BACKGROUND PAPER FOR
The Respiratory Care Board of California

Joint Sunset Review Oversight Hearing, March 24, 2026
Senate Committee on Business, Professions, and Economic Development
and Assembly Committee on Business and Professions

IDENTIFIED ISSUES, BACKGROUND AND RECOMMENDATIONS REGARDING THE RESPIRATORY CARE BOARD OF CALIFORNIA

BRIEF OVERVIEW OF THE RESPIRATORY CARE BOARD OF CALIFORNIA

History and Function of the California Respiratory Care Board

The enabling statute to license Respiratory Care Practitioners (RCPs) was signed into law in 1982, creating the Respiratory Care Examining Committee. In 1994, the name was changed to the Respiratory Care Board of California (RCB or Board).

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

The Respiratory Care Practice Act (Act) requires licensure for individuals performing respiratory care. According to the Board, to carry out its mandate, the Board reports that it takes the following steps:

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

RCPs are one of three licensed health care professionals who work at patients' bedsides, the other two being physicians and nurses. RCPs work under the direction of a medical director and specialize in evaluating and treating patients with breathing difficulties as a result of heart, lung, and other disorders, as well as providing diagnostic, educational, and rehabilitation services. RCPs are utilized in virtually all health care settings.

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. Common RCP patients include individuals suffering from:

- Asthma
- Bronchitis
- Heart attack
- Cystic fibrosis
- Emphysema
- Stroke
- Lung cancer
- Premature infants and infants with birth defects
- High-risk influenza/COVID-19

The Board's mandate is to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care (Business and Professions Code (BPC) § 3701). The Board is further mandated to ensure that protection of the public shall be the highest priority in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount (BPC, § 3710.1).

The Board's current mission statement is as follows:

> ***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.***

Board Membership and Committees

The Board is comprised of nine members, four RCPs, four public members and one physician and surgeon member. Two public members and one RCP are appointed by the Governor. One public member and two RCPs are appointed by the Speaker of the Assembly. One public member, one RCP and one physician are appointed by the Senate Committee on Rules. Board members receive $100-a-day per diem. All meetings are subject to the Bagley-Keene Open Meetings Act.

The current board members are as follows:

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

The Board currently has four standing committees. According to the Board, committees enhance efficacy, efficiency and allow for prompt attention to certain issues and Board functions. The following is a list of Board committees:

Executive Committee. The Executive Committee provides recommendations to the Board on pending legislation that may impact the Board's mandate and operations. The Executive Committee also provides guidance to administrative staff for the budgeting and organizational components of the Board and is responsible for directing the fulfillment of recommendations made by legislative oversight committees.

Enforcement Committee. The Enforcement Committee is responsible for developing and reviewing Board-adopted policies, positions and disciplinary guidelines. Members of the Enforcement Committee do not typically review individual enforcement cases but rather help develop the overarching policy of the Board's enforcement program.

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

Professional Qualifications Committee. The Professional Qualifications Committee reviews and develops regulations regarding educational and professional ethics course requirements for initial licensure and continuing education (CE) programs. Committee members monitor various education criteria and requirements for licensure, taking into consideration new developments in technology, managed care and current activity in the healthcare industry.

The Board maintains membership in the American Association for Respiratory Care (AARC), the Council on Licensure, Enforcement, and Regulation (CLEAR), and the Federation of Associations of Regulatory Boards (FARB). The membership provides the Board with valuable resources and best practices related to enforcement, licensure, examinations, and issues within the respiratory care profession. Membership does not confer voting privileges. RCP Board members are individual members of the AARC and its state affiliate, the California Society for Respiratory Care (CSRC). To stay abreast of national trends, emerging practices and developments within the profession, several board members also attend the AARC's Annual Conference and the CSRC's Annual conference and

regional meetings.

Fiscal, Fund and Fee Analysis

As a regulatory board within the DCA, the Board is entirely funded through regulatory fees and license renewal fees and does not receive funds from California's General Fund (GF).

The Board's FY 2025/26 projects budget authority of $ 4,190 million, with 6.1 months in budget reserve. The Board's fund condition is included below:

Fund Condition

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

DOLLARS IN THOUSANDS

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

According to the Board, enforcement activities account for 53.5 percent of expenditures, licensing and examination accounts for 14.2 percent of expenditures. Administration represents 16.4 percent of expenditures and DCA Pro Rata accounts for 15.9 percent of the Board's expenditures.

