased from 6 months to 24 months consistent with many other boards and bureaus under the DCA. The Committees may wish to amend the Act to ensure the RCB is solvent and to allow the RCB to eliminate burdensome fees by licensees and applicants.

RCB Response:

The Board's fee authority... has historically provided sufficient flexibility to maintain fiscal stability. After nearly two decades without a fee increase, the Board implemented a phased adjustment to the renewal fee—from \$230 to the

¹ Respiratory Care Board of California, "Board Budget Update (as of 3/31/26)," March 2026, https://rcb.ca.gov/about_us/forms/03_26_budget_update.pdf.

current statutory maximum of \$330—primarily due to rising costs outside of the Board’s control. As a result of these increases, the Board’s fund condition has stabilized, and at this time, the Board does not anticipate the need for additional fee increases in the foreseeable future.

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

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

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

The Board respectfully requests that the Committees consider [deleting the initial license fee, increasing the renewal fee to \$330, authorizing the RCB to increase the renewal fee in regulation up to \$375, and deleting the reserve limit of six months].

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

Sunset Recommendation: This bill contains all three of the RCB’s fee requests.

- 2) *Issue #7: Basic Respiratory Care Services by LVNs.* As noted in the staff sunset review background paper, the RCB and BVNPT have had different views of whether LVNs are legally authorized or even trained to provide certain respiratory services in varying degrees for over 20 years, with particular focus on ventilator care.

However, more recent discussions around the use of LVNs in home and community-based settings to perform respiratory functions, namely that it was happening to a significant degree but without agreement on the legal authority to do so. In recognition of this absence of a

regulatory framework to govern ongoing practices, in 2019 the RCB and the BVNPT began to work collaboratively and issued a joint statement clarifying RCP and LVN roles relating to patient care, particularly for patients reliant on mechanical ventilators. However, that process ultimately led to disagreement between the boards.

Further, the VN Act is unhelpfully vague as to what an LVN's scope of practice includes, aside from specific services that require additional training, such as injections. It simply says, "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." At the time of the disagreement, naturopathic doctors were not included as being able to direct an LVN.

For purposes of what is taught in approved LVN training programs, the curriculum must, at a minimum, prepare LVNs for the NCLEX-PN administered by the National Council of State Boards of Nursing (NCSBN). The NCSBN develops and administers the licensing examination for both LVNs and registered nurses. To pass the NCLEX-PN, modern LVNs must understand the concept of physiological adaptation for purposes of identifying clinical changes (decompensation) in patients with acute, chronic, or life-threatening physical health conditions.² In patients requiring respiratory care, the NCLEX-PN establishes competency by requiring LVNs to demonstrate the ability through several respiratory-related tasks:

- Respond and intervene to a client life-threatening situation (e.g., cardiopulmonary resuscitation).
- Intervene to improve client respiratory status (e.g., breathing treatment, suctioning, repositioning).
- Provide care for a client with a tracheostomy.
- Provide care to client on ventilator.³

However, the NCLEX-PN is a computer test. It tests an LVN's clinical understanding and cognitive application of these tasks, but does not necessarily reflect the ability to apply this ability to a variety of patients in any given setting. That depends on the clinical experience gained in school and on the job. Further, a newly licensed practitioner may have trouble distinguishing the threshold between the manual or technical skill, the identification of decompensation, and the respiratory task beyond their scope without any clearly delineated legal boundaries.

In 2022, the RCB's sunset bill amended the VN Act in an attempt to draw those boundaries. It authorized LVNs, with additional training, to perform specific basic respiratory tasks identified by the RCB. The intent was to ensure that LVN involvement in respiratory care was distinct from the specialized judgement and skills of RCPs.

The bill also attempted to address the unique needs in home settings by authorizing additional tasks pursuant to employer training that would not be considered the practice of

² National Council of State Boards of Nursing, *2026 NCLEX-PN Test Plan* (Chicago: National Council of State Boards of Nursing, 2026), 18.

³ *Id.*

respiratory care. By the time the sunset bill took effect, the RCB had presented the topic and issue at public board meetings and the language in the bill had been considered at numerous public Legislative hearings.

