ADVISORY COUNCIL ON RADIATION PROTECTION

Bureau of Radiation Control

Hilton Garden Inn Tampa Airport Westshore

Tampa, Florida

09/26/2017

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CERTIFIED TRANSCRIPT

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Hilton Garden Inn

Tampa Airport Westshore

Tampa, Florida

Tuesday, September 26, 2017

10 a.m. - 2:19 p.m

Reported by

Rita G. Meyer, RDR, CRR, CRC
Realtime Reporter and Notary Public
State of Florida at Large

ADVISORY COUNCIL MEMBERS PRESENT:

Randy Schenkman, M.D., Retired (Chairman)

Mark S. Seddon, M.P., DABR, DABMP (Vice-Chairman)

Alberto Tineo, CNMT

Adam Weaver

Chantel Corbett, AS, CNMT, RT(N), RSO

Kathleen Drotar, Ph.D., M.Ed., R.T. (R)(N)(T)

Christine Crane-Amores, RRA, RTCR

Brian Kent Birky, Ph.D.

William (Bill) W. Atherton, DC, DACBR, CCSP

Mark Wroblewski

Matthew Walser, PA-C, ATC

Efstratios D. Lagoutaris, DPM

DEPARTMENT OF HEALTH STAFF

Cynthia L. Becker, Bureau of Radiation Control

James Futch, Bureau of Radiation Control

Brenda Andrews, Bureau of Radiation Control

Douglass Cooke, Bureau of Radiation Control

Lynne Andresen, Bureau of Radiation Control

Lisa Gavathas, Bureau of Radiation Control

Sophie Aromoso, Bureau of Radiation Control

Also Present: Keith Nadaskay (Mayor of Wachula)

AGENDA

MORNING SESSION

AFTERNOON SESSION

RANDY SCHENKMAN, CHAIRPERSON: Good morning, everybody. I hope everybody -- everyone and their families did well during this last storm.

It's a little after ten. I was going to see if we should wait for Kathy, but we decided we're going to get started.

So as we usually do, we always introduce ourselves. I'll start by introducing myself.

My name is Dr. Randy Schenkman. I am a retired radiologist. And the hospital I worked at, I started the women's imaging and breast imaging. And even though I'm retired, I still try to stay up with most things.

And now I'm going to turn it over to Brenda.

BRENDA ANDREWS: Good morning, everybody. Thank you for getting here on time and safely.

And the first person I'm going to introduce is one of our new members of the Bureau, and it is Douglass Cooke. Some of you met him last night. Douglass was hired with the Bureau as the business consultant, which is the position that I was in before. He has over seven years of experience utilizing accounting, analytical problem solving techniques, systems development and data analysis skills.

He also has a background in staff training, developing operating policies and procedures and quality customer service. And Douglass will also serve as my back up for the council so you will get to know him a whole lot better during our meetings and in the planning process.

So that's Douglass. And then Cindy is also going to introduce our other new members.

CYNTHIA BECKER: Lisa.

LISA GAVATHAS: Lisa Gavathas.

CYNTHIA BECKER: She has many, many years of experience, but interestingly enough, I first met her in the Mississippi Department of Radiation. So she started there and she came with us and was working in the Fort Lauderdale area. So those of you from that area might remember her doing inspections down there. And we're lucky enough a few months ago she transferred up to Tallahassee and is now in the mammography coordinator position.

So if you remember Dan Okey who was in there for years and years. Lynn was in there for a time until she transferred. And now we have Lisa Gavathas in there and so she brings many years of experience in inspection and also licensing from old days in Mississippi.

LISA GAVATHAS: I'm doing shielding as well.
CYNTHIA BECKER: Oh, shielding as well.
JAMES FUTCH: You left something out.
CYNTHIA BECKER: I did.
JAMES FUTCH: We'll fix that. Would you like more? We can give you more. There's no more money.
LISA GAVATHAS: Interim medical advance as well, but we're hoping to pass that one.
CYNTHIA BECKER: Yes.
LYNN ANDRESEN: Oh, Lynn Andresen. I work for James Futch in the radiologic technology program. I specifically deal with enforcement issues of technologists.
BRIAN BIRKY: I'm Brian Birky. I'm Executive Director for the Florida Industrial Phosphate Research Institute. And we are an institute within Florida Polytechnic University, Florida's newest public university. Twelfth university. And been there since 2000 and executive director the last six years.
CHANTEL CORBETT: Chantel Corbett. Nuclear medicine technologist, Fusion Physics, a medical physic consulting company. I'm also the TAG representative for the Society of Nuclear Medicine for the State of Florida and part of the FMT Council

for the State of Florida.

MATTHEW WALSER: Matt Walser, Gainesville, Florida. UF Health PA in orthopedics. I am currently on this board as a person that doesn't know anything about anything. Radiology. But I teach radiology for PT school up at UF and have been up there for about 11 years.

STRATIS LAGOUTARIS: Stratis Lagoutaris from Jacksonville, Florida. I'm a private practice podiatrist.

ALBERT TINEO: Albert Tineo, Halifax Health, Daytona Beach. I'm one of the administrators at Halifax.

KEITH NADASKAY: I'm Keith Nadaskay. I work for Mosaic. I, too, don't know anything. I just came to kind of listen and you guys probably already know this, but Brenda has a fantastic memory.

BRENDA ANDREWS: I'm so glad you said that today.

BILL ATHERTON: Bill Atherton. I'm a chiropractic radiologist in private practice in Miami, Florida.

CHRISTINE CRANE-AMORES: My name is Christine Crane-Amores. I'm a radiologist assistant up in Tallahassee. I work for Radiology Associates of

Tallahassee and I've been in that position for the last four years.

MARK WROBLEWSKI: Mark Wroblewski. I'm an basic machine operator and also office manager of a couple offices Tampa, Florida.

KATHY DROTAR: Hi, I'm Kathy Drotar. I'm the radiologist technologist therapy member and I am a university department chair for radiologic technology at Keiser University.

ADAM WEAVER: Adam Weaver, I'm the radiation safety laser safety officer University of South Florida. Primarily in Tampa.

SOPHIE AROMOSO: I'm Sophie Aromoso. I'm the regulatory supervisor for this profession as well as EMTs and paramedics. I've been with the department about three years. I've worked with massage therapy in investigations and consumer services and acupuncture council, so I've been around for a while. I'm excited to join you guys and be here today. I didn't get to come last time.

MARK SEDDON: Mark Seddon. I'm the chief physicist and emergency safety officer for Florida Hospital System, which is pretty big. I've been there about twenty years. I represent the medical physicists on this council.

RANDY SCHENKMAN, CHAIRPERSON: I've introduced myself. It's up to you.

JAMES FUTCH: I wasn't ready. It was the person in front of me.

James Futch, health physicist for the Florida of Bureau of Radiation Control responsible for RAD tech certification. Sophie, preventive radiological, nuclear power, all sorts of stuff. But that's me, so --

CYNTHIA BECKER: Truly is everything.

JAMES FUTCH: Yeah.

CYNTHIA BECKER: I'm Cynthia Becker, Bureau Chief, Bureau of Radiation Control. We kind of skipped around. Been there for a number of years working with James and with others. So welcome everybody. All right.

RANDY SCHENKMAN, CHAIRPERSON: Brenda, you've got to do it, too.

BRENDA ANDREWS: I am Brenda Andrews and I've been with the Bureau since 2012. And I had the fortunate opportunity to move up into the management review specialist position. I report to Cindy and I'm loving that. And so, I mainly do problematic operations in overall kinds of things for the Bureau. HR, budget, and those kinds of things.

RANDY SCHENKMAN, CHAIRPERSON: Well, welcome everybody. I guess the next thing in line is we need to approve the minutes from the last meeting. Is there a motion to approve?

KATHY DROTAR: I make a motion to approve the minutes.

RANDY SCHENKMAN: Anybody second?

ALBERT TINEO: Second.

RANDY SCHENKMAN, CHAIRPERSON: Everybody in favor say aye.

ALL MEMBERS: Aye.

RANDY SCHENKMAN, CHAIRPERSON: Anybody opposed?

(No Response)

RANDY SCHENKMAN, CHAIRPERSON: Okay. So we have done that.

And now Sophie, your turn.

SOPHIE AMOROSO: I know Bianca had previously and given an update on the amount of active licenses we had, our processing timelines and we had some issues we were working on with IT. So we have some things that have been completed for IT. We have some outstanding items, though, but I have an update from them that we received this morning on the outstanding items.

So our open applications. The previous number

Bianca had given the past presentation was 809. We currently only have 592 open applications.

The previous number for the assistants was seven. We currently have three.

Now these, I only did the data from the past meeting where she stopped collecting data to September 1st.

The number of clear and active licenses, previously we had 27,191. We have increased that.

Our radiologic assistants actually stayed the same since last May.

Average processing times 1.49, radiologic technology. So this is the number of business days it took to issue a license and that's after we deem them qualified. So once they send in all their documents, once their application is complete, they may not have tested yet, but their application is complete. That's when they're deemed qualified to take their exam.

If they've already taken their exam, then it gets done a lot more -- a lot quicker, but at this time, it's from -- that time frame is just when we approve them to take their test. It's not from the time frame where they've taken it and they're waiting to be licensed from that.

Okay. So these are the issues that we have experienced. All the licenses that have expiration dates over 24 months, those have all been corrected. The temporary licenses for nuclear med tech applicants, those have been corrected as well. So the transaction on the online system wasn't allowing them to go through. It's now corrected.

The expiration dates, where they had all been given the August 2016 date, when they were given the incorrect date to begin with, those have all been corrected as well.

The initial licensure date of 1801, so we have quite a few that show up that way. And I have an e-mail from IT that we've got an update from that this morning, so they have approved the change that we requested to change all these license statuses back, but they would also like to look through all of our data to make sure we don't have any false data.

So he says that the next, the realistic date this would be completed is October 5th. And I'm sure James and I will check back with them consistently to see if that's been done or not.

JAMES FUTCH: Kathy just doesn't want anybody to think she got her license in 1801.

KATHY DROTAR: No, I don't.

RANDY SCHENKMAN, CHAIRPERSON: Come on.

KATHY DROTAR: I've been around for a long time, but that's a little further than, little further back.

JAMES FUTCH: Steven's e-mail said there were a number of other false dates that were showing up in various peoples' data that was online. So 1801, 1901.

CHANTEL CORBETT: Mine's been 1901 since I started. I'm right there with you.

JAMES FUTCH: Just in case anybody worries about it, we have this online display that says, we're primary source verified, so you can really trust that anything you see online really is true. So they hopped right on fixing this one.

So any time any of the computer databases that we use has a null date or no date at all, between the in-house system and the system that displays on the website, when it saw the empty field, it just made up what a computer thinks of is like the oldest possible date for that system. So it will go to 1-1-1801, 1-1-1901. Probably even go to 1-1-2001 at some point. Everybody realizes that's only 16 years ago.

KATHY DROTAR: That only showed up when you went online to look for the licenses. It wasn't on the one that was, that everybody hangs on the wall.

JAMES FUTCH: That's good.

KATHY DROTAR: That's a good thing.

SOPHIE AROMOSO: These are things we're just working on right now. I have submitted a ticket, because our ticketing system, that's how IT works with us and fixes our issues. There was a lot of not getting responses from us for applicants for a lot of people. We currently have three RS1s who are processors. So we have one RS2, she works with all our exam modules and does all of our criminal history; all the reviews with James. So I've spoken with them about making sure they send out a notification. No matter what, you get a document, you say thank you, I've received this document, and they send out the e-mail.

Now, for a licensure letter, they had no way of knowing until the next day or unless we called them because there's no letter that generated. A few years ago, there used to be. So I put in this ticket to create a global licensure letter. It's actually going to be used for all professions. It's going to have the profession name, the date you were

issued, your license type, all that information and they're going to see if they can make it automatically run so we don't have to go through the steps. That's quite a few steps in an application to go through all these things just to print a letter to approve you. It's going to automatically do that.

So we're currently working on those and everybody has been getting licensure letters since May. They should be getting an e-mail. If an e-mail is on file, they get an e-mail sent to them saying, congratulations, this is your license number, and they can use that to verify with whomever they need to.

And I also very well need to send an e-mail from myself if you have any students or anybody that's having issues with that.

VO uploads that is on --

JAMES FUTCH: What's VO?

SOPHIE AROMOSO: The online system.

JAMES FUTCH: Okay.

SOPHIE AROMOSO: So that is our online system where you apply online. After you apply, you can also upload your documents. And I talked with IT about this because they don't receive a notification

that anything has been uploaded. So after quite some time with this, they're still working on it and there are still some roadblocks. They're going to enhance the system, the entire online portal so they will get responses back from those. Unfortunately, the only way they can know if we received it is if they see it in an attachment on their profile or if they call us to ask.

CHANTEL CORBETT: So on that, if somebody is either applying for renewal or something and they're uploading a document, do they, at this point, need to call in?

SOPHIE AROMOSO: I wouldn't request them to call in. We have a --

CHANTEL CORBETT: I know that's a lot to you guys, too.

SOPHIE AROMOSO: We have a report that we run that's a VO uploads report. We run that daily. We can -- we see all the items that they've uploaded and we --

CHANTEL CORBETT: Okay.

SOPHIE AROMOSO: -- we issue the deficiency letter if they needed any other document. So they're aware it has been uploaded. I think that that has been in -- that was something that we

increased our time on. I'm going to be able to check that every single person daily because right now, I have one person checking all of those documents.

Helpful tips. Make sure students provide Social Security number in their applications. On the online system, it does not require you. There's a little star there, but it's not a requirement. That's false. But when they apply and they don't have their Social, we can't approve them to take the test because ARRT won't allow us. And also, I get a lot of calls from people stating that they can't schedule with ARRT and everything has actually been completed on our side, but they just haven't paid ARRT.

So there's a little bit of confusion. I plan on updating our website just to make it a lot easier for you to follow the steps.