The DCA provides centralized administrative services to all boards, committees, commissions and bureaus which are funded through a pro rata calculation that appears to be based on the number of

authorized staff positions for an entity rather than actual number of employees. The Board paid DCA $600,000 in Pro Rata for FY 2024/25, an average of 15.9 percent of its expenditures compared to the 19.6 average reported during the FY 2020/21 sunset review.

Expenditures by Program Component

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

Dollars listed in thousands.

During its 2016 sunset review, the Board noted a growing concern of costs outside of their control such as pro rata and personnel costs. The RCB was forced to increase renewal and renewal-related fees to account for increased operating costs as identified below. Prior to these incremental increases, the RCB had not raised its renewal fee since 2002. The RCB has not raised any fees since the 2021-22 sunset review.

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

The Board also notes, although an immediate shortfall isn't forecasted, they are proactively considering raising the statutory renewal fee ceiling to provide a safeguard against unexpected financial expenses and help ensure the Board's long-term financial stability. Raising the Fee Ceiling Increase is discussed in Current Issues below.

Staffing Levels

The Board is currently authorized in the Governor's budget for 17.4 positions; the Board currently has 16 staff, 14 of whom were employed at the Board during its last review.

The Board has statutory authority to appoint its own Executive Officer (EO), who is tasked with performing duties as delegated by the Board. The Board's former EO, Stephanie Nunez, retired in late 2024. Following her retirement, Assistant Executive Director, Christine Molina, served as Interim Executive Officer beginning December 2024 and was formally appointed as Executive Officer in February 2025.

Over the last four FYs the Board has spent approximately $1,000 on staff training and education. Costs are associated with courses taken outside of DCA such as the Certified Professional Collector Program; a course the Board's staff probation monitors take to maintain certification in collecting specimens for drug testing. Staff have also participated in several other courses including but not limited to: Information Security Awareness Fundamentals, Workplace Violence Prevention Training, Sexual Harassment Prevention and Responsible AI for Public Professionals.

The Board staff also participated in job-shadowing at the University of California Davis Medical Center, allowing them to observe licensed RCPs in their clinical settings. This experience provided a practical perspective to the clinical responsibilities, scope of practice, and interdisciplinary collaboration that RCPs encounter in their daily work. According to the Board, staff gained meaningful insight into the complexities of the profession that will better inform future policy decisions, enhance licensing and enforcement standards and support regulatory efforts that align with both the profession and respiratory care consumers.

Licensing

The Board currently issues over 1,200 new licenses and renews over 10,000 licenses each year. As of June 30, 2025, the Board had 21,390 active licensees, 2,799 delinquent licensees, and 891 current but inactive licensees. Of these licensees, 1,536 live out of the state or country. An additional 1,474 licenses have been placed in retirement status as of June 30, 2025.

The Board's licensee population is outlined below:

Licensee Population

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

Licensing Data by Type								
	Application Type	Received (opened)	Approved	Closed *	Initial and Renewed Licenses Issued	Pending Apps at Close of FY	Cycle Times (in days)	
							Complete Apps	Incomplete Apps
FY 21/22	License/Exam	1,601	1,240	165	1,240	659	10	64
	Renewal	10,924	9,832	856	9,832	N/A	-	-
FY 22/23	License/Exam	1,695	1,347	148	1,347	636	16	66
	Renewal	10,901	10,031	768	10,031	N/A	-	-
FY 23/24	License/Exam	1,487	1,369	108	1,369	476	4	55
	Renewal	11,206	10,126	802	10,126	N/A	-	-
FY 24/25	License/Exam	1,464	1,232	108	1,232	538	1	41
	Renewal	11,397	10,295	1,034	10,295	N/A	-	-
* Closed includes initial license applications that are withdrawn, abandoned, and denied, and open renewal applications that update from delinquent to canceled.								

As of June 30, 2025, the average cycle time to process a complete application from date of receipt to date of licensure was eight days. The average cycle time for incomplete applications was 57 days.