Since then, the RCB was made aware of licensed home and community-based facilities and patients not covered in the exemptions outlined by that bill. Settings with only one or a few patients requiring respiratory services make it impracticable to hire a full-time RCP, so the RCB identified additional types of facilities, like small facilities outside of acute care facilities and independent providers who provide for transport or overseeing care of patients during daily activities, such as an outing, attending school, or providing a few hours of relief for parents' in-home care.

Follow-up legislation amended added the new exemptions, authorizing LVNs employed by exempt home health agencies or working in designated home and community based "exempt" settings to perform additional respiratory tasks, beyond basic level, if they have received appropriate task and patient specific employer training and obtained valid competency certification for each respiratory task from a board-recognized organization.

In March 2024, the RCB initiated the first of several new regulatory packages to define RCB-approved basic respiratory tasks and services that LVNs may lawfully perform. The regulatory language, which was discussed extensively at public meetings, listed the tasks that the RCB considered "basic" and listed those that were categorically not basic. The regulation became effective on October 1, 2025.

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

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

The PQC has determined that superficial nasal suctioning, within the nasal cavity only, is commonly treated as a basic nursing or caregiver task and does not involve airway entry, and therefore, does not rise to the level of requiring a clinical respiratory assessment. Nasal

suctioning becomes a respiratory task when it enters the pharynx or airway therefore requiring a clinical respiratory assessment.

The PQC has determined that suctioning that remains confined to the interior of the tracheostomy tube and does not pass beyond the distal end of the tube is commonly treated as a basic nursing or caregiver task and does not involve airway entry, and therefore, does not rise to the level of requiring a clinical respiratory assessment.

The regulation does not address oral suctioning. Currently, oral suctioning is permissible when it is limited to the visible oral cavity and does not enter the airway or the oropharynx. The PQC has determined that oral suctioning becomes a respiratory task when it enters beyond the oral cavity into the oropharynx or airway therefore requiring a clinical respiratory assessment.

At the March 2025 RCB meeting, initial conceptual regulatory language was presented for three proposed sections implementing the original intent of the exempt settings framework. The RCB received feedback from board members and stakeholders to help refine the draft language. The clarified task lists aligned the terminology with national respiratory care standards, and separated the rulemaking package into three coordinated components:

- 1399.361 - Define the scope of respiratory care tasks and services LVNs may perform in home health and community-based settings.
- 1399.362 – Establish training guidelines (to be developed in collaboration with the BVNPT) including certification requirements, for LVNs practicing under the new exemptions.
- 1399.363 - Set forth guidelines for Demonstrated Limited-Competency Certification issued by the California Society for Respiratory Care, California Association of Medical Suppliers or another organization identified by the Board.

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

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

RCB Response:

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

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

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

physiology, pathophysiology, pharmacology, and evidence-based practice, as well as substantial clinical training dedicated to respiratory care across a range of patient populations and acuity levels.

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

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

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

Similarly, at Gurnick Academy of Medical Arts, LVN students receive instruction in general nursing topics, including basic physiology, pharmacology, and limited respiratory-related skills such as oxygenation within broader coursework. In contrast, the respiratory therapy program includes a dedicated sequence of courses focused entirely on respiratory care, including airway management, aerosol

therapy, arterial blood gas analysis, patient assessment, mechanical ventilation, and clinical practicum experience in hospital settings.

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

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

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

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

Through prior legislation and rulemaking, including SB 1436 (2022), SB 1451 (2024), and the Board's adoption of CCR, Title 16, § 1399.365, significant progress has been made in clarifying the boundaries of LVN involvement in respiratory-related tasks. However, despite these efforts, confusion persists among stakeholders, in part due to inconsistent interpretation and application across settings. Accordingly, the Board believes that targeted statutory refinements are still necessary to improve clarity, support compliance, and ensure consistent application of the law while maintaining patient safety. To address remaining gaps identified through stakeholder engagement, the Board is proposing limited amendments that would: •Streamline and consolidate existing exempt settings into a clearer, more cohesive structure; Align training and competency requirements across all exempt settings; and •Add a limited number of additional home and community-based settings where similar patient care circumstances exist. These refinements are based on feedback the Board has received during implementation of recent legislation and ongoing stakeholder discussions. Some of the changes are intended to clarify or better align existing facility categories so the law is

applied consistently. Others reflect care settings where similar services are already being provided but were not previously included in statute.