KATHY DROTAR: I just have a question on that, too, since we encountered that. Hi. If their number is -- because our students don't take -- they don't schedule their tests through ARRT -- or through DOH. They already have done it through ARRT. But that same, same Social Security number block was there.

SOPHIE AROMOSO: We have to have it on their application.

KATHY DROTAR: Otherwise, we need to send you the copy of the card.

SOPHIE AROMOSO: Yes, ma'am. Also, the name they provide on the application -- this is a big deal that we've had. Someone will include a middle name. They will include a married name. But it's not the same as what's on their license. And then when they go to test or to register, they won't allow them to. So we have to make those necessary changes. We have to get those documents showing why your name is changed, all that information, before we can send them back to ARRT. So that's a delay in the exam process for them.

This is just the reminder of the renewal functions. They have been sent down to licensure services. And you saw this in the previous PowerPoint that you saw. Any calls, they're sent downstairs. If we have anything in our, our ZZ box, that's our main box that all of these go to if you go to the Rad Tech e-mail. All of those, if they're referring to renewals, we just automatically send them a response and send them down to licensure so they're aware we do not handle this, but they are in

the correct place.

Also, continuing education for their renewal. And there is the information where they can reach licensure services at.

Now, we have a new program operations administrator. Her name is Irene Lake. She's been with the Department about fifteen years. She's working in prosecution services. She is wonderful.

Erica White is our executive director, which is our unit manager. She's wonderful as well.

And that is it. Can I answer any questions?

RANDY SCHENKMAN, CHAIRPERSON: Anybody have questions?

KATHY DROTAR: I'm sorry. I just wanted to thank Sophie for all the support and help she's given to our various programs because she's helped us iron out a lot of difficulties and helping our graduates get their licenses, so thank you.

SOPHIE AROMOSO: Thank you.

JAMES FUTCH: I wanted to follow up on a couple of things that Sophie had mentioned.

Sophie, by the way, is, for those who have been on the council for a number of years, remember Gail Curry? Sophie is in the job that Gail was, Gail was in many years ago. Gail is working in a different

part of MqA and we talk frequently; compare notes. Especially on common problems on some of the things that happened to the different professions.

But I also wanted to thank Sophie very much for kind of shepherding all this and bringing it to us and giving us a nice update.

Miss Bianca, who was here last time, Irene Lake that Sophie mentioned, is, is taking Bianca's position. Bianca has left the Department. Happy doing something else, I hear.

SOPHIE AROMOSO: Yes.

JAMES FUTCH: And I also wanted to continue everybody to tell us when you see things that are wrong, especially with the computer systems -- that seems to be the nexus of a lot of potential good and a lot of things that have need to be fixed over the years.

The 1801, basically, was something that Kathy had noticed. The VO upload and not receiving notice afterward is something Alberto had brought up, I think at the last meeting. So thank you very much and continuing sending that, sending that in to us.

Along the lines of the problems we had talked about last time that Sophie very nicely followed up on, I think covered just about everything I could

think of. We're also working on a complete examination of the Versa online system to make sure it comports with what the paper application requires and what the regulation requires. And that's taken a lot longer, because there are lots of nooks and crannies and all of those online applications where if you had yes this time instead of no, you skip an entire screen that you don't see. And then you have to go try and find what would happen if you answered it this way. Is it doing the right thing.

SOPHIE AROMOSO: There's one gentleman in charge of doing every single profession. Every single one.

JAMES FUTCH: Yes, we need to clone him. But -- so the, so the things like the Social Security number required, that was one of the things that we've got in the mix to, to actually make it do what this -- what the rule and the statute and everything else says, which is, yes, require it on the online and don't allow people to, to not put it in. And in the circular feedback report, Sophie's folks have to go back out and get it from them.

And also, the way the system orders the whole file attachment and the conviction history documents and the background history, excuse me, the disciplinary history documents, we're trying to

reorder that and, and apply some language changes so it flows better -- and a bunch of other stuff that I won't bring up -- but all of that is in the works. And hopefully by the next council meeting, it will be implemented and online. We'll see.

RANDY SCHENKMAN, CHAIRPERSON: Well, it looks like it's a dramatic change from the last meeting as far as time it takes to process the applications and everything else, so congratulations.

SOPHIE AROMOSO: Thank you.

MARK WROBLEWSKI: Quick question. We noticed that a lot of these smaller schools, latest being Ultimate Medical Academy, have dropped their BMO programs. Is there a list of schools in the area that still have a BMO program? We've done a lot with them. That's why I --

JAMES FUTCH: We actually, for the BMOs, it's different from all the other professions.

MARK WROBLEWSKI: Sure.

JAMES FUTCH: Because the way the BMO statute is structured, it doesn't require someone to attend the formal education program as we would think of it.

MARK WROBLEWSKI: I understand.

JAMES FUTCH: Over the years, since I've been with the Department, this function of the Department

since '98, because -- this is my theory -- because of that fact, the number of BMO programs has, has been shrinking. There used to be a lot more of them at, at, you know, places like community college; things of that nature.

So what we do now for the, for the best list is we go to the Department of Education and there are still several, I don't know the exact number, but it's, you know, probably less than ten, almost all of which, if I recall, are private, private entities.

And then there are a number of medical assisting programs that include a pretty hefty BMO component. Kathy may know more about some of those. And that's what, that's what comprises the best list that we know about, which is basically the Department of Education asked for anybody in the, in the basic category.

MARK WROBLEWSKI: Thank you.

JAMES FUTCH: Sure. That's by statute. That's not our, you know, the Department implements what's in the statute. It's not necessarily what we would, you know --

MARK WROBLEWSKI: No, I understand. I thought maybe we had -- if you guys had a list.

SOPHIE AROMOSO: I'm going to look them up right now. If I can find a list, I'll send it to you.

MARK WROBLEWSKI: Sure. Thank you.

RANDY SCHENKMAN, CHAIRPERSON: Any other questions? Adam?

ADAM WEAVER: Will this work for me, too?

JAMES FUTCH: Let me pull it up, Adam. Hold on.

ADAM WEAVER: Okay. I just was asked to give a quick overview, what we do at University of South Florida in regard to --

JAMES FUTCH: When Adam says he was asked, he was very gracious in providing this talk this morning. And thank you very much.

ADAM WEAVER: Sure. Well, we have radioactive material, which I'll discuss; x-ray machines and we have some lasers.

You know, we have a radiation safety program to comply with the Florida Statute; administrative codes. We basically have two main radioactive material licenses, 806-1 is our broad scope academic license. I don't actually know how many are within the state, but Cindy may cover that later on how many broad scope academic.

But basically, what that allows us to do, we have a radiation safety committee that meets and

when someone wants to use radioactive material in his or her research, non-human research, they have an application they fill out, the committee reviews it, either approve it or we go back. And if they have questions for what radioactive material they need to use for their research.

The committee is made up of other faculty members that are experienced using radioactive material in their research, so it's a peer review. And we also have an administrative, typical on most radiation safety committees.

We also have another license for gamma research radiators, which are used for cell, mostly cell studies. And we also -- I'm also associated, which Chantel knows the Byrd, PET CT license, because they do a lot of research there.

I didn't know it did the fading. Cool.

So basically, I already summarized that. So whenever a new researcher comes to University of South Florida, he or she may be coming from up north or another university, so we run things a little bit different. So we just go over -- the application's only three pages long. We help them fill it out. So we're very user friendly to try to, you know, if they need to use it and it's an appropriate use,

then we work with them to get them to use the radioactive material safely.

And I'm not going to read through all this, but basically, the office is, myself, a health physicist, and one radiation safety technician. We have about 50 approved principal investigators. Maybe half of them use it during the year. So some of them get a permit because some of the grants that they go after require them to have radioactive material approvals to use it. They may never plan to use it, but some grants, like NIH grants or something like that, may require them to have the capability of using radioactive material. So a lot of people have it for those reasons. Not necessarily they are planning to use it in their research.

But we do all this -- the operations for the researchers is centralized. We order the material. We receive it; we bring it to them; set it up. We give them all the materials to use it safely.

We do a lot of surveys. We have a couple -- quite a number of x-ray machines. That's why the state likes to come to our x-ray inspections. I think right now we have 25. All non-human use. Most of them are analytical.

Does this have a little laser? I see it.

This is a typical analytical machine. The actual beam size is, is like microns. But it's a very intense beam. This, this is a typical one for cell radiation. This one could be used for small animals or for doing localized x-rays.

And this is actually a small, a small animal CT that also has a PET component to it and a SPECT component to it. So we can do the full set up for doing imaging.

So we still have some fraction units, cavity units; things like that.

If you have any questions or anything, feel free to ask.

These are the common radioactive materials, just based on their toxicity, of what we're using at the university. We use, you know, the cesium is in the gamma radiators. We don't use it as an unsealed source. We use very small amounts of iodine.

When I first got to the university about 17 years ago, a lot of people were doing their ionizations, which used maybe five to ten millicurie amounts to get a product of maybe 200 to 300 microcuries out of it. But now all that's done by the great -- the big manufacturers, the Perk and

Elmers, American Radio Chemical, big companies like that. No one does ionizations anymore at university level that I'm aware of.

We do a lot of the medium to low Phosphorus-32 is very common. Carbon-14. Chromium-51. Some of the other ones, exotics, some people use them. We have a lot of researchers using Tritium in the biomedical research, various studies.

One of the new ones that we're using, I'll talk more about later, is Actinium-225. And actually, there's someone -- there's a component out of, I think Sloan Kettering up in New York with a company called Actinium Radio Pharmacy or Pharmaceuticals. I don't know if you guys have got it, but there's a phase three of a drug that's out there now being used. It gives quite good results for a -- I think theirs is for leukemia. We're looking at another end of it. These are based -- the rankings are just based on relative toxicity.

I'm not going to spend a lot of this, but if you've ever worked with Carbon-14, you know it has a very long half-life. It's going to be around for a long time. We do use a lot of tritium because that's very common and acts just like the regular hydrogen, so you can use it in various things. Very

low energies.

S-35, it's kind of expensive to use, but some people do use it.

Again, the P-32, these are the shorter half-life materials. We're allowed to hold anything per regulation for decay and storage of less than 120 days half-life.

Iodine-125, usually when people use that, they use it in what's called RIA kits now. Very small quantities, five to ten microcuries. Very, very small amounts. Usually we don't need a lot of shielding working with that material now.

Chromium, we have a couple researchers that use this pretty regularly. It's used for a couple different assays and it does require a little bit of shielding. It does have primarily a gamma emitter, but again, not, not high energy.

These are kind of the things that Moffitt, we help out with Moffitt's non-human research and one of their big groups is the sale imaging for small animal imaging.

Positron, I'm sure most everybody knows what that is. Here, we do a little SPECT isotope again. We had that one machine that can do, usually, you know, you run the CT on the, on the animal and then

you can do either do a SPECT imaging or PET imaging depending on what isotope you're checking into.

This is a relatively new. We've been doing it for about two years. Actinium-225. It's another alpha emitter. We haven't started using it yet, but it's used in some hospitals for pain management. You've probably heard of that.

Radium-223. So that's pretty much established. But we have a couple researchers looking at it from another end, maybe for some other possible therapy.

But Actinium is used as a therapy, an alpha emitter, therapy drug. It's very -- it works great. I can't show any pictures, but we have -- we've taken pictures where the animal has a tumor, and after the treatment, the tumor is essentially gone. So right now, they're working on a type of skin cancer that's very -- that spreads very rapidly.

So we get the, we get the, actually the material comes from Oakridge. It's from the -- it's kind of a waste product of Uranium-233, which is produced in the reactor in Pittsburgh a long time ago, in some of the DOE reactors. It comes out as a nitrate, but we, we work with another university who converts it into a liquid. They basically add a chelator to it and they add a peptide to it, various

peptides, to try to get the drug go where we want it to go in the body or in the animal. So that's where it's, it's made up in Oakridge.

This is how we get it as the Actinium drug and you can see there's, there's, I believe, five alphas for decay and they're very high energy, alphas. After the ten days, it's very rapid. Very short half lives. So if you get an alpha to the tumor, in the area of the tumor, that's a lot of energy that can potentially kill the tumor. And so far, we're seeing it -- we're still, you know, there's still a lot of work, very early work, but Actinium seems to be -- and other universities are using it. And again, I believe there's one, one or two drugs in phase three trial.

MARK SEDDON: I got a proposal last week.

ADAM WEAVER: Yeah, they are trying to get into Florida.

So we started using this again in an area that we initially set up to do PET and SPECT imaging and we didn't need all that shielding for Actinium. There's not a lot of -- there's some gammas associated with it, but they're very low yields and no where near the PET isotope energies or the SPECT with like Tech or Valium.

But the big concern when you're working with Actinium is annual limit of intake. You don't want to get it into your body. I've worked with alpha emitters before, so we're very careful with it. We use it in very small quantities. We usually get it in maybe, maybe we get 500 microcuries from our other university that we're working with.

As you can tell, it's much lower, much more controlled, just comparing the annual limit of intakes, for injection, oral inhalation, you can see Actinium is a tiny amount to get into you, to get to your annual limit of intake.

So it's just a common comparison. These are what we typically work with, very high, you know, very easy to work with, but we had to put a lot more controls when we're working with Actinium. Because we're -- we basically get it as a, in little tiny vials, and we have to put it in syringes, so it's a lot of work. You've got to be careful when you're handling syringes with this material.

So some of the control measures that we put in place. Specific training. We have a crew of maybe five, six people that work with us. We do a lot, helping out a lot of work. We do use L shields; some engineering controls, not necessarily for

shielding purposes, but primarily to make sure if there's everything -- but you're injecting it into live animals. We can get a splash or mishap with a syringe. So everyone's, you know, we go through the training, we review the training every time we use it. We do it about quarterly. That's typical what we're working with.