As part of the application for licensure process, the Board requires the following documentation directly from the source:

- Department of Justice background check.
- Federal Bureau of Investigation background check.
- Official education transcript(s).
- Licensing examination verification
- Board-approved Law and Professional Ethics Course verification
- Out-of-state licensure history
- National Practitioner Databank (NPDB) query for applicants whose residence or education may be outside of California

All applicants have been fingerprinted to ascertain any criminal history. The Board also requires applicants who reveal they have been licensed out-of-state to have those states where licensure was held, submit a license verification directly to the Board's office, indicating if there is any history of disciplinary action.

Following the passage of AB 1972 in 2014 (Jones, Chapter 179, Statutes of 2014), the Board began using the advanced respiratory credentialing examination as its licensing examination on January 1, 2015. An applicant must successfully pass both the National Board for Respiratory Care's (NBRC) Therapist Multiple-Choice Examination and the Clinical Simulation Examination. The NBRC prepares and administers all examinations pursuant to a contractual agreement.

The Therapist Multiple-Choice Examination is designed to objectively measure essential knowledge,

skills, and abilities required of entry-level respiratory therapists. The Clinical Simulation Examination is designed to objectively measure essential knowledge, skills, and abilities required of advanced respiratory therapists.

The NBRC also offers voluntary credentials upon passage of each exam, the Certified Respiratory Therapist for passage of the Therapist Multiple-Choice Examination and the Registered Respiratory Therapist for passage of the Clinical Simulation Examination. While passage of the RRT examination is required for licensure, holding the actual credential is not, though the RRT credential is required for various reimbursements and is recognized by the medical community.

The NBRC exams are administered in English on a daily basis. Applicants may apply to take the examination online or via paper application. Upon verification of meeting entry requirements, applicants may schedule themselves to sit for either examination at one of 42 locations throughout California. Applicants are given three hours to complete the Therapist Multiple Choice Exam and four hours to complete the Clinical Simulation Exam (exceptions are made in accordance with the Americans with Disabilities Act). Once applicants have completed either examination, they are notified immediately of the results. Those results are then shared with the Board on a weekly basis. Applicants may take the exam up to three times. After the third attempt, applicants must wait 120 days to retake each failed examination.

From FY 2021-22 through FY 2024–25, the pass rates for first-time takers averaged approximately 79 percent for the written exam and 69 percent for the clinical exam.

The NBRC is sponsored by the American College of Chest Physicians, the AARC, the American Society of Anesthesiologists, and the American Thoracic Society. It is a voluntary health certifying board that was created in 1960 to evaluate the professional competence of respiratory therapists. Its executive office has been in the metropolitan Kansas City area since 1974. The NBRC is a member of the Institute for Credentialing Excellence, and both the Therapist Multiple Choice Exam and the Clinical Simulation Exam are accredited by the National Commission for Certifying Agencies.

According to the Board, in January 2027, the NBRC will launch a redesigned examination pathway with the goal of simplifying the process for individuals entering the respiratory care field, while retaining the profession's high standards. The redesign will merge existing examinations to accommodate recent graduates and broaden access. The updated examinations will combine clinical judgement testing within an expanded multiple-choice structure, providing a more comprehensive measure of knowledge, critical thinking and practical readiness.

There are 36 respiratory care education programs in California that are approved by the Board by virtue of their accreditation status. Each program must be accredited by the Committee on Accreditation for Respiratory Care (CoARC) as well as an accrediting body recognized by the US Department of Education. Twenty-seven of the 36 programs are accredited by WASC while the other 9 are accredited by other agencies recognized by the USDE and are approved by the Bureau for Private Postsecondary Education (BPPE). Pursuant to B&P §3740, the Board requires two components of education for licensure:

1) Completion of an education program for respiratory care that is accredited by the Committee on Accreditation for Respiratory Care and
2) Possession of a minimum of an associate degree from an institution or university accredited by a regional accreditation agency or association recognized by the United States Department of Education.

Most often, these components are one in the same, but in some instances, they may be distinct. A degree will be issued by a different institution usually when the respiratory care program was completed prior to 2001 (when education requirements were changed) or if the respiratory care education was received outside of California. Otherwise, 35 schools in California offer an associate degree in respiratory care with Loma Linda University only offering a bachelor's degree as entry into practice. Overall, the number of schools to offer a baccalaureate degree in respiratory care has increased to include eleven community colleges and one private school with six campuses statewide.