[The changes currently in this bill] are intended to maintain the existing statutory structure while improving clarity, consistency, and compliance across settings where respiratory-related tasks are performed.

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

Ongoing Policy Discussion—Setting-Specific Exemptions for Respiratory Care Tasks. Existing law, via the RCB’s prior sunset review bill and subsequent regulations, limits the respiratory tasks that an LVN can perform to those identified by the RCB as “basic respiratory tasks” unless the LVN is working in home health setting or educational setting. The RCB regulations for home health were approved by the board for submission for rulemaking in November 2025.⁴

As noted by both the support and opposition, there is disagreement amongst stakeholders as to whether the list of settings in the bill is sufficiently comprehensive. The opposition also questions whether it is appropriate to limit LVN practice based on setting.

As discussed earlier, the RCB’s rationale for the current list is founded on a specific need and access gap identified in congregate, day center, and home health settings. In these settings, the RCB is weighing what it perceives as the risks of a scope expansion with the smaller training gap in settings with smaller patient populations, less turnover, and more homogenous acuity.

The opposition’s rationale is that it is paradoxical to authorize more services in settings with arguably less oversight. Another common mechanism for authorizing additional scope of practice are the creation of standardized procedures or facility protocols, both of which become more comprehensive in settings with greater levels of organization.

The opposition further argues that the acuity in some of the exempted settings can be higher than the acuity expected of the settings excluded. For example, the CPDH describes congregate living health facilities as providing “skilled nursing care on a recurring, intermittent, extended, or continuous basis. This care is generally less intense than that provided in general acute care hospitals but more intense than that provided in skilled nursing facilities.”⁵ In addition, congregate living health facilities can be quite large, reaching up to 59 beds when operated by a city and county.

Lastly, the opposition argues that this distinction between settings will make it confusing for employers who have both exempted and non-exempted settings. They have raised a concern

⁴ Respiratory Care Board of California, "Agenda Item 3: Consideration and Possible Action to Initiate a Rulemaking for the Proposed Regulation to Adopt California Code of Regulations, Title 16, Section 1399.361, Home and Community-Based Respiratory Tasks and Services," November 14, 2025, https://www.rcb.ca.gov/board_meetings/forms/nov25/3_1399.361.pdf.

⁵ California Department of Public Health, "Congregate Living Health Facility Initial Application Packet," last modified May 27, 2025, <https://www.cdph.ca.gov/Programs/CHCO/LCP/Pages/AppPacket/CLHF-Initial.aspx>.

where the LVNs may move between facilities and is limited in the services they can provide despite being qualified to provide the services

For purposes of this bill, the exempt settings model is existing law, and the changes are intended to reduce barriers identified by the RCB in that model. However, because there is still disagreement, the Committees continue to work with the RCB and stakeholders on this issue.

Ongoing Implementation Discussions:

- 1) *Implementation Date.* Two supporters of this bill have requested a delayed implementation date to comply with the new training requirements after January 1, 2028. However, it is currently unclear how to craft the exemption without authorizing an LVN to provide respiratory services without the required training.
- 2) *Basic Respiratory Tasks vs. Exempt Settings.* Currently the VN Act only authorizes LVNs to provide respiratory tasks identified by the RCB as basic. However, the intent of the exempt settings is to allow more than basic services in those settings.
- 3) *Overlapping LVN Functions vs. Non-Respiratory Care.* As alluded to in the opposition's letter, stakeholders have cited confusion and disruptions over varying interpretations of the RCB's regulations and the statutes established in the RCB's prior sunset review. One aspect of this confusion stems from the fact that basic services appear to be an exhaustive list of all respiratory and respiratory adjacent tasks. The opposition has noted anecdotal reports of CDPH inspectors telling facilities that if the task is not listed, it is not authorized, regardless of whether the task requires a respiratory assessment or is clearly authorized as basic pursuant to the RCB's subsequent guidance.

Sunset Recommendation: This bill updates the exempt settings that LVN's may perform respiratory care services, as specified, and requires LVN's complete patient-specific and task-specific training, and competency standards, as specified. The recommended amendment at the end of this analysis amends both practice acts to clarify the three categories of LVN respirator-related practices at issue in this bill: 1) those that do not fall within the practice of respiratory care, 2) basic respiratory tasks, and 3) those that will be identified for exempt home care settings. The details of this clarification and the other questions around settings are still being discussed.