We do a lot of bench coating. We cover the whole area. It's kind of like the old, if you do iodine therapy, you remember all the covering all the surfaces in the bathrooms and whatnot. We do the same thing when we're working with Actinium because it, like most alpha emitters, it will travel around. So you want to make sure it's on absorbent material quickly and at the source when you're working or near the source.

We always cover all our carts. And we dedicate pipets, tweezers and syringes for this work. We don't -- they're segregated. We hold them for decay most of the time. We don't use them for other projects.

We always wear double gloves. We find that a very thick glove and then a thinner nitro gloves on the outside. And we, and we replace those frequently.

We can detect Actinium very easily with a meter, level three or 14C with a pancake probe works very well. We cover the probes with, usually a wax material to keep -- prevent them from getting contaminated.

We also have a pressurized ion chamber to measure dose rates if we need to; things like that. And we, we wear Tyvek rather than the regular lab coats to prevent the -- because those are, you know, resist the absorption of water; moisture.

One of the big concerns we have, we have dose calibrators down in these areas. It's the same, essentially the same one that you would have in a nuclear medicine department. But we're using it for, for research, so we had to figure out -- we talked to the manufacturers about settings. We talked to other users of Actinium, but they actually -- no one was using a biodex. We basically had to come up with our own.

We came up with one and so far, it seems to be working pretty well. Again, we're comparing it to where we're getting it from, our other university that we work with on this project.

So it's all over the place. But we -- and that's where we're doing more work on now is to get

more information on the detection on our -- on this operation.

But the three main things as the health physicist, radiation safety officer, I want to make sure we can detect the contamination, and can we detect -- do we know what it is from. If there's any other contamination. So because we can always do liquid scintillation counters. We have a liquid scintillation counter that can give you a spectrum on it. So that's what the Actinium-225 spectrum looks like. That's primarily from the alpha, the various alphas. Again, it's five alphas per decay through the daughters.

This is a -- you're probably familiar with the white counters most people have in their nuclear medicine labs. It's the sodium iodine thallium well counter. Typically, I think it's a half-inch well. So that's the spectrum we get with Actinium. So we use that also for information where we run it with a dose calibrator.

And we also have access to a high purity triammonium gamma system, which can definitely show the peaks. This one is, I believe, 140, 140 or 230 and 440. Something like that.

So they're very distinct peaks, but you can

still see them with that. We can definitely tell that it's Actinium because we've run other samples. We've printed out other spectrums. So we can -- it's a way we can determine is our contamination Actinium or something else.

So one of the lessons learned working with Actinium, and you've probably read some stories recently about it, probably acts very similar to the Actinium -- no, excuse me, Americium-241 that's in the news right now. It sticks to everything and it will want to travel. It's basically because of the recoil atom of the -- when it emits the alpha, the atom has so much energy, it moves. But liquid scintillation counting works very well. It's very sensitive.

So that's our preferred method, but we don't have liquid scintillation down in the scan room, so we have to run the scans over to the med school, which is only about a two-minute walk, so it's not a big deal.

We found that alcohol works really well to clean up for decontamination, especially if you get to it early. So if we know we have a problem, we clean it up fairly quickly.

That's also pointed out, we do have lasers at

the university as James is aware.

JAMES FUTCH: I like your warning.

ADAM WEAVER: Yeah. You know, we basically, there's four major classes. Lasers are very cool, very useful, but they can be very dangerous. And this is -- when I first got to the university, this is one of our most powerful lasers was an old CO2 TEA laser in the physics department. It was actually made there. And they actually pumped the gas into it. It leaked all the time CO2, but it produced a pretty strong beam. But now you can get a stronger laser down to this size (indicating).

JAMES FUTCH: Is that an actual cathode ray tube on the device, bottom right corner over there on the floor, a monitor? Computer monitor?

ADAM WEAVER: Yes, an old picture.

JAMES FUTCH: Is that a dot matrix printer on top of it?

ADAM WEAVER: It is an old picture. But we -- our physics department was very proud of these lasers and they worked when you get the seals all right and -- but they took up pretty much a whole lab. And now you can get the same energies, even a better quality beam, which is what they are very interested in, down in a size, probably even smaller

than this now.

And then they're even getting smaller. Lasers are getting smaller.

JAMES FUTCH: Thanks to diodes.

ADAM WEAVER: These diodes can be very powerful now. Depending on what filters they put into them or don't put into them can present a hazard because, you know, these diodes, they probably cost probably fifty cents to make in a mass manufacturing plant. And you put them together, they can produce a Class 3B or 4 laser, which can be pretty much, you could easily fit this in your hand.

JAMES FUTCH: And the colors, too.

ADAM WEAVER: Yeah, and the various colors. That's one of the big concerns. So I just threw that in there, just to -- And then, of course, you did have sound.

I worked at the Department of Energy a long time ago. I always like these old signs, so. And this is one of my favorites surveys. We're there to help everybody do the research.

So thank you for your time. I hope I wasn't too fast. If anyone has any questions or anything.

RANDY SCHENKMAN, CHAIRPERSON: When you use this, the Actinium in --

ADAM WEAVER: Yes.
RANDY SCHENKMAN, CHAIRPERSON: -- animals.
ADAM WEAVER: Yes.
RANDY SCHENKMAN, CHAIRPERSON: If it's so potent, what happens to the animals, themselves?
ADAM WEAVER: We use it in mice. Primarily mice. The animals are sacrificed at the end and we analyze their tissues and --
RANDY SCHENKMAN, CHAIRPERSON: You have to -- are you giving it systemically?
ADAM WEAVER: Do a tail vein injection. These animals are stored in a controlled area, and we have -- and there's various studies, because we put -- we inject, like, different amounts in each, in to various groups of animals.
RANDY SCHENKMAN, CHAIRPERSON: But what happens to them before they're sacrificed? Does this kill them or does this only go to the site because of whatever --
ADAM WEAVER: It mostly goes to the site, but some of it does go to the liver and the kidneys, you know, because it is -- but we haven't seen any -- we have a level right now that doesn't kill the animals. So we keep it -- if we keep it below eight microcuries per the animals, because the animals are

maybe, maybe 100 to 150 grams, they are very small animals. So -- and it's a very small amount that we inject that in volume wise and the flush afterwards is very small. Because we're working with the vets, you know. All this is approved by our IACUC Committee, which the university has. And the vets are always, you know, keeping on us to make sure we're doing it right and we're very careful with the injections.

But we have a space that's separate from the rest of the animal population where we store these animals. We change their beddings, what their requirements are; things like that. And the bedding unfortunately is, we hold it for decay, so our waste site really gets smelly. But, you know, that's -- but it is -- that's a good question.

MARK SEDDON: Is there a reason why you guys are working with Actinium versus Uranium for your PI?

ADAM WEAVER: This Actinium, it seems to be so effective.

MARK SEDDON: More effective than Radium.

ADAM WEAVER: Radium has, I think, one or two alphas with its decay. And I think the Actinium right now, it can be manipulated easier.

MARK SEDDON: For binding.

ADAM WEAVER: It works well with a, you know, typical chelating agent, like DOTA, something like that. So chelators work really well with it and they get into a peptide or protein, whatever they are trying to work with, and it seems to go -- they get enough to the tumor that it kills -- seems to really work.

Again, it's very early phases. For us, what the Sloan Kettering does is more of a whole body.

MARK SEDDON: With leukemia.

ADAM WEAVER: Yeah. They had a couple different forms. Different chemical groups.

MARK SEDDON: Their binding is antibody. So it's pretty effective.

ADAM WEAVER: Yeah.

MARK SEDDON: Okay.

CYNTHIA BECKER: Adam, it sounds like you share with other universities your experiences. What, what method do you, do you guys do that as --

ADAM WEAVER: I mean, you know, everybody wants to publish papers.

CYNTHIA BECKER: Right.

ADAM WEAVER: There's a couple papers in the works. And in Sloan, I mean, they -- because there's is now in Phase 3, when they were doing the

initial research, they shared a little bit, but not, you know, because everybody wants to have their magic drugs. So usually these are tied to some kind of drug manufacturer or potential patent.

So there is some sharing. But we do share the experience and I don't know if you can put it up there, but we've been working on a -- there's another PDF, an Actinium -- in radiation safety, we like to have, you know, it all in one page. So we've been working on a radiation safety data sheet that we're trying to get out there.

Brian probably knows, there's a lot of them out there for it and I think some are in your -- I don't think they're in your book, but some --

BRIAN BIRKY: Not specifically.

ADAM WEAVER: We couldn't find a lot of information on Actinium, so we're trying to put one together. I don't know if you could find it.

JAMES FUTCH: There it is.

ADAM WEAVER: We've been trying to put something like this together so it's all in one place for other researchers that are potentially going to be using it, because I know there's an actual company out there that's pushing the Phase 3 drug.

MARK SEDDON: Actinium Pharmaceuticals.

ADAM WEAVER: Yeah, that's right. And they are working with it. I think the medical physicist who's going to be calling potential hospitals in Florida, getting it on this Phase 3 trial. So this would be helpful, we think, to, you know -- it's a very common format, so we're trying to put it together. As soon as we get it further along, we'll share it out.

CYNTHIA BECKER: Great.

JAMES FUTCH: So, Adam, when you're working something like this, the eventual intended use is, is people, hopefully.

ADAM WEAVER: Right.

JAMES FUTCH: So method of administration versus extreme toxicity, how does that balance?

ADAM WEAVER: That's why there's more research that needs to be done. I mean, because typically, when you're doing alpha emitters, you know, most of your imaging you're putting millicurie amounts in. When you're doing alpha emitters, you're talking microcurie amounts. Even with the Radium, I think the dose is maybe 50 to 100 microcuries, but it's a, it's a much smaller amount of radioactive material because of the potential radio toxicity. Because these are alpha emitters, that means they are higher

atomic numbers so they can be a problem with the kidneys, problem with the liver. But if you get that right balance, then it potentially, you know, right now it's the bone, it's mostly for palliative care, but it works really well, from what I understand.

MARK SEDDON: Yeah. They're finding it to be pretty effective. Most of the administrations are palliative, so your patients aren't -- are less fibrous.

CHANTEL CORBETT: What are your badge ratings on the people? You said you had five users using this.

ADAM WEAVER: Minimal. I don't think we had a positive reading. We have finger rings, too, we're working with.

CHANTEL CORBETT: I saw that.

ADAM WEAVER: Yeah. It's very low.

MARK SEDDON: Do they even measure?

ADAM WEAVER: I don't think we had a positive measure. It's tough because at the same time, we do a little F18 research and C11 research.

CHANTEL CORBETT: You've got enough of it.

ADAM WEAVER: Right. We actually have a -- we do actually C11 research, too, which is a very short

half-life material. Still again, non-human research. Very quick.

JAMES FUTCH: You mentioned papers in process for publication. Which journals are you typically seeing this kind of research?

ADAM WEAVER: What are the various cancer -- I don't know. There's so many different cancer --

JAMES FUTCH: Mainstream. Specialized for --

ADAM WEAVER: Yeah. But I know a lot of people are working on it and we have one, a couple guys that are working just on the detection end of it to try to, you know, because that's one of the questions when you put it into a dose calibrator and you have so many different alpha emitters, how do you know the amount of Actinium versus the daughters? And that's going to be hard to -- so they're working on that now.

MARK SEDDON: You guys are doing imaging studies with the --

ADAM WEAVER: Yes. We can image it.

MARK SEDDON: Okay.

ADAM WEAVER: The SPECT image on that equipment that we have isn't the greatest so we've actually been bringing them to nuclear medicine where we, you know, package the animal up. It can actually be

seen there on a, on a good SPECT system. So that's an interesting point that they're looking at, too.

Again, this is all early phase. We've been working with it probably, I think about two years. I think, I'm sure Sloan Kettering and those folks have been working with it even longer because I think that Actinium Pharmaceuticals was a spin off of Sloan. But Oakridge has been producing or has the capability of producing 150 millicuries a year. So if we go exceed that amount, then they're going to have to -- and some of the national labs are looking at producing Actinium in maybe some accelerators. There are ways to do it in some of the higher energy accelerators.

CYNTHIA BECKER: So, Adam, this brings to mind, as you know from being in our group before, at what point can we introduce our inspections staff to figure out what changes they would be encountering when they inspect? And I don't know, you know, I know it's the early phases, but you, you are working with it now.

ADAM WEAVER: Right.

CYNTHIA BECKER: Just trying to figure out --

ADAM WEAVER: We've invited -- they can come down and watch us.

CYNTHIA BECKER: Okay. That was going to be my next question.

ADAM WEAVER: Any time.

JAMES FUTCH: She didn't want to really ask.

CYNTHIA BECKER: I was trying to beat around that bush.

ADAM WEAVER: The only thing they may not want you to do is take pictures because they don't like pictures unless, or something -- but beyond that, you guys don't take pictures during your inspections most of the time anyway.

CYNTHIA BECKER: No, but we are trying to get our technical staff together at some point, maybe January, February, March time frame, probably in Orlando area, but maybe that's something we can talk about.

ADAM WEAVER: Sure.

CYNTHIA BECKER: Okay. Thank you.

ADAM WEAVER: All right. Well, thanks.

RANDY SCHENKMAN, CHAIRPERSON: Anybody have any other questions? Comments? Okay. So now we're going to move on to Lisa.

LISA GAVATHAS: Okay. As Cindy said, I just moved to Tallahassee, I think in July, and started with the program there. I was an inspector in the

field before that, so I'm learning.

Forewarning, when I was invited to come to, to the advisory council meeting, I thought it was just a free trip to come and see what was going on. And last week, I learned I actually had to say something. So I didn't have a lot of time to prepare, but I'm going to basically give you a rundown of the program.

As of right now, we have seven employees full time. Six of those employees are in Tallahassee. One is teleworking from the Jacksonville area, Willie Burgess, and I think he's been -- he was as of the last meeting, he was also teleworking then.

We do have one advertised position who will be handling medical events and I will be really happy when that person is hired. And they will also be doing violation correction, so if anybody knows of anyone who is interested in coming to work for the state, we have that position. It's open right now.