The Board notes that staff review each respiratory care program and school one to two times annually to verify the programs and schools continue to hold valid accreditation. In addition, the Board also confers with the BPPE to ensure private institutions continue to hold their approval. The Board reports that it posts annual exam pass/fail rates for all California programs on its website.

Continuing Education

In 2017, a Respiratory Care Workforce study was conducted, and the Board developed several goals in its Strategic Plan 2017-2021 to improve its CE program, and student clinical education outcomes. The workforce study revealed the need to improve clinical education and outcomes and exposed the anticipated gaps in management in the respiratory care field, unveiling the expected retirement of 35 percent of people in management, while amplifying the desire for leadership development among existing licensees to fill that void.

In response to the workforce study, the Board adopted regulations in 2023 that implemented significant changes to its CE requirements. Previously, licensees were required to complete two-thirds or 20 hours of the required 30-hour CE coursework directly related to clinical practice in any format. The revised framework now requires:

- A minimum of 10 hours in leadership,
- A minimum of 15 hours directly related to clinical practice,
- Up to five hours in courses or meetings indirectly related to the practice, and
- 15 of the 30 hours of required CE be obtained through live courses, including interactive online sessions or meetings that provide interactions in real time.

To address the shortfall outlined in the workforce study for qualified educators and to strengthen clinical education, the Board established a leadership CE category to prepare more licensees for supervisory roles and, to expand the pool of experienced preceptors, offer CE credits to licensees who complete preceptorship training.

RCPs are required every two years, to complete 30 hours of approved CE meeting the new framework. During every other renewal cycle, RCP's must also complete a Board approved Law and Professionals Ethics course which may be counted as three hours of leadership CE credit, as set forth in CCR §1399.350.

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

The Board reports in FY 2021-22 that CE audits were significantly impacted due to pandemic related waivers that temporarily hampered enforcement. The Board resumed audits on March 22, 2022, after the last waiver expired and now audits at least 5 percent of renewals each year.

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

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

Enforcement

The Board's enforcement program is charged with investigating complaints, issuing penalties and warnings and overseeing the administrative prosecution of licensed RCPs and unlicensed personnel violating the Act. The Board notes that its enforcement program is key to the Board's success in meeting its mandate and highest priority of consumer protection.

In 2010, the Board established performance targets for measures developed by DCA, as a result of the Consumer Protection Enforcement Initiative. The Board's overall goal for all cases to be completed, from the date the complaint is received to final adjudication, is 540 days (18 months). Since FY 2017-18, the Board has met this target goal. From FY 2021-22 to FY 2024-25 the Board averaged 444 days to complete the entire process, falling below the targeted completion goal.

In the prior 2022 sunset report, board staff noted that since the onset of the pandemic there was a decrease in arrest records received with an average of 434 convictions with only 380 received in FY 2020-21. During this sunset review period, the Board received an average of 377 convictions, with only 280 of those received in FY 2024-25. The Board reports that the continued reduction in convictions suggests the trend may be permanent.

Complaints are received from the public, generated internally by the Board or based on information the Board receives from various entities through mandatory reports, as outlined below. On average, the Board receives about 800 complaints per FY (55% of these complaints are a result of new criminal activity identified). The Board utilizes guidelines that are in line with DCA's Complaint Prioritization Guidelines which are intended to help staff determine the priority for handling complaints, The Board notes that special consideration is given to complaints involving a child, dependent adult or even an animal.

- "Urgent Complaints" are categorized as those in which the RCP has allegedly engaged in conduct that poses an *imminent* risk of serious harm to the public health, safety, and welfare and where the time that has lapsed since the act occurred may be weighted in the risk factor.

- "High Priority Complaints" are those in which the RCP has allegedly engaged in conduct that poses a risk of harm to the public health, safety, and welfare.

- "Routine Complaints" are strictly paper cases where no patient harm is alleged, expert or additional investigation is not anticipated and may require routine personnel or employment records but not medical records.