- 3) *Issue #: Enforcement—Automatic Revocation.* The RCB is requesting authority similar to that of the Medical Board of California, which authorizes automatic license suspension upon felony conviction for specified offenses and automatic license revocation for licensees convicted of specified felony offenses involving sexual misconduct or serious violence. The RCB states this proposal balances protecting patients with an enforceable mechanism while maintaining due process for licensees through limited hearings on procedural issues.

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

RCB Response:

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

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

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

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

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

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

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

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

The Board respectfully requests that the Committees consider [the language currently in the bill].

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

Sunset Recommendation: This bill allows the RCB to automatically suspend and revoke licenses for certain felony convictions.

- 4) *Issue #10: Technical Changes.* The RC Act currently requires the National Board for Respiratory Care's (NBRC) Registered Respiratory Therapist (RRT) examinations, which include both the Therapist Multiple-Choice (TMC) Examination and the Clinical Stimulation Examination (CSE).

In January 2027, the NBRC plans to launch a redesigned examination with the goal of simplifying the process for entering respiratory care. This will merge the existing examinations and implement new clinical judgment testing components.

Sunset Recommendation: This bill updates the NBRC examinations title to reflect the consolidation of the examinations.

AMENDMENTS:

- 1) To address the second implementation concern raised on page 20 of this analysis and clarify that the basic services restriction applies to all settings except the exempt settings, which are intended to have separate regs that are not necessarily limited to basic functions, amend the bill as follows:

SECTION 1. *Section 2860 of the Business and Professions Code is amended to read:*

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), *the following apply:* **a**

(1) 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.

(2) Notwithstanding paragraph (1), a licensed vocational nurse may perform the respiratory tasks and services as authorized under paragraph (9) of subdivision (a) of Section 3765.

- 2) To partially address the third implementation concern raised on page 20 of this analysis regarding non-respiratory overlapping LVN functions, amend the bill to authorize suctioning as follows:

(c) In accordance with subdivision (a) of Section 2859, but notwithstanding any other law, the practice of vocational nursing includes the following:

(1) Oral suctioning performed within the oral cavity that does not enter the oropharynx or beyond.

(2) Nasal suctioning performed within the nasal cavity that does not enter the nasopharynx or beyond.

(3) Tracheostomy tube suctioning when the suctioning device remains within the tracheostomy tube and does not pass beyond the distal end of the tube.

(4) Removal and replacement of an external speaking valve for purposes of suctioning the tracheostomy tube.

3) To partially address the third implementation concern raised on page 20 of this analysis regarding non-respiratory overlapping LVN functions, amend the bill to exempt 1) clerical documentation and 2) tasks that are not specifically identified by the RCB and do not require respiratory assessment as follows:

SEC. [X]. *Section 3762 of the Business and Professions Code is amended to read:*

3762. *(a) Nothing in this chapter is intended to limit, preclude, or otherwise interfere with the practices of other licensed personnel in carrying out authorized and customary duties and functions.*

(b) For purposes of this chapter, the following are not considered the practice of respiratory care:

(1) Documenting observations and gathering and reporting data to another health care provider, without analysis, interpretation, or independent clinical decision-making.

(2) (A) Notwithstanding subdivision (c) of section 1399.365 of title 16 of the California Code of Regulations, a service or task requiring a license issued under this division if it does not involve either of the following:

(i) Any task or service defined as respiratory care pursuant to Sections 3702, 3702.5, or 3702.7, except as specified in subdivision (c) of Section 2860 or paragraph (1).

(ii) Any task requiring respiratory assessment at the time of the task.

(B) For purposes of this paragraph, "respiratory assessment" means conducting analysis to make recommendations concerning the respiratory management, diagnosis, treatment, or care of a patient or as a means to perform any task in regard to the respiratory care of a patient.

REGISTERED SUPPORT:

California Assisted Living Association
California Association of Medical Product Suppliers
California Society for Respiratory Care
Pediatric Day Health Care Coalition
Respiratory Care Board of California

REGISTERED OPPOSITION:

American Nurses Association/California (unless amended)
Association of California Healthcare Districts (unless amended)
California Association of Health Facilities (unless amended)
California Hospital Association (unless amended)
LeadingAge California (unless amended)
1 individual (unless amended)

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