I did add a hand out in our pamphlet here. It kind of gives us a breakdown of how many facilities based on what kind of facility we have. Right now, we have over 19 -- around 19,000 active facilities and that amounts to over 54,000 active tubes in the state.

As you can see, if you look at the handout, most of our facilities are dental. We have over 7800 dental facilities in the state, which amounts to 32,000 of our tubes. A lot of inspections.

We -- the rest, we have hospitals, you can kind of -- there's a legend on the second page that tells you what kind of facility there is.

We're also currently in the renewal phase, which is when we send out all of the renewal notices. Those have not, as of yesterday, gone out.

Everything -- I note that during the last council meeting, it was discussed about staggering the renewal times, but that hasn't gone into effect. We haven't come up with any plan to do that and I don't know that there would be anything happening in the near future with that.

So all of our registrations expire as of October 28th. It's a really busy time for the x-ray program, so as soon as these go out, we'll be -- I think everybody will be working with renewals trying to get those out.

The other thing we do is mammo, mammography, which I was hired to be the coordinator for the state, but I have not gone through all of my training yet. So I'm working with someone who's

doing the interim, the interim coordinator, Nick Patkashel (ph), who was excellent. But if you have any questions, you can always call us.

As you know, the FDA regulates mammography. We have a contract with the FDA. As of the last council meeting, that had not been signed. However, all the items have been worked out. Everything -- the mammos contract has been signed and went into effect on September 1st and the inspectors are now back out doing inspections.

The other, something else. Also, registered vendors. I think it's a free service, if I'm not mistaken, but anybody that comes in to the state to work on x-ray machines to do any kind of service, they have to be registered in the State of Florida. And we handle those registrations as well.

The other big issue we have is medical events. Any medical event that is reported to us has to be investigated. And we have Lynn here that's going to give us a run down on medical events that have happened in the past and give us some -- and what we're trying to do in trying to improve the program.

LYNN ANDRESEN: Okay. So we at the Bureau of Radiation Control, we're in the process of creating a more collaborative investigative team approach to

medical event investigations and report preparations. So when a medical event occurs, we typically receive a call from a medical physicist at the facility. And that call goes to the radiation machine program section, where Lisa is the interim coordinator for that position. And she will schedule or that person will schedule an investigative site visit at the facility. We try to do that within a two-week time frame.

And then an investigative team, a representative of the x-ray program, right now Lisa, myself for technology, and a representative from the inspections program will go out and will conduct a site visit and will gather information. It's a fact-finding mission. We'll conduct interviews of the therapists or the technologists, medical physicists, whoever was involved with the event. We'll take that information back; compile a report; submit the report to the program administrators and the Bureau chief for their approval. And at that time, it will be determined whether a facility violation has occurred. If a fine will be imposed, we'll notify the facility of that determination and let them know about an appeal process if that's warranted.

Also, with technology, we will determine if a technology violation has occurred. And if so, then we will file a complaint with MqA for action.

So, also, I want to share that all the BRC investigative team members have been through advanced investigative training with MqA. That's the division of Medical Quality Assurance. They have a huge investigative section in that division. And we've learned a lot as far as interviewing, evidence collection, report writing -- can you add anything else that -- very informative. About a two-week training period. A basic course and an advanced course. And we appreciate them allowing us to participate with that process.

I also wanted to just share a couple of examples of medical events that have been investigated by the Bureau. One was a patient who received treatment to the wrong site. Second round of treatment was given to the first treatment site incorrectly. Six treatments were delivered before the error was discovered. So that was one example.

Another example, patient who received more than thirty percent of the weekly prescribed dose. Patient was prescribed qd or once daily treatment, but was treated bid, twice daily treatment for

nineteen treatments.

And another example. Patient received a dose delivered to the wrong site. Patient received treatment to incorrect area of the spine. And the error was discovered after one treatment and corrected.

So any questions on medical events?

RANDY SCHENKMAN, CHAIRPERSON: Who has to report them and how do you -- how do we know that they're actually being reported? All the events?

LISA GAVATHAS: We don't. And most events probably are not reported. I think there's been some studies with, I'm not sure what governing body, but they say that less than eight percent of medical events are actually reported. And I think -- that was told second hand to me, so I'm not exactly sure if that's true or not, but I do think that there's a low number.

The problem comes is that we don't have a specific definition of a medical event. And I know that was discussed during the last advisory council meeting as well. We've been working on that. There is a handout with some proposed language changes in, in the handout. However, there are some other, other outlying factors that I think need to be

addressed as well because of technology changes and what have you.

But what we're doing is just trying to put something out there saying we are looking for input. We are requesting any information that would help us try to define what a medical event is. Because if you have -- because, like, a medical physicist has called before and said, I'm reporting a medical event. However, I don't really know if it is one or not. So it's -- then we have to determine is it a medical event? Because they say, okay, what if it was a geometric miss? What if it was this, what if it was that? So these are things that we also have to take into consideration.

So, Cindy, do you have something to add with this?

CYNTHIA BECKER: Just that it's the very early phases of us trying to collect information from different sources. You know, we have the AAPM, we have Astro, we have our contacts that we have throughout you all, plus all the other associations that are out there. And other states, you know, have been involved with this for a very long time. And as soon as you start to get close to it, then, of course, technology changes. So any help you can

provide, any places you can direct us to go search for more, more answers, we'd be very appreciative of that.

JAMES FUTCH: I think if you look in the pamphlet on -- it looks like, the pages look like this if you haven't found it already. I think what Lisa meant was there's actually a couple, a couple different kinds of definitions of what constitutes a medical event. And from my experience dealing with the technologist, the operator side of it, it's kind of like which one of these holes do I fit into or does it fit into any of these holes -- particular categories.

The first couple I think are not, not as difficult to understand. You know, if you look at 85(c)(1), something that results or will result in permanent functional damage to individual's organ or physiological as determined by a physician. Well, we've been involved in scads of these over the decades and I can't think of one where a physician actually said that, had that level of damage. I don't know if that didn't happen, but they certainly haven't really, you know, gone overboard in reporting those.

The next two are the most, I think, common and

the easier to understand. You got the wrong person. You know, pulled up completely wrong treatment chart for Mr. Smith and you gave it to Mr. Jones. Maybe it was the same part of the body. Probably was. Something along those lines.

But the next one, three there, wrong treatment, wrong mode of treatment, wrong treatment, wrong treatment site. That treatment site business I think is what gives rise to much of what the proposed language -- or not the proposed language -- much of the focus is on treatment site. And the rest of them get very specific, you know. Is it treatment that consisted of different qualifications, three fewer refractions and the total administered dose was different than the total prescribed more than ten percent. Now we're into percentages.

Why ten percent? The governing standard body, whoever it was that was the original architect of all this, probably put in some sort of, well, ten percent is, you know, we're not always exactly on target, so ten percent maybe more than that is the, is the way to go about it.

And then you start getting into the administrative weekly dose, is thirty percent

greater or it differs from the prescribed by more than twenty percent overall.

And then in Part 16, which I had something to do with a number of years ago, for this particular kind of therapy, which is the electronic brachytherapy, we kind of winnowed it down to kind of a, a more, I think, understandable, at least at that point in time for that particular kind of device, set of categories.

And then the rest of it, you see from there to the next page is, I believe Clark, who is Lisa's supervisor who is the architect of all this, I think what he was going for was to try and tackle, you see there's no changes to one through three for medical event. Is trying to tackle some of the other stuff about and provide a definition of what treatment site is.

I don't know if it does it and we're not saying we're going forward with any rule making. We're really just throwing something out, or Clark is throwing something out there for discussion and for anyone to, you know, say, well, yes, we don't believe him, for example, is working on something new or we find this to be useful at our facility.

But I think it would -- the idea was trying to

figure out how close is close enough if you're talking about you're off by a little bit on your treatment site.

Now, treatment site, oh, treated the left leg instead of the right leg. That's pretty understandable, right? You know. Okay. I'm in the spine and I treated a thoracic vertebrae instead of lumbar. Okay. That's pretty much understandable. Wrong treatment site.

What if it's the exact target volume but you're slightly, you're slightly off? You know, you got ninety-five percent of what you were trying to do and you hit five percent or fifteen percent of more healthy tissue than you intended. Is that a medical event? That's my sense of where this is coming from.

LISA GAVATHAS: Is there a critical structure right there in that area or is it a re-treat. Like if that area's been treated previously, then that becomes a concern. So that's where we are on that.

JAMES FUTCH: So unfortunately, Doctor Williams is not here, but Kathy and Mark are here. And anybody else who wants to weigh in.

MARK SEDDON: I think for, for event reporting, I think you may see more of the -- I'm not sure

about medical event or not, I don't want to be first to say safe to let you know so we can do a full investigation. If it was not as punitive and more of an informative, corrective action, let's make sure the patient is safe, let's make sure we've corrected it any processes at the facility, that would be more effective in improving your reportable rate. Because people would be more willing --

LISA GAVATHAS: I agree.

LYNN ANDRESEN: I agree.

MARK SEDDON: -- to go ahead and contact the state to have, to have the process looked at.

One of the -- at a national level, one of the things that was created was the ROILS, which is the Radiation Oncology Information Learning System, because as you say, errors in radiation oncology were frequently underreported because people were afraid of, you know, to types of actions and/or they didn't quite understand the results of the no harm/no foul kind of, you know, thinking as well. It was like, well, I mean, the patient has got cancer. We just gave it treatment to an area that now they say, I'm going to treat that other area. A lot of it is based on their judgment, how they're going to treat.

Technology changes where, you know, twenty years ago, we were treating very broad sections of tissue. Now we're treating very fine, tiny little structures. So we're really defining our PTV to a very small area, which in the past, we would include the whole section of tissue. I think that also makes a, makes a different -- difference as well.

But the, like the ROILS was created to allow a process for studies to report to a patient safety organization, errors in radiation oncology they can frequently report anonymously and in effect, everyone else can learn from it, other facilities around the country can learn from it, to learn what's really happening out there. What are the errors that are occurring that may not qualify as medical events under some definitions or maybe are not being interpreted as medical events as the current regulation's applied in that specific state.

So that would probably help. I think in Florida, if you think our reporting is too low, because I know I've heard anecdotally there's some concerns from folks that it was a, you know, a minor error what they thought and then they thought there was a very rather heavy-handed approach to the inspections.

So I've never experienced that, but I've heard that. That sometimes can be, especially when you have the three, like you have the MqA folks come out and look at the potential effect on licenses or the individuals as well, so that's a concern for individuals not to report, and that they may feel, I don't want to, you know -- because the medical physicist reports it to the state, the therapists are the ones actually reported to the medical physicists.

LISA GAVATHAS: Right.

MARK SEDDON: So if they know that when they have an error, they reported it to their boss, to report to the state, they're not going to want to report that because they're going to lose their license or be fined.

KATHY DROTAR: Or lose their job.

MARK SEDDON: Or lose their job. Hospitals already have that in place. If there's a patient error, you're not, you're not going to lose your job over a patient error. Patient error, you have to report it, and they want to encourage reporting. So risk management system, that's one of the things that the -- they are not to have any disciplinary action against you for errors like that.

Now, repeat errors and not following policies and procedures, that's one thing. But if you, if you come across an error that occurs and, you know, the expectation is you report it. That's more important. The first thing is patient care.

LISA GAVATHAS: Right.

KATHY DROTAR: And I think just having a place that you can call and say, most radiation physicists and radiation oncologists are -- want to hear what, what you've seen that day or if there's something that occurred that maybe you have a question about, but not everybody is, and so I think, you know, if you've got a question, can you -- is there a place that you can go to to say, I think this needs to be checked. Or if you're seeing things that maybe aren't quite what you think they should be so that you can, you know, and as you said, define that, no, this is acceptable limits. Because I don't think we really have anything except for broad based, you know, this is, this is going to impact on the patient.

But, you know, if you're -- the one you talked about with, if you're not centered where you're supposed to be centered on the spine but maybe you're a little bit to the right but there aren't

any critical organs there, but if you -- if you're higher in the thoracic spine and go to a little bit to the left, then you've got lung and heart in there. And then that becomes that, that reportable, you know.

And making, making people not afraid to report, I think is, and having maybe some kind of a database that might give you numbers that you could talk to somebody about that would be anonymous, that you would get more of that information. Because I think as therapists and -- that if you see something that's not right, your training is to say something to somebody. And the only thing that really holds you back is, what are they going to say to me? And, you know, the response should be, well, if there's anything wrong, thank you for telling us so that we can report it and we can, we can take care of the patient and do what's right by the patient.

MARK SEDDON: Because I think the majority, in 85, the majority of the, of the items listed are, you know, the bigger items and they are definitely -- if you have wrong patient, wrong site, I mean, the wrong dose, you know, substantial, then those are reported because people know it's a big mistake.

It's like if a painter paints the room a wrong color, well, everyone notices it. If you, like, maybe along the edges, they're going outside the lines a little bit along the ceiling, well, you know, that becomes is it acceptable or not acceptable by the individuals.

That's, I think, where we have, you know, some confusion. The wrong site is what you're talking about is -- if you're painting a whole wall, it's not a big deal. If you're painting up there, it's tight, it becomes important.

So the majority of those types of errors are caught by the therapists.

LISA GAVATHAS: Right.

MARK SEDDON: Wrong site, wrong location, that's the therapist. That's why if we have a less-punitive reporting process or an investigation process for those, we'd probably see improved reporting. And then if they're reporting them, we can see where -- what is the cause of those errors? What's causing the shifts that are not being caught? What's causing the variations in, in set up every single time, every infraction, and then that could be worked on.

Because that's really what has been happening.

People turning a blind eye to it so no one is looking at fixing that specific part of the treatment process.

Lots of checks and balances then for dosimetry and for prescriptions. Not a lot of checks and balances in for --

RANDY SCHENKMAN, CHAIRPERSON: Location.