The Board received an average of 50 mandatory complaints over the last four FYs. The mandatory reports about licensees are in compliance with the following:

BPC § 3758. RCP employers must report any leave, resignation, suspension, termination or request to place on a "do not call" list for cause of any RCP related to the suspected or actual: use of controlled substances or alcohol to such an extent that it impairs the ability to safely practice respiratory care; the unlawful sale of controlled substances or other prescription items; patient neglect, physical harm to a patient, or sexual contact with a patient; falsification of medical records; gross incompetence or negligence; or theft from patients, other employees, or the employer. An employer is subject to a fine not to exceed $10,000 per violation for failure to report to the Board.

BPC § 3758.5. RCPs must report violations by other RCP licensees to the Board.

BPC § 3758.6. RCP employers must report the name, professional licensure type and number and title of the person supervising an RCP who has been suspended or terminated for cause. An employer is subject to a fine not to exceed $10,000 per violation for failure to report to the Board.

The Board's Cite and Fine program allows the Board to "penalize" licensees rather than pursue formal discipline for less serious offenses or offenses where probation or revocation are not appropriate. The Board amended its regulations in 2012, to increase most fine amounts to the maximum of $5,000 pursuant to BPC § 125.9 but also has authority to cite and fine other specific violations up to $15,000. To be eligible under the Board's cite and fine program, no patterned behavior may exist, and no child, dependent adult or animal may be neglected or involved in a crime as a victim or otherwise.

According to the Board, an average of 46 citations were issued annually between FY 2021-22 and 2024-25 with 71% of citations issued for driving under the influence of alcohol convictions (with no priors within seven years), 4% issued for CE violations and the remaining 25% issued for other less egregious criminal convictions such as perjury or unlicensed practice.

Current law authorizes the Board to request fee recovery from any licensee found guilty of violation of the licensing act to pay for the reasonable costs of the investigation and enforcement of their case. Cost recovery is a standard term and condition specified in the Board's disciplinary guidelines for all proposed decisions and stipulations.

In the last four FYs, the Board reports between 19 and 33 cases annually that had potential for cost recovery. The Board initially sought full cost recovery in all 102 of these cases. Ultimately, costs were ordered in all cases. The most common reasons the Board would not continue to pursue full cost recovery is either 1) evidence supporting *Zuckerman vs. Board of Chiropractic Examiners* which states a Board may not increase or impose costs on a person claiming they have a financial hardship and/or 2) the costs and time to non-adopt the decision do not outweigh the benefit (e.g., revocation) for those cases where the Board believes consumer protection is at imminent risk. The Board may non-adopt a case when the case is heard by an Administrative Law Judge (ALJ) and the Board disagrees with the ALJ decision. The board may non-adopt an ALJ decision to add terms and conditions of probation, lengthen or shorten the probation period, or increase cost recovery. If the board non-adopts an ALJ decision, it will immediately thereafter draft its own decision with any changes the Board finds appropriate.

There is no specific amount of cost recovery ordered for revocations, surrenders, and probationers, as each discipline case has its own amount of cost recovery ordered depending on the investigation and prosecution costs incurred. Most cost recovery is due within 12 months of the order's effective date. If cost recovery is determined to be unrecoverable, the Board uses the Franchise Tax Board's Offset intercept program to collect the amount due. Generally, there is not a problem recovering costs from licensees because cost recovery is a term of probation, and failure to pay could result in license revocation. A fiscal overview of the Board's cost recovery program is available below:

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

The Board collected 65 percent of the costs ordered during the last four FYs. The Board notes that it is most successful in collecting costs in those cases that result in probation or a public reprimand, because licensees are more vested in retaining licensure. According to the Board, in nearly all cases, in which formal discipline results in a surrendered license, the board will agree to forego cost recovery to expedite stipulated decisions and not accrue additional unrecoverable hearing costs. However, if the surrendered license holder petitions to reinstate their license, those costs must be paid in full before a petition for reinstatement will be considered. The most difficult cases from which to collect costs are those resulting in revocation. As noted by the Board, the average cost recovery ordered per case increased from $8,264 in FY 2021-22 to $16,105 in FY 2024-25. Payment is typically due within one year from the date ordered (although the Board reports that it is very flexible with payment schedules/extensions).