CHANTEL CORBETT: I don't know. It may be an option, too, like, three people from a higher agency walking in as a group is probably very intimidating to most people. So I don't know if there's maybe, like, an option for a staged investigation, where one individual would come in and gather the majority of the data, and then, if necessary, elevate it and bring in additional people.

Because I know in some of our accrediting bodies, if one person walks in for an inspection or something, it doesn't cause much ruckus, let's say. If you have three people walk in, then everybody kind of goes on high alert. Everybody is a little more panicked. Everybody is a little more, you know, uptight about everything and it makes everybody real nervous. So I don't know if that's an option, too.

LISA GAVATHAS: Right. And MqA kind of

addresses that in the investigator training as well. It's like, if you're interviewing one on one, you should be one on one. You should have -- if there's more than one person in there, you should be face to face with that person. The other people are -- if there's someone else in the room, they should just be taking notes and that sort of thing.

CHANTEL CORBETT: And I don't know if that would make me less nervous with two other people taking notes and one person talking to me.

MARK SEDDON: I think you do an affidavit. I think the people involved, they have to do something like a signed affidavit. It seems very formal. So I think that's what scares a lot of the -- usually most of our therapists have, you know, they are crying afterwards and they are not happy.

LISA GAVATHAS: For MqA, they do have to do the affidavit. For the state, as far as we're concerned, it's not an affidavit. It's just a statement of what happened.

MARK SEDDON: Right.

LISA GAVATHAS: But they do have to sign it.

RANDY SCHENKMAN, CHAIRPERSON: But I think that most of the techs are very concerned about the repercussions of --

LISA GAVATHAS: Yes.

RANDY SCHENKMAN, CHAIRPERSON: -- of doing that. And there are repercussions usually within the department, within all kinds of things. So --

LISA GAVATHAS: And we have been asked by physicists, please make this nonpunitive, specifically.

JAMES FUTCH: Yeah. Speaking as the guy who determines probable cause against the operators, and it being recorded, there are a set of guidelines in the statute and the regulations that are mitigating or aggravating circumstances. It's obvious things. Repetition is an aggravating circumstance; you know, things of this nature.

From my perspective, the don't be so punitive, I think, is an outgrowth of, at least in part, the number of events that kind of mushroomed on us all in one particular fiscal year. Traditionally, you guys have been, and for a little while, may remember Don Steiner or Tom Tomcheck, two of the folks in the program, x-ray program before Lisa, would go to the annual AAPM meetings and give an update on all the medical events that had happened in past years. Sort of like what Lynn did, perhaps with a paragraph. You do that often enough, you see the

same things over and over. It kind of looks like, ten years, we're still doing the same thing. Same things are happening.

But the number was not huge. It was per year, on the order of a couple, two, three. And then in one particular fiscal year, not too long ago, it was seventeen or eighteen. Just happened all in one year. And I think there was some discussions about is the state becoming, you know, overly regulatory or in particular, the Bureau of Radiation Control. And it really had absolutely nothing to do with us becoming overly regulatory or punitive or anything like that. It was just they all happened. Some physicists at some facility called us about every single one and prompted and said, we had this happen. But then we, you know, we had to deal with that. Because it kind of like, look, these guys are going out twice a month now, different parts of Florida, and all these different things are happening.

Really, I don't think changing, at least from my perspective on the operator's side, didn't really change anything in terms of what we were doing.

And so I wanted to throw that out as historical background. I think we're at, for whatever reason,

somebody turned off the medical event machine and we're back to, like, a couple, two, three, a year now.

BILL ATHERTON: That was my question. Those three or four events you said were all events you had this year or what time frame?

LYNN ANDRESEN: No. They are just past, examples of past. I just wanted to share.

JAMES FUTCH: But the numbers are back to historical averages.

BILL ATHERTON: Which are two or three?

LYNN ANDRESEN: Two or three a year.

RANDY SCHENKMAN, CHAIRPERSON: But that's the ones that are reported.

JAMES FUTCH: Yeah. Comparing apples to apples.

CHANTEL CORBETT: If you get people to start reporting them all in one year, then you're going to see that kind of, like, high alert level, everybody nervous kind of thing.

MARK SEDDON: About ten years ago, I was on the National Board at that time, and people were coming out and testifying in front of Congress and there was a national initiative for patient safety in radiation oncology. A number of different things came out.

So that may have correlated to your increase in reporting, because it raised awareness, too, across the industry.

JAMES FUTCH: I would love to know what caused it. Something in the water that year. I don't know.

CHANTEL CORBETT: I mean, if your average is two or three, and you go to fifteen, obviously, it's a huge growth percentage. But it's, you know, it's all relative.

JAMES FUTCH: Yeah. It's really small --

CHANTEL CORBETT: I mean, you know. It's one of those things, you're penalizing and the end is probably no different. But individually --

JAMES FUTCH: To the industry, though, there's not a huge number of facilities. There's even a smaller number of medical physicists dealing with all of it, going to meetings and talking about it.

CHANTEL CORBETT: Right.

JAMES FUTCH: So fifteen, seventeen, eighteen looks like a bunch --

CHANTEL CORBETT: Right.

JAMES FUTCH: -- at that particular meeting.

CYNTHIA BECKER: How about the number of therapies being done, treatments also increased. So

could it be just that especially in Florida, being who we are here with the retirees and such, that there is more treatments being done and then also, the technology advances, you're going to have more, more errors, or are they really, like we said, medical events or not. Because now we're just fine tuning, like Mark had said, we're getting really close to just pinpointing and targeting the actual tumor whereas in the past, everything that would've been done would've been considered, in today's terms, as medical events.

MARK SEDDON: Right. And we --

CYNTHIA BECKER: Just like before we had the old, we didn't have dedicated mammography x-ray units. We had just a cone that was attached. And that was part of the BENT program back then. So I think a lot of it is technology.

MARK SEDDON: So it may require some redefining of the definitions, like you said. That's what you guys are doing.

CYNTHIA BECKER: Right.

JAMES FUTCH: In doing that, we historically have looked to national standards or standards of relevant organizations, professional societies involved. So we really don't like to recreate, you

know, the wheel for new things. It's also much harder to defend it when it gets into a hearing if it's something we just thought of in Florida and nobody else is doing it.

MARK SEDDON: Didn't the NRC, the ACMUI, didn't they just have this discussion just two months ago at the National, at the --

JAMES FUTCH: I wish I could tell you. Not being the author of that particular piece, that could be something that caused Clark to --

MARK SEDDON: They had a likely discussion and some presentations, whoever was the advisory person at that task group that worked on revising medical events, I think they basically came up with, they -- his recommendation was not to more closely define it because they want to keep it opened ended for changing technology and for just to --

JAMES FUTCH: Open. I can see that.

MARK SEDDON: -- to allow for the cause, I'm not sure this is the event or not. So what do you guys think?

CYNTHIA BECKER: That was NRC, ACMUI, were they focused just on materials?

MARK SEDDON: Yeah. They were looking at materials. And so, they were looking at materials.

JAMES FUTCH: And that's, I think, another aspect of this that maybe not everyone is aware of is that a lot of this, we as an agreement state in regulating through the transferred authority of the Nuclear Regulatory Commission, have to follow fairly closely what they put forth as a recommended regulation. We -- that's not true when it comes to machine-based therapies. We've, I believe, always had the opinion that it's radiation. We really should be agnostic in terms of the source of the radiation and not apply one set of standards because it came from materials and another because it came from a device you plug into the wall.

But that also means we don't have a, I guess an FDA or another group out there on the machine side that's saying, this is what a medical event is, we need to comply with it.

MARK SEDDON: NRCPD has --

JAMES FUTCH: Has some state regulations.

MARK SEDDON: You were at the last meeting.

CYNTHIA BECKER: Yes, and there were several discussions involved in that. And I'm going to the CRCPD board meeting in October and AAPM will be represented there as well as FDA, EPA and DOE and all the others and I know that that is something

that's probably going to come up again. So I intend to kind of make use of the contacts there to say, you know, help us with this.

MARK SEDDON: Within AAPM nationally, it's like Lynn Farvin and those folks are working hard on trying to respond to requests for information.

CYNTHIA BECKER: Melissa Martin and Kate Hitlang (ph), I usually see them. I hope to see them in October. So, but, yeah, CRCPD is a great organization as far as getting involved with the state programs and seeing what other states are doing and kind of trying to make it consistent throughout the United States and really throughout the world, but that gets even harder.

MARK SEDDON: Yeah.

CYNTHIA BECKER: So --

JAMES FUTCH: And so, one more aspect of this that I wanted to bring out. When the team goes out, it's -- one of the reasons it's not just one person is because it's a very complex subject from the standpoint of oncology in general and then the machine and the physics side of it. And then the operator, all the different, you know, there's the dosimetrist, there's the microphysicist, there's the oncologist, there's the therapist side of it. So

it's very hard to find one person to kind of cover all that, so we ended up with a team approach.

But what, what they generate is basically an investigative report. And then it, and then it goes to the, the x-raying section for workup into, what are you going to do with that? Does this meet the definition for a violation of any of the different types of violations you've got established? That's a decision for my counterpart, Clark Eldridge and Bureau chief.

After all that's done, the output of all of that, that report especially, and then we typically wait until the machine program has determined what they're going to do, because we don't want to get in the middle of it on the, the operator side. We'll take all the material and then just look at it from just the operator perspective. When I say operator perspective, I don't necessarily mean just the radiation therapists. There are several licensed professions that are involved in this. There's the physician as well as the medical physicist, as well as the operators.

The one profession that's not, of course, is the medical dosimetrist, which is not licensed in the State of Florida. So if the therapist didn't

follow procedures or was guilty of negligence or it appears was guilty of negligence, there's really no recourse at the state level for us to do anything with that.

However, all the other total package of folks who were involved in this particular range of events, could be multiple therapists, usually at least two, sometimes if it's multiple infractions, a lot more than two, we'll look at that. And then there are parts of, at least the area we're responsible for, the technologist's side of it, we'll look at it and look against those mitigating and aggravating circumstances and at least, actually before you even get there, just determine whether or not there is a rule or a regulation that appears to have been violated. And then we'll package that up and send it over to the prosecutors to look at.

They don't always do anything with it. They may think that it is not, in fact, something that rises to the level of really violating that, that rule and that statute. If they do, they will bring it back and they will present it and say, is this, is this evidence or not. We'll say yes or no and then leave. It's out of our hands at that point. It goes back to the prosecutors and they, they

determine penalty.

It could be a letter of guidance, which is a non-disciplinary type of event. We're basically saying, just maybe messed up one time, they didn't really harm the patient, and they will write a letter that says, hey, this is a violation. Don't do this again. Here's the statute. Here's the regulation. Or it could be a whole range of things everybody thinks about, a reprimand, a fine, suspension or revocation. Rarely, if ever, is this ever going to end up being a suspension or an revocation. It's usually a letter of guidance and reprimand or fine.

And they will take the aggravating and mitigating circumstances into account.

RANDY SCHENKMAN, CHAIRPERSON: But --

JAMES FUTCH: Not just --

RANDY SCHENKMAN, CHAIRPERSON: -- but the point that's been brought up is because of that potential, people don't want to put themselves --

JAMES FUTCH: I understand.

RANDY SCHENKMAN, CHAIRPERSON: -- or other people that they are associated with in that position.

JAMES FUTCH: Agreed. I understand that. I've

found it quite difficult to -- making a determination one way or another, is hard enough. Developing a policy or an inclination that says, well, that's just a mistake, you know. That's not something that we need to follow through on the process with that. That kind of puts you in a very dangerous spot. The folks on the front end just think, does the inspector do that? Does the Bureau chief do that? Do I do that? I would prefer people, you know, report what they want to report and we'll deal with it. And we'll make an honest determination, just like we do everything else. I don't think their reputation will bear out that we're, you know, like certain other, perhaps regulatory agencies that people can think of. I won't name them.

CYNTHIA BECKER: You won't name them?

JAMES FUTCH: Yeah. That you trying to screw you to the wall, so to speak.

RANDY SCHENKMAN, CHAIRPERSON: Well, maybe there's a way to find a happy medium. You know?

LISA GAVATHAS: That would be good.

RANDY SCHENKMAN, CHAIRPERSON: I think that's what it looks like it's boiling down to. So that you get the reports and can see what's going on or

at least the questions, but, you know, people won't do that if they think they're going to be punished or they're going to be fired.

CHANTEL CORBETT: Unfortunately, I don't think the firing part of it, I don't think the state's going to have any control over. Obviously, that's going to be an institution thing.

JAMES FUTCH: It probably happened already if they thought it was. And I would like to say the flip side of this is, there are places that do have repeat violations. Facilities have repeat violations. Kind of more so probably than the individual operators.

MARK SEDDON: And that's where you want to report those because that means it's a process problem at that facility and you want that process to be addressed.

JAMES FUTCH: Yeah. And then there are instances in the past that one can think of that are, you really would like to find some regulatory mechanism to, quote, "make things better", and there isn't one. And the place just goes on with bad management and frequent changes of personnel. And the new person on the block is astounded they are doing these things. So you get another report; so

forth.

CYNTHIA BECKER: That fine line of trying to be a regulatory body, at the same time an educational one. It would be much nicer just to be an educational one.

JAMES FUTCH: You know what our attorneys tell us, right?

CYNTHIA BECKER: I know what they tell us.

JAMES FUTCH: We're not consultants and educators.

CYNTHIA BECKER: We're not consultants. We can't give opinions.

RANDY SCHENKMAN, CHAIRPERSON: But that may be a way to get around this, is that if there are reports, particularly repetitive ones, then in order for those people to keep their license, they need to have extra education and they need to prove to the state that they've had it.

CYNTHIA BECKER: That would be --

JAMES FUTCH: That's good.

CYNTHIA BECKER: That would be a nice thing to put in there, wouldn't it?

CHANTEL CORBETT: Like a probationary period.

RANDY SCHENKMAN, CHAIRPERSON: Yeah. Something along those lines. In order to correct the problem.

But still have people want to report it.

KATHY DROTAR: I think it's not a generally known -- it's not generally known that, that each, each incident would get looked at independently and stand on its own merit or not. So that it's not necessarily something that is punitive or considered punitive. Because like you keep saying, it may or may not be and you have to look at the situation to determine what you're going to do and it's not just therapy. We just have bigger numbers in therapy, so it's more evident there's going to be some impact on the patient. But it happens with CT, with nuke med, with any of those, any of -- and technologies that we haven't used yet. So --

KATHY DROTAR: Back to square one.

CYNTHIA BECKER: Back to square one.

RANDY SCHENKMAN, CHAIRPERSON: Okay. Anybody have anything else on this topic or --

BILL ATHERTON: One quick, on just these numbers. I noticed that the, in the top, the number third most numerous radiation facility is veterinary. Is that one of the groups to have a representative of them on this council or not or is that not -- is that not necessary?

JAMES FUTCH: Yes. So the.

BILL ATHERTON: I mean, obviously, there's no people involved really, except for the people taking the x-rays are just a few.

CHANTEL CORBETT: Or giving iodine in the case of cats. Which is like the number one user, I believe, in Florida.

JAMES FUTCH: Right. So, yeah. If you look at the breakdown of facility types, either by tubes or by machines, the dentists are way out in front. They won the war, I guess, on that one.

(Laughter)

JAMES FUTCH: 32,000 tubes.

ADAM WEAVER: Little less expensive.

JAMES FUTCH: In terms of the make up of the council, that's one of the things that's hard coded into the law. It's in the statute. Actually, it's in -- not Chapter 404, where the authority for the registration, inspection of machines and materials is, but it's in the Rad Tech certification statute, which is why we have a lot of medical folks on this particular group.

Point taken. Out of our control.

BILL ATHERTON: That's fine. It's just a question.

JAMES FUTCH: Legislator kind of matter. But,

yeah, we've heard, heard that. Also with the cardiologists, I think we talked about once before, right?

CYNTHIA BECKER: Yeah.

JAMES FUTCH: The best way for that to happen actually, come to think of it, is we have two, two positions on the council.

RANDY SCHENKMAN, CHAIRPERSON: Lay person positions.

JAMES FUTCH: Lay persons. And Dr. Cognetta actually is in one of them right now. So when either of those become available next time, that's a possible. It just has to be somebody who's not in one of the licensed radiation professions or something closely related to that. So a cardiologist or veterinarian, I think would work. So that's a nonstatutory change way of trying to do it.

RANDY SCHENKMAN, CHAIRPERSON: Right.

JAMES FUTCH: Statutory changes are few and far between.

RANDY SCHENKMAN, CHAIRPERSON: Okay. Anybody else with any comments?

I guess it's lunchtime.

JAMES FUTCH: And we're going to come back

at --

RANDY SCHENKMAN, CHAIRPERSON: 1:30.

JAMES FUTCH: I think we have lunch ready out there?

BRENDA ANDREWS: Yes.

RANDY SCHENKMAN, CHAIRPERSON: Is that good for everybody, 1:30?

(Proceedings recessed at 11:38 a.m.)

(Proceedings resumed at 1:00 p.m.)

(Mark Wroblewski and Keith Nadaskay are not in attendance)

RANDY SCHENKMAN, CHAIRPERSON: So welcome back, everybody. We are now going to turn it over to James, as soon as he's ready.

JAMES FUTCH: As soon as he's ready, yes.

RANDY SCHENKMAN, CHAIRPERSON: This is the Radiologic Technology Update.

CYNTHIA BECKER: Is that what it is?

JAMES FUTCH: Very specific.

CHANTEL CORBETT: Nothing new. Always a troublemaker.

JAMES FUTCH: Okay. So we have an issue that we talked about, we have an issue and Chantel's related to it. No, Chantel, of course, is the nuclear medicine technology position, so she's been

the focus of -- and her predecessor, of several communications from the Society of Nuclear Medicine and NMTCB starting back in 2015.

So you may recall, right now in Florida, we have what we call specialty technologists and these are new categories of certification that were added after the law was changed in 2012. Prior to that, we had three primary types of certification: Nuclear medicine, general radiography and radiation therapy. And then we had the limited scope or the basic as we called it in Florida. That was in the statute from '78 to '84, '84 onward.

So in 2012, we were dealing with the inability to add any other kinds of certification without having to go back and change the statute and we had actually been trying, through assistance with different organizations, to get the law changed back in -- Cindy, you can tell me.

CYNTHIA BECKER: No, it's like, how long ago.

JAMES FUTCH: Just hit me in the back of the head if I say something wrong.

So we had been trying to add some new kinds of certification in Florida, and one of the kinds of certification that we were trying to add was the CT technologist. And that was partly because of fusion

imaging. Starting in '97, '98, '99, they started in the industry fusing x-ray images in various forms and ways with nuclear medicine images. And when the societies finally decided to open up the CT technologist certification and the PET certification, ARRT for the CT exam, NMTCB with the new PET exam, two folks from different primary areas, that was supposed to kind of solve the problem. A lot of nuclear medicine technologists went to ARRT and got CT certified.

And that worked for a number of years. We had the scope of practice change from nuclear medicine to allow fusion imaging to work, wherein the nuclear medicine tech could do a limited form of CT.

But after they had gone to ARRT and got fully certified in, shall call it, freestanding diagnostic radiology kind of CT, they wanted to be able to use that in Florida and we had no way to allow that to happen. So the 2012 law was passed. And it gave us the ability to add other kinds of certification through rule making, without having to go back to the Legislature. And we did. We added CT, we added mammo, we added PET and added MRI and then pulled that back a few years later.

And in doing that, the only CT registry that

was in existence, at that point in time, was ARRT.

So right now, just to give you some, let's see, approximate numbers, there's, I think, about 175 CT techs licensed in Florida. To give you a comparison, 400 something mammo techs; six PET technologists. Now, these are Florida certified, Florida licensed folks.

At the national registry levels, there are a lot more, of course, than that. CT and mammo are very popular with ARRT. There's thousands and thousands of CT techs.

But what happened in 2015 which gave rise to this discussion, many of you were part of the council back then. This discussion, you'll see in the minutes from the May 2015 meeting, is when NMTCB came back and created their own CT registry.

So at that point, I think they had had a few, a few people go through, like, 100 or 200 CT techs, that had gone through this brand new certification and become certified by NMTCB to do CT. Any kind of CT, not fusion imaging CT.

And so, now we have two different registries, but our Florida regulations are written so that only the people from the, pardon me, only the technologists nationally certified by ARRT, NCT,

could become licensed in Florida to do CT.

Okay. So this is, this is Cybil Nielsen, who was with us at that point, representing NMTCB -- she was a board member -- in describing all of the things that go into what it takes to become certified through NMTCB to do CT. There's 40 pages of this. We talked about this for a long time.

Alberto had some comments in here; Tim Williams, who is not with us, Becky McFadden, who's not here, is in his position; Kathy had a bunch of comments. Lots and lots of discussion back and forth. I'll save you the trouble because I read all this last night again.

NMTCB has, at this point in time, 2015, according to Cybil, Arizona and Oregon were in the process of accepting NMTCB certified techs into practice in those states. At this point in time, the Joint Commission was recalibrating to recognize this particular kind of alternative CT. So Cybil spent pages and pages and pages explaining the difference between and the reasons behind why they had a registry in addition to ARRT that goes something like this:

ARRT's mechanisms for becoming certified in CT -- both of these, by the way, are what you would

call post primary; so therefore, these folks are not going back to a traditional classroom educational program necessarily to become qualified to sit for either one of the exams.

The biggest difference is ARRT -- and this is still -- I reread the qualification requirements also -- this is still pretty much the same, as far as I can tell. To become able to sit for the CT exam for ARRT, you have to do a certain number of, call them didactic hours, in different -- the appropriate subjects that you would think of for CT, as well as perform a certain number of exams from a certain number of different kinds of CT imaging. And the number, I think, is five areas out of seven.

KATHY DROTAR: 125.

JAMES FUTCH: Five of each, for a total of 125 exams. But the bottom line is you have to do a certain number of procedures; has to be signed off on; has to be proven. All the rest of this kind of stuff. And then they sit and take a very comprehensive CT examination.

So all of the nuclear med techs who wanted to become CT's prior to the NMTCB certification for CT starting, did this. And there was some issues with that, which we talked about extensively, which is

this, this kind of hard-and-fast number of exams in different areas.

And NMTCB's philosophy, as described in these minutes, please go read them yourself in your leisure time, was different. They don't want to specify a certain fixed number of exams in different kind of areas. They have a certain number of hours of experience in doing all forms of CT that they require. And it's 500 hours is what they require. And their didactic course work is, I think, 35 contact hours on top of that.

These days, since 2011, a lot of this can be accomplished actually in the nuclear medicine educational program, because the curriculum standards have been recalibrated for the JRC and MT accredited schools, which is all, as of 2016, NMTCB accepts anymore. To incorporate CT into the base curriculum.

So a lot of that experience that they need, those 500 hours, if it's accomplished within three years of applying for the CT and sitting for the CT exam, you can count some of that. You can count some of your school work if your school work happened to cover CT.

There was a lot of back and forth; Alberto,

you had a whole bunch of questions; Kathy, you had a whole bunch of questions; other folks, really, we picked this thing apart. We didn't mean to be. We were trying to understand all the different aspects of what it would take before we accepted another national registry into Florida certification for CT.

And what it came down to was mostly that there wasn't a practice standard specific to CT for the MNTCB-CT persons.

I don't know if you remember, when we did PET, which also, of course, comes from NMTCB, we accepted that registry, there also was not a practice standard. This was, back in 2012, rolling over into 2013. There was the General Nuclear Medicine Society, Society of Nuclear Medicine had, which is the professional association that produces these things for the registry, NMTCB. They had kind of incorporated into the base document for all nuclear medicine technologists. That wouldn't work because in order for us to pass, to go through the rule making to create a category in Florida, we have to have a practice standard that's specific to this.

When we did PET, Society Nuclear Medicine, I think we were actually the reason that they went back and created a PET specific practice standard,

do you remember that? So when it came time to do this for CT, the same kind of problem happened. Which is that, oh, the base document, the nuclear medicine practice standards -- which are in the corner over there if you want to see a copy or up on the web later on -- because they recalibrated the profession, basically, to incorporate CT, much more so than just about any other profession, they, they didn't have a specific document for that.

So at this point in time, in 2015, Cybil basically said, well, ASRT, which is the practice standards that we've had in rule at that time for the folks who we were issuing CT licenses for, because it came from ARRT and ASRT had the practice standard for it, Cybil said they're in negotiations, they are in discussions with ASRT and rather than come up with one for ourselves, we're just going to pursue this and see if ASRT will incorporate our registry into their practice standard -- which they've done many years in the past. If you look at the ASRT practice standard for nuclear medicine, it covers both registries. So this is something that's been done in the past.

Okay. That's a long way. So fast forward to now. And the Society of Nuclear Medicine has

written letters to us; written letters to Chantel, and NMTCB has written letters, I didn't know until Chantel came in here and said, oh, look, there's another letter from NMTCB.

So they have convinced ASRT as of June 2017, in their new -- in ASRT's new practice standards, which look like this -- I do have a couple copies of this.

LYNN ANDRESEN: I have two copies if anybody wants to look at them.

JAMES FUTCH: There's one there. I'll circulate one this way. There's one on this side of the room if anybody wants to look at.

In their practice standards for June 2017, they do now include NMTCB-CT. And let me go back here for just a second and I'll just throw it up on the board here for a second -- on the screen here for a second. So this is the CT practice standard.

CHANTEL CORBETT: Page five.

JAMES FUTCH: This is the one date some place, effective June 25th, 2017. I think I have it highlighted in here. It will hit me in the face. There it is. That's the relevant section, right?

CHANTEL CORBETT: Mm-hmm.

JAMES FUTCH: Okay. So education

certification, you all can read it for yourself. Eligibility to take the post primary exam computed requires the appropriate primary certification. You've got to be nuclear med or radiography or something. Documentation, structure, education, clinical experience, all that stuff that I talked about.

Those passing ARRT use the credential this. Those passing NMTCB. So this is the first time this is now reflective of the fact that, yes, there is an NMTCB pathway into use of these practice standards.

CHANTEL CORBETT: The paragraph right above your highlight is the one that says by obtaining appropriate primary certification from either of the two. So that gives you the primary has to come from one of those before they can take this.

JAMES FUTCH: This right here. Now, here's the interesting thing. There's almost -- Lynn went through and compared this practice standard to the one we currently have adopted in our regulation for use by Florida CT techs. I think this is like the only two paragraphs.

LYNN ANDRESEN: That was 2011.

JAMES FUTCH: Yeah.

LYNN ANDRESEN: So --

JAMES FUTCH: There may have been -- I doubt this one was in between.

LYNN ANDRESEN: I'm not sure.

JAMES FUTCH: They don't do it that often. So there's very little difference in the actual standard in what you can do and, you know, the general requirements, the specific duty; things of this nature. It was basically this -- made it a little more generic in some places and specifically referenced NMTCB-CT. That was a long way to go, but --

RANDY SCHENKMAN, CHAIRPERSON: Are the programs similar or are they different?

JAMES FUTCH: Well, you mean --

CHANTEL CORBETT: What do you mean by program?

RANDY SCHENKMAN, CHAIRPERSON: I mean the -- to become certified, is it more similar now or is it still very different?

CHANTEL CORBETT: It's the same thing. I mean, than it was. It is 500 clinical hours in a CT environment.

RANDY SCHENKMAN, CHAIRPERSON: But not specified as to --

CHANTEL CORBETT: Not specific exams. The problem, for the most part, with the exam's

specification, is that if you're employed at an oncology center, let's say, you may do five, at the most, of the 125 options. And that means you would have to go outside of your current employer to be able to get those other tests. And there's really no point, honestly. And the whole point of this, really, is not nuclear medicine to go take over a CT job in a hospital. This is mostly for the oncology centers who have a PET CT and they are putting diagnostic CTs in between their PETS, right now they are having to employ two different technologists, for the most part. So it's going to prevent that requirement.