PRIOR SUNSET REVIEW: CHANGES AND IMPROVEMENTS

The Board was last reviewed by the Legislature through sunset review in 2021-22. During the previous sunset review, nine issues were raised. In January 2026, the Board submitted its required sunset report to the Senate Committee on Business, Professions, and Economic Development and Assembly Committee on Business and Professions (Committees). In this report, the Board described actions it has taken since its prior review to address the recommendations made. The following are some of the more important programmatic and operational changes, enhancements and other important policy decisions or regulatory changes made. For those which were not addressed, and which may still be of concern to the Committees, they are addressed and more fully discussed under "Current Sunset Review Issues."

- **Mandatory reporting requirements updated for RCP's.** During the last Sunset Review, the Committees determined there were gaps in the mandatory reporting requirements for RCPs that allowed practitioners to continue to work without discipline. In response to this concern, The was amended with the passage of SB 1436 (Roth, Chapter 634, Statues of 2022) to expand mandatory reporting requirements to ensure all violations are reported to the Board within 10 days, including but not limited to, any employment terminations, suspensions, administrative leaves, or resignations. The Board must also be notified if an RCP is placed on a do not call list by a facility, or if any confirmed or suspected incidents of substance abuse, patient harm or gross negligence are reported.

- **Auditing of new CE requirements.** To assess whether the newly implemented CE requirements are effective or how the CE requirements could be improved, in 2026, the Board will be administering a survey as part of the CE process to gather feedback from the licensees on their experience. Staff will also formally track how many licensees are pursuing preceptor activities to better gauge the effectiveness of this method and to determine if preceptorship is a necessary component of professional development.

- **Consolidation of RCP examinations.** Effective January 2027, the NBRC examination structure will change which will necessitate a technical revision to the exam title referenced in BPC§ 3739. The NBRC plans to redesign the credentialing process by consolidating the current examinations to reduce barriers for new graduates, enhance accessibility and create a holistic assessment of a candidate's knowledge, decision making and readiness for practice.

- **New Executive Officer appointed.** Assistant Executive Officer, Christine Molina was appointed as Executive Officer in February 2025, following the retirement of the Board's longtime Executive Officer Stephanie Nunez.

- **Additional regulatory legal counsel assigned to support the Board.** To facilitate the processing of regulation packages, DCA now has two regulatory legal counsels working under the new Regulation Unit within Legal Affairs. The Board reports that the regulatory process is significantly more efficient with the additional counsel exercising appropriate discretion while providing substantive legal review.

- **Option to email licensees now available.** Through the BreEZe licensing system, the Board has the ability to email targeted correspondence directly to licensees that have provided their email addresses enhancing communication related to regulatory developments and policy changes.

A copy of the Board's 2026 Sunset Review Report is available at
https://www.rcb.ca.gov/about_us/forms/sunset2026.pdf

CURRENT SUNSET REVIEW ISSUES

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

BOARD ADMINISTRATIVE AND BUDGET ISSUES

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

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

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

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

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

Staff Recommendation: ***The Board should inform the Committees on the necessity of increasing the renewal ceiling fee. The Board should update the Committees on whether it believes the reserve limit should be increased from six months to 24 months consistent with many other boards and bureaus***

under the DCA. The Committees may wish to amend the Act to ensure the Board is solvent and to allow the Board to eliminate burdensome fees by licensees and applicants.

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

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

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

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

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

In the 2026 Sunset Review report to the Legislature the Board notes that they annually verify that the NBRC continues to meet the requirements related to occupational analyses and ongoing item analyses outlined in BPC § 139. Over the last four fiscal years the Board has not incurred any direct examination expenditures.

BPC § 139(c) states, "Every regulatory board and bureau, as defined in Section 22, and every program and bureau administered by the department, the Osteopathic Medical Board of California, and the State Board of Chiropractic Examiners, shall submit to the director on or before December 1, 1999, and on or before December 1 of each subsequent year, *its method for ensuring that every licensing*

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

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

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

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

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

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

The Governor's Executive Order includes direction for various state entities, including, "Legal counsel for all State agencies, departments, and boards subject to my authority shall consider and periodically evaluate for any potential impact of GenAI on regulatory issues under the respective agency, department, or board's authority and recommend necessary updates, where appropriate, as a result of this evolving technology."