I'm not saying that everyone is going to switch to the dual, but we've already got hospitals in Florida who have said, as soon as this goes across, you know, we'll -- we have no problem. We can use that nuclear med tech that has a CT license as a back up for CT in our CT department. But at that point, they're going to drop down to the CT pay grade. They're not going to get their nuclear med pay to go into CT.

And so that's the other thing that I think a lot of people really want to push from a nuclear med perspective is, we honestly get paid better doing

nuclear med. So this is not something we're really trying to push into the CT, you know, field to just go do CT. This is really to incorporate it into their jobs where they're in an oncology center and they have that option.

KATHY DROTAR: And that was a good part of it because the, the CT person couldn't do the nuclear med portion of it. They need that nuclear med person there, as you well know.

CHANTEL CORBETT: Correct.

KATHY DROTAR: But the other thing was that nuke med people who were nuke med couldn't train in CT because they weren't covered by the --

CHANTEL CORBETT: Schools.

JAMES FUTCH: The student exemption.

CHANTEL CORBETT: Right.

JAMES FUTCH: The Florida law is still written basically, unless you're in that particular area, you can't do those kinds of images unless you're a student. Student meaning in the, in the tradition of, hey, there's an accredited school, you're an enrolled person attending it and you can do it.

Now, there are some programs that do that in Florida. They kind of, I think, recognize the -- I'll give you some numbers. But 2100, 2200 total

nuclear medicine technologists in Florida, ballpark. And when we started this in '98, I think there was, like, 1800. And I don't know, but a fairly high -- you work in the field. Alberto, you were nuclear med. I think a fairly high percentage of nuclear medicine departments and nuclear medicine techs, I mean, CT, PET CT has kind of taken over a fair amount of what's going on.

So this is a big deal. This is why they put it in the curriculum in 2011 for the core nuclear medicine technologists.

CHANTEL CORBETT: Truthfully, from my research, and I may be wrong, outside of Florida, but in Florida, the majority of the nuclear med programs offer more CT education in their program than x-ray does.

KATHY DROTAR: Yeah.

CHANTEL CORBETT: So, you know, as of this point, you can come out of an x-ray classroom and do on-the-job training and get CT certified.

JAMES FUTCH: Which brings us to --

CHANTEL CORBETT: -- and be done with no additional anything.

JAMES FUTCH: Now, Tim Williams made -- went back and forth, a lot of questions to Cybil in here

from Tim. And one of the points that he brought out was, you can be certified in the primary area of radiography in Florida and because that primary area licenses you and covers any form of x-ray, you can do CT without getting a CT certification from either the State of Florida or from either one of the national registries.

CHANTEL CORBETT: Right.

JAMES FUTCH: That's perfectly legal. That's allowed.

CHANTEL CORBETT: Right.

JAMES FUTCH: Tim ended up, as I read the minutes, Tim ended up coming down on the side of, well, what they're doing is better than that. You know, it's much better. I'm not saying it's bad in any way, shape or form, but he ended up, I think, saying --

CHANTEL CORBETT: More education.

JAMES FUTCH: There's a lot more education involved in this, and you've still got to pass that test.

And let me show you, because you had asked something about --

CHANTEL CORBETT: The exam covers a lot more.

JAMES FUTCH: You had it in hard copy I think,

right?

CHANTEL CORBETT: I did. I gave you what I had.

JAMES FUTCH: Content specifications. There it is. So this is off the website last night. CT content specifications. Standard 200-question exam. And the person who has done this has completed the 500 hours and the 35 of the, of the contact.

You can see, we're talking about general areas here, fifteen percent of the questions, patient handling. Fifteen percent medications; contrast agents. Nuclear medicine always gets heavily involved in those areas, for obvious reasons.

Procedures and anatomy. Here's where it starts to get out into the nitty gritty. Exams of the head. You see exams of the neck, spine, musculoskeletal; chest.

I mean, you know, a lot of detail about -- I'm sorry, Alberto, did you.

ALBERTO TINEO: So this is going to become more of an issue going forward, so it was going to start January of 2018, but I think it was delayed, but CMS now is going to require anybody doing CT's to be -- to have some kind of certification. You cannot be a tech without certification in CT.

So they're either going to have the ARRT-CT or the NMTCB-CT. So I think we're just at the end of a wave that we're going to have to allow this to happen as long as they have good education. Because it's just, it's just a matter of time that nobody can perform CT without certification in that field.

JAMES FUTCH: Let me show you one more thing, also. And you and -- you had some thoughts, too, on -- because you were here before and I think a lot of folks had questions. But it seems like, in talking to everybody, we've kind of adjusted to this and it's --

ALBERTO TINEO: Yeah, I think at the end, it was just -- we were just waiting for them to take the -- to convince the ASRT to allow them to accept NMTCB as part of the scope of practice. So as soon as, I think where we ended was, as soon as that happened, the council at that time was okay to proceed with this.

KATHY DROTAR: It was the timing was in allowing the curriculum to go before the ASRT as the delegates to get voted on and accepted and it is.

ALBERTO TINEO: Correct.

CHANTEL CORBETT: Yeah, I mean, honestly, if the Florida regulations would allow, outside of the

student exemption, I think we would have tons more already through ARRT. It's just the fact that most full-time technologists, the ones that are out in the field, they don't have the time or money to go back, outside of their normal business hours, you know, into a school program at this point.

I've had people travel outside the state even to get those clinical hours done. So where it's legal to do it. And then, you know, get their ARRT. Because that -- their job really kind of depended on it.

JAMES FUTCH: So some of the discussion went back and forth. It was like we had the 125 exams camp and the 500 hours camp, which is kind of reflective of the way, you know, NMTCB, up until December 2015, used to have, what did they call it, alternative --

CHANTEL CORBETT: Pathways.

KATHY DROTAR: Yeah.

JAMES FUTCH: Pathway. it was for the base NMT exam, they would allow, it was 4,000 hours you had to have and not a certain number of exams in a certain number of -- because historically, that's the way they are verse the other registry. So it's like there's good and bad in both.

The commentary before talks about, well, you can go and take 125 exams and, you know, if you're doing rotations through emergency or something like that in a big hospital, you can do 125 in, like, two weeks or three weeks.

CHANTEL CORBETT: You can do each exam five times, so really divide that by five and that's how many you have to have.

JAMES FUTCH: Or you could say, well, you could take the 500 hours and you could do it all in, you know, just this particular area that's only available and the rest of it. And you can see that both of those, it would kind of be nice if we had like a certain minimum number of exams and certain number of hours for both of these groups, but that's not under our control.

KATHY DROTAR: I almost think they're comparable in what they look at. All of the ARRT examinations are competency based, where when you do it, you have somebody who is registered in that discipline to oversee you and make sure that you are doing it and that you're competent. They sign off and verify it so that you've done practice on it and now you're doing it.

With the -- and part of that is because the,

in the core curriculum, in x-ray, you're learning about x-ray and safety and, and, and most of us have included more CT or axial pathology, et cetera, in the curriculum. And what, what -- NMTCB is doing, you would need this many hours and so, it comes down to probably doing similar things, just the apple and oranges way of looking at it. The curriculums are the same.

CHANTEL CORBETT: Yeah, I mean, nuclear medicine, we've had cross sectional anatomy in our curriculum for, basically, since SPECT has been invented, you know, whereas, you know, you don't get that in a lot of the other programs. So it comes down to more specific CT; anatomy, obviously, being able to read that and the didactic requirements.

JAMES FUTCH: So this is the form that's required as part of the application process. This is the, basically, the validation of the 500 hours. It's got some instructions.

I really kind of expect, as time goes on, most people are going to get most of these done as part of their base nuclear medicine program. And the people who aren't doing that probably have already done, a large number of them have done the ARRT method. And I haven't seen the numbers. It would be

interesting to see --

CHANTEL CORBETT: The ARRT method really has not been done because they're not allowed to touch the go button. I mean, that's what this comes down to.

JAMES FUTCH: I'm really not supposed to, but --

CHANTEL CORBETT: Well, I mean -- and we kind of tried to, even at some point, we've asked, like, can we get something in writing saying that if we do everything else in the exam that we're allowed to do and not touch the start button, can we count that? But nobody would ever give the written yes. So, really, that's the hold up on the ARRT version.

JAMES FUTCH: But this is the form and then you can see the expectation of the 500 hours right there in the middle. It talks about what kind of standard you use and all that. But the expectation is that the hours include at least, you know, these kind of generic categories.

And they talk about not requiring a specific number of CT's because I think the hours is more important, because it takes a while to do 500 hours.

Anyway, that's, that's the form for that.

So here's where we're at as the Bureau. We

had quite a bit of information, minimum MNTCB provided before. We read the rules and statute back then. Really, the only thing that seemed to be holding us back, based on the sense of the council was, waiting for ASRT to put folks from NMTCB-CT pathway into their document. That's no small thing. This is the American Society of Radiologic Technologists. This is largely thought of being associated with the other registry. So they could've said, pound sand, but they didn't.

So at this point, I think we have what we need to proceed and make the regulation changes to start accepting someone from NMTCB-CT registry into the Florida -- and we have to do this anyway. We need to update the ASRT practice standards regardless because these are the current ones. The ones we have are old ones from few years back.

Once we do that, we've, just for the other side of the coin for the existing CT techs, we've already got NMTCB in the practice standards. It would be kind of silly not to allow them to be certified at that point.

So we have a couple different areas that we have to go modify and put some language together and start that whole process, which as I've mentioned to

a few people, is not quick anymore. I mean, you're talking minimum ninety days, and we had one that took a year, right?

BRENDA ANDREWS: Yes, we did.

JAMES FUTCH: That was really without any --

BRENDA ANDREWS: Actually was.

JAMES FUTCH: -- objecting to a lot of stuff at all.

So that's the issue, I guess, is does the council agree. Should we do this? Should we start the ball to accepting CT from NMTCB into the Florida certification so they can become certified as CT techs in Florida.

ALBERTO TINEO: I make that motion.

KATHY DROTAR: I second.

RANDY SCHENKMAN, CHAIRPERSON: Are we ready for a vote? All in favor? Say aye.

ALL: Aye.

RANDY SCHENKMAN, CHAIRPERSON: Opposed?

(No Response)

RANDY SCHENKMAN, CHAIRPERSON: Okay. That passes.

JAMES FUTCH: They should all be like that.

RANDY SCHENKMAN, CHAIRPERSON: Yeah. Actually, your next paragraph says medical imaging and

radiation therapy professionals performing multiple modality hybrid imaging should be registered by certification agencies recognized by the ASRT.

JAMES FUTCH: That's good.

RANDY SCHENKMAN, CHAIRPERSON: So we can use that as a part of --

JAMES FUTCH: I see what you mean.

RANDY SCHENKMAN, CHAIRPERSON: -- your rule.

JAMES FUTCH: So with your permission, moving on to another part of the --

RANDY SCHENKMAN, CHAIRPERSON: Absolutely.

JAMES FUTCH: If you were to go and look at the regs. that we've adopted in the past, there are practice standards for CT; there's practice standards for PET; there's practice standards for mammography. All of those are the ASRT practice standards.

We have three areas of primary certification for which no actual practice standard is adopted in Florida regulation or law. You have, instead, what we've been riding on for many years is in the statute, it talks about the practice of radiologic technology. And that term has been defined -- and let me find it for a second -- in a fairly simple way.

The practice of radiologic technology means the performance of activities requiring special knowledge and skills, including positioning and technique, safe operation of radiation equipment and radiation protection.

It's kind of minimalistic. For example, it doesn't even mention contrast or any of the other things. To show you by comparison, standards, here's radiography at the national level. This document -- whoops. It's thirty-two pages long. You know, practice standards are not super specific, but they are not that minimalistic. So this is radiography.

LYNN ANDRESEN: James, I have copies of radiography, nuclear medicine, and radiation therapy if someone would like to look at them.

JAMES FUTCH: Okay. Thank you.

So we were thinking, hey, we're adopting these practice standards for all of the specialty areas that have low numbers, relatively low numbers of technologists actually certified. We have 19,000 general radiographers, give or take; 2200 nuclear medicine technologists and just under 2000 radiation therapy technologists and all they have for a practice standards is what I just read to you, which

is not even two sentences long as displayed in this particular regulatory document.

On the other hand, here's a nice national association that has many, and the one for nuclear medicine is even written to cover both of the major nuclear medicine registries.

Would it not be better, with the Council's agreement, to go and adopt the document, for example, this radiography one, for our general radiographers that says, it's not overly restrictive, but it does have more meat on the bones. And a lot of these areas we get asked about over time. We've had to come back to the council in this particular case of nuclear medicine a number of years ago, and ask because the issue of medication kind of comes up every once in a while if we can do this, right? And we brought reams of documents to the council. We brought the curriculum standards for nuclear medicine. We brought the content specifications for the -- especially the NMTs for the exam, it's a little more specific, and explained, hey, these are what nuclear medicine techs are being educated to do. This is the kind of stuff they're being tested on. And throughout the whole thing, just to use the example, medication

administration, NMTCB'S were so specific, it had lists of pharmacological agents that they are tested on.

So it seemed, at least from our perspective, that this might be something that would be a good idea. But we wanted to hear from you. And when I say good idea, I mean to actually go and let's adopt a practice standard for one of the other areas, from the national registries, and use that.

ALBERTO TINEO: I think would be a great idea, because this comes up a lot in hospitals, of techs that are allowed to do everything according to the scope of practice, but the scope of practice is really this one. Nobody's in their license. So I think it would be concurrent with what the practice really is.

KATHY DROTAR: Well, there's also one for limited licensure.

JAMES FUTCH: Yeah.