The Board reports it has not received any complaints involving telehealth practice. There are no legal restrictions against using technology in healthcare delivery, provided that the services are rendered by licensed professionals in California. The standard of care remains consistent, whether care is provided in-person or via telehealth. DCs are required to adhere to the same responsibilities and patient privacy

protections, regardless of the mode of interaction.

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

BOARD LICENSING AND WORKFORCE ISSUES

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

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

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

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

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

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

Currently, there are 35 Board-approved programs that award an associate's degree in respiratory care, nearly half of which are offered at private institutions. Since the Board's last Sunset Review, which reported three Board approved bachelor programs, there are now 11 community college campuses offering both an associate degree and a bachelor's degree in respiratory care. As one example, the Modesto Junior Community (MJC) college offers a two-year Associates of Science in Respiratory Care program designed to prepare students for entrance into the practice of Respiratory Care. Tuition costs are approximately $4,500 and include enrollment and materials fees, health clearance, uniforms, books, board exams, and licensure fees. Upon completion of the program graduates are eligible to take the National Board of Respiratory Care Therapist Multiple Choice Examination and the Clinical

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

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

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

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

The current minimum education requirement of an associate's degree for licensure for respiratory care therapists requires competency in the modes of respiratory care and proficiency in providing bedside care, patient assessments, and technical skills. As noted in the study, 67% of respiratory care education

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

Staff Recommendation: ***The Board should update the Committees on the status of the CoARC new standards on clinical training. The Board should update the Committees on any impacts or effectiveness from the revamped CE requirements on the quality of clinical education standards. The Board should advise the Committees of the impact to future licensees, applicants, the public, and reciprocity options if the Act is amended to require a bachelor's degree in order to become a part of the dynamic RCP profession. The Board should advise the Committees whether a bachelor's could be an option, rather than a requirement, in an individual's pursuit of livelihood as a practicing RCP.***

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

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

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

Currently, the Ohio State University Master of Respiratory Therapy (MRT) is the only CoARC accredited advanced practice clinical master's degree for respiratory care in the nation. The MRT full-time program is five semesters, and the total cost is approximately $28,463 including tuition, fees and living expenses. Applicants must have graduated from a CoARC approved institution, have a bachelor's degree in respiratory care, at least one year of work experience as a Registered Respiratory Therapist (RRT) and be licensed to practice in the state of Ohio. The APRT curriculum consists of 47 credit hours in a five-course semester, and students are required to complete 1,000 hours of supervised practice by a licensed physician in a clinical specialty. The advanced courses are applied in inpatient and outpatient settings and students may indicate their interest in a specific area of practice such as adult/critical emergent care, pediatric or neonatal critical care, pediatrics, primary respiratory care,

neuromuscular respiratory care and sleep disorders. The MRT program is designed to prepare APRTs as clinical specialists with an expanded scope of practice in a variety of settings. In 2021, the MRT program had its first graduating class of seven students and now currently has 14 APRT graduates working throughout the United States.

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

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

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

While access to care issues remain significant for millions of patients throughout the state, it would be helpful for the Committees to understand the practical impacts of this proposal and whether it may be premature, given that there is currently only one program in the nation that provides the type of additional education and curriculum that would be envisioned as necessary for advanced practice. It would be helpful for the Committees to learn about discussions with other healthcare providers, healthcare facilities, and payors about the opportunities that may exist for RCPs to take on additional practice authority. The creation of a new category of licensed or regulated professional is subject to Government Code provisions that require a plan and numerous data sets to better allow the Legislature to evaluate the impacts of a licensure proposal on members of the profession, the public, and government agencies. The profession and Board may wish to work with the Committees to develop a formal plan and respond to the Sunrise Questionnaire worksheet the Committees utilize.

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

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

Background: An interstate licensing compact represents a legally binding agreement between multiple states to facilitate cross-state practice for licensed professionals without requiring them to obtain full licensure in each participating state. To participate in such a compact, a state must adopt model statutory language provided by a compact organization. Typically, a practitioner must already hold a license in their home state before seeking authorization to practice in a compact member state. Compacts are often viewed as a means by which licensees can gain additional portability and practice in other states, reducing administrative burdens of becoming licensed in multiple states. Compacts have particularly been touted as beneficial to military spouses; however recently enacted federal legislation allows clearer portability for servicemembers and their spouses to be able to use their professional licenses and certificates issued in one state when they relocate to another state due to military orders.

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

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

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

BOARD ENFORCEMENT ISSUES

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

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

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

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

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

harm that the Board is made aware of via requirements to take enforcement action for unlicensed practice.

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

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

2. Nurse-to-patient ratios established years ago may have led to the evolution of the definition of "skilled nursing services" to include respiratory care tasks and services erroneously. Because RCPs providing respiratory care services are not counted toward this ratio, and there is no reimbursement for respiratory services in home and community-based settings and it is convenient for some providers to claim respiratory care is included in nursing services in order to meet the nurse-to-patient ratio in the most fiscally prudent manner. This interpretation has likely led to unauthorized health care providers like LVNs performing tasks they are not fully trained, educated or competency-tested to perform.

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

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

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

included in the equipment reimbursement and are not separately reimbursed. As a result, although RCPs may provide important home-based respiratory support, California's reimbursement framework does not clearly create a distinct payment pathway for those setup, education, and follow-up functions when they are tied to home respiratory equipment. For patients where family members are the sole health care providers and/or do not utilize a home health agency, RCPs employed at HMDR facilities serve as a key bridge between the patient and the doctor in addressing problems.

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

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

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

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

community-based settings. This data represents the facilities, programs and individuals specifically included in the statutory exemptions of BPC §§ 3765 (i) and (j).

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

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

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

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

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

does not rise to the level of requiring a clinical respiratory assessment. Nasal suctioning becomes a respiratory task when it enters the pharynx or airway therefore requiring a clinical respiratory assessment.

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

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

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

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

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

This framework was designed to ensure that any expansion of LVN performance of respiratory care is coupled with consistent training, supervision, and competency safeguards as required per statute. At

the November 2025, board meeting the regulatory language clarifying the scope of respiratory tasks that LVNs may perform in exempt settings was approved. The rulemaking process is anticipated to be completed by January 2027. The 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.

In addition to health-related settings, school nurses and school districts have also sought clarification to ensure that the longstanding practice of students who rely on the support services of a LVN while they are at school continue. Last year, SB 389 (Ochoa-Bogh, Chapter 582, Statutes of 2025) clarified the limited circumstances under which a LVN can perform specified basic respiratory tasks and services like suctioning for a student in a school under the supervision of a credentialed school nurse. Now, the Education Code (§49423.5) specifically allows students with exceptional needs who require specialized physical health care services during the regular school day to be assisted, for basic respiratory services, by a LVN under the supervision of a credentialed school nurse. Specialized physical health care services include catheterization, gastric tube feeding, suctioning, or other services that require medically related training.

One school district has weighed in requesting to statutorily authorize other non-LVN school personnel to be able to provide the basic respiratory services and tasks that LVNs can provide under school nurse supervision, however it is unclear how patients and the public would be protected by this new authority. Currently, qualified designated school personnel are not authorized to provide services beyond those that are routine for the student, services that pose little potential harm for the student, services that are performed with predictable outcomes as defined in the individualized education program of the student, and services that do not require a nursing assessment, interpretation, or decision making by the designated school personnel. (Education Code §49423.5)

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

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

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

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

According to the Board, the current process of pursuing disciplinary action against RCPs requires case

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

The Board reports that their overall goal for all cases to be completed from the date the complaint is filed to final adjudication is 540 days or 18 months. In FY 2021-22 through FY 2024-25, the Board notes the adjudication process for cases was completed in an average of 444 days well under its target processing goals. The only exception is for cases that are referred to the OAG and are out of the Board's control. The Board acknowledges that the OAG has made significant progress in reducing processing times and is largely responsible for the marked improvements enabling the Board to largely meet its target goals over the last four years. As noted in the Board's 2026 Sunset Review report, 76% of cases in which formal discipline of a license or denial of an application pursued through the OAG were closed in one year.

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

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

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

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

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

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

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

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

TECHNICAL CHANGES

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

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

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

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

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

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

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