KATHY DROTAR: So if there's any certification exam or discipline, there's a practice standard for each of them. But one of the things that happens is, on an annual basis, all of these practice standards and scope are all reviewed by committees. And then any modifications -- so that they are

maintaining the current practice standard. And any changes that are -- any changes are voted on by the house of delegates so that it's representative of practice throughout the United States. Not just any one area.

RANDY SCHENKMAN, CHAIRPERSON: So if that's the case, then would it be possible to put it in writing that we keep the most updated of the practice standards for each of the groups?

JAMES FUTCH: You can at least start with a motion that says you think these are good documents to adopt by the Bureau.

I just wanted to show you before anybody starts making motions. This is the way the practice standards are organized. Here's a general description of the scope in the beginning, which is kind of like common sense, right?

Evaluating images, performing quality assurance, et cetera, et cetera. Also includes these other things. And then you go into different areas, like, for example, the first area is assessment; clinical performance standards.

There would be a rationale. There would be general criteria. Sometimes the general criteria is fairly specific. Sometimes it's actually, as the

name implies, fairly general.

And then afterwards, there would be specific criteria. So this is kind of like if you really want to go and see what it is your profession does, you start looking through all of these specific criteria and general criteria, each of the different subject areas.

So here's analysis determination, standard number two, the general criteria, selects the most appropriate action plan, determines course of action, et cetera.

Some of these make my eyes glaze over.

MARK SEDDON: Are there any standards which conflict with what are in the current regulations?

JAMES FUTCH: We have to go through, like we did, if you remember, the radiologic assistant way back in '08, '06, something like that, we'd have to read it and make sure there isn't anything, as Mark implies, that would directly contradict, like, the law for the --

MARK SEDDON: Fluoroscopy.

JAMES FUTCH: -- the law for radiologic assistant excluded nuclear medicine and therapy. And the radiologist assistant's practice standard, at least back then, had a few areas that spoke to

that issue. And so when we adopted it in the regulation, we had to say, you know, we adopt this, and this is the scope, with the exception of number whatever, which contradicted the statute. So we'd have to go through and do that.

KATHY DROTAR: We're all -- it's within the scope of practice for a radiologic technologist to perform.

MARK SEDDON: And monitor.

KATHY DROTAR: But not in order to -- but it can't be used in order to position a patient.

JAMES FUTCH: Yeah.

KATHY DROTAR: So that there's that delineation. You can do, you can do a procedure, but you can't use it just to go in and center L4, L5.

JAMES FUTCH: There's actually a different regulation in Florida Administrative Code that speaks to that issue you're talking about.

KATHY DROTAR: Yeah.

JAMES FUTCH: Mark is probably thinking about that, too. Obviously, things have to be adapted, too, to what would be -- if there's statutory authority for it, we can change the regulation if it's conflicting with something that makes sense at

the national level.

Anybody want to see therapy or nuclear medicine? It's more of the same.

CHANTEL CORBETT: No.

JAMES FUTCH: Different words.

KATHY DROTAR: I've seen them.

JAMES FUTCH: A few different words. Same general idea.

CHANTEL CORBETT: I don't see specifically is contrast in the nuclear med practice. I think the SNM actually specifies --

JAMES FUTCH: Really?

CHANTEL CORBETT: It does say medication, so I'm sure it's under the definition.

JAMES FUTCH: At the end of the practice standards, I didn't pull up all the little associated documents, but there's, like, the last page or two, there's a whole bunch of specific documents about different, I call it -- I like to think of it as problem areas. You know, there are some areas we've had some difficulty in the past, so we need to say some specific stuff. It could be in one of those because there's a lot of medication and related stuff on there.

KATHY DROTAR: Chantel, that also might be

in -- under the practice standards. There's another document that has some of those other things in it.

CHANTEL CORBETT: Okay.

JAMES FUTCH: I know it's more specific than the means of performance of activity requiring special knowledge and skills including position techniques, safe operation radiation, radiation protection. It's a lot more specific than that, but still not, not being completely constricting. It still had some fairly, you know, general areas to it.

CHANTEL CORBETT: That would be my only concern, just to make sure that that's included. So that if a hospital, for instance, is going to say, you've got to go by this, and that excludes contrast, then that would be an issue.

JAMES FUTCH: And we'd definitely take that into account.

RANDY SCHENKMAN, CHAIRPERSON: Okay. So I'll move to accept these practice standards, depending on the laws of the State of Florida, and updating them as needed as if the practice standards are updated by the national registries. Does that make sense?

MATTHEW WALSER: I second.

RANDY SCHENKMAN, CHAIRPERSON: Anybody want to comment on it? Change it in any way? Okay. Can we take a vote? All in favor, say aye.

ALL: Aye.

RANDY SCHENKMAN, CHAIRPERSON: Opposed?

(No Response)

RANDY SCHENKMAN, CHAIRPERSON: None. Okay. So we passed it unanimously.

JAMES FUTCH: All right. Thank you for your guidance.

LYNN ANDRESEN: Two for two.

JAMES FUTCH: Do you want to do your stuff?

CYNTHIA BECKER: Sure.

JAMES FUTCH: Lynn, is there anything else that we --

LYNN ANDRESEN: No, those were the two main items.

JAMES FUTCH: Okay. So -- well, that's it for me.

RANDY SCHENKMAN, CHAIRPERSON: Okay. So now we have the Radioactive Materials Update.

CYNTHIA BECKER: Yes. And the update, for one thing, talking a little bit about this earlier at lunch, but one of the things that we do during an impending storm is we call the IC licensees or try

to contact them through e-mail. The ICs are increased controls licensees. We have about 60 of them that have the higher risk sources.

And we put out a message to them before the storm saying, basically, secure your sources; let us know if you need any help. Make sure we have the proper contact for you. And then, please let us know after the storm passes if your sources are still secure.

So we did that message pre-storm and we also did that message post-storm. And in past years, we knew more of an area that the storm was headed to. This year, of course, we just sent that out to all of them.

JAMES FUTCH: Pensacola, too?

CYNTHIA BECKER: Yeah. Yeah.

RANDY SCHENKMAN, CHAIRPERSON: Be on the safe side.

CYNTHIA BECKER: And we did really well here in the State of Florida. Texas, I know they did have some issues with flooding and with problems with sources.

The other thing that we do that you may not be aware of is that the nuclear power plants, they are required by NRC to start powering down when tropical

force winds are expected to be within 48 hours of hitting their plant. And so St. Lucie and Turkey Point both started shutting down, which they did. I think they power about twenty percent of the electricity in the southeast area of the state.

So shutting down means, of course, now, you know, having more issues with the electricity in the area. So they did power down.

One of the requirements, then, that NRC has is before they can start back up, they have to have us, as our contracting person with them -- our contract stipulates that for the power plants, we will go in and we will survey their monitoring and surveillance equipment to make sure that there was no damage during the storm so that when they start back up, their surveillance and monitoring equipment are working properly.

And our staff do that. The staff that work out of our Orlando environmental radiation for John Williamson, that's what they do right after the storm passes and it's safe enough for them to travel to the plant. So that those, those surveillance and monitoring equipment were inspected as well and found to be operating. So the power plants came back up fairly quickly.

So that's kind of the storm-related activities.

The other update is that I think Chantel brought this up at one point. Was it the last meeting or was it the meeting -- because --

JAMES FUTCH: It was in between.

CHANTEL CORBETT: I wasn't here last time.

CYNTHIA BECKER: Yeah, it was the one I wasn't here and you were here.

JAMES FUTCH: I think it came in since the last meeting if I remember right. You asked about this. Decay and storage.

CHANTEL CORBETT: Yes.

CYNTHIA BECKER: Decay and storage issue. NRC, as you know, and I think James mentioned this also, is that we're an agreement state. There's 38, 39 agreement states I think now, which means that we signed an agreement that we would regulate all radioactive materials within the state with the exception of federal facilities and nuclear power plants. So we do our regulations. But, of course, we have to be compatible and adequate health and safety regulations with them.

A lot of things are compatible, ABC, which basically means they're either going to be verbatim

what the NRC requires or we have a little bit of lax in certain areas, as long as we're still health and safety related.

We can be more restrictive in a lot of cases, and the decay and storage may be one of those issues. It came up in, interestingly, you brought it up, but then also Mike Stevens is kind of our rule guru. You know, he's been with us since 1985. He went to the Office of Agreement state meeting, which is sort of a subset of the radiation program, program director/NRC, it's, as it says, Office of Agreement States. What they do it's a formation of the Agreement States, 38, 39 of them, and the staff from them get together and discuss NRC rules, compatibility requirements, and discussions come up. And that came up in a meeting which was just in August.

Were you there?

CHANTEL CORBETT: No, but I figured it might come up.

CYNTHIA BECKER: Okay. It came up. And the issue, I guess, first to explain the issue, is that NRC does not require for medical sealed sources to decay and storage. They allow them to be disposed of if surveys -- proper, adequate surveys, show that

the sources are now at background radiation, then they can call a company and dispose of them.

CHANTEL CORBETT: Prior to the ten half lives.

CYNTHIA BECKER: Right. Prior to the ten half lives. In our rules, we still say you have to wait ten half lives in order to -- you're decaying and storage is what we're doing. You're holding that for ten half lives until you can safely dispose.

So when that came up, they asked some of the states that had gone with the NRC and changed their rules to allow that now, to allow disposal.

What they were finding and Mike had said that they were finding that there were a few more compliance issues. They were finding violations from licensees who were not doing proper surveys. They are not using -- taking away the shielding and doing a survey, which is important. Some of the licensees were keeping shielding in place and doing the survey; and therefore, thinking they can dispose now. And then some of it was ending up actually in the waste stream.

Now, that's what he said a few states had said.

JAMES FUTCH: The waste stream, by the way, is monitoring itself now.

CHANTEL CORBETT: Not like water.

CYNTHIA BECKER: Yeah, not like water. Waste stream, in like the land fills.

CHANTEL CORBETT: My only response to that would be if they're going to do that for that method, I don't see them doing anything different if they waited ten half lives. If they think that they're going to be able to do the monitoring with the shielding still present, then, if that's their train of thought, I don't see their train of thought changing after ten half lives. They still would go that route. Maybe I'm wrong.

ADAM WEAVER: That's a key, too. It's also a minimum of ten half lives. Some things you have to keep longer.

CHANTEL CORBETT: Correct. You still have to monitor -- some things are not.

ADAM WEAVER: Right.

CYNTHIA BECKER: So it's the minimum, right.

And one of the things, too, that came up is that, you know, are we having any questions from licensees. We haven't had any. I don't know --

JAMES FUTCH: Chantel has been answering all of them.

CYNTHIA BECKER: Okay. See.

CHANTEL CORBETT: That's actually why I called, because I had quite a few of my clients asking.

CYNTHIA BECKER: Really?

CHANTEL CORBETT: Yeah.

CYNTHIA BECKER: So we haven't, beside you bringing it up, we haven't heard that part of it yet. But the other thing that some of the states brought up that their licensees brought up when they changed it is that it was costing them more because they were having to contact disposal companies, like it was costing more to dispose than just for them to decay and storage and then discard.

CHANTEL CORBETT: That doesn't make sense, because the only thing we have to pay to dispose of now, is things that we cannot decay in storage. Like --

CYNTHIA BECKER: Okay.

CHANTEL CORBETT: There would be no reason to pay anybody.

ADAM WEAVER: Unless you're paying them to take it off your site for decay and storage.

CYNTHIA BECKER: Right.

CHANTEL CORBETT: Right. That doesn't make sense.

ADAM WEAVER: Or returning the source to the

vendor.

CYNTHIA BECKER: Right, then you have to pay for that.

CHANTEL CORBETT: We've had actual state inspectors tell clients in other states that they've come from previously, that this is why all this started, that once it was dead, you could just pull the labels off and throw it away. And so, we actually had somebody do that and luckily, I found out within 12 hours and it was still in Sharpes container. So that's why I started investigating and I'm like, I've never heard of such a thing. Like, that sounds absurd.

But then there was the NRC rule that actually said, like you could do it if it was background and you could throw it away. So I guess it depends on how it's interpreted as throw it away, you know, if it's dead.

CYNTHIA BECKER: Right.

CHANTEL CORBETT: So if it's a sealed source, if you have a cookie sheet, you know, sheet source for a camera and it's dead, you know, is throwing it away taking the labels off and throwing it into a normal trash can. Because there's -- there is no labeling at that point and it's dead. Or are you

still going to require them to pay to ship it out.

In that case, to me it doesn't change anything because right now, I've got people with twenty sources that are dead sitting under their cabinet because they don't want to pay to ship them out and go back to the manufacturer.

CYNTHIA BECKER: So that wouldn't change.

CHANTEL CORBETT: So if they would throw them away in the normal trash, that would be free and we would have that many fewer sources in inventory. But right now, they're not shipping them back because with the cesium vial, you know, it's $600 plus shipping. With a germanium source, for a PET source, it never goes under $600, no matter how dead it is, plus shipping. You know, a Cobalt sheet source goes down to $200 plus shipping. So -- and they only will do a one-for-one exchange.

So when a client buys a new source, typically, it's including to shipped one dead; one back. That only is good for six months.

They do have a, depending on the person and how nice you are to them, they may give you a couple more months on that. But a lot of people will sit on that for whatever reason, they don't send them back and so they start accumulating all these dead

sources and so they have these cabinets full of dead sources that, you know, we're still having to inventory to make sure that they are still there.

CYNTHIA BECKER: And that came up because, that came up as far as now we have to do inventory, we're storing those sources.

CHANTEL CORBETT: Right.

CYNTHIA BECKER: So it was almost like this, do you change it, do you not change it, you know.

CHANTEL CORBETT: Right.

CYNTHIA BECKER: It takes, as we talked about before, a long, long time to change something.

CHANTEL CORBETT: Right.

CYNTHIA BECKER: But the thought was that if they started hearing from people, and you said you are hearing from licensees to change it, but then the only thing is we'd have to be really careful about the other part of that is to make sure that they're not doing that and just removing the labels and going, oh, heck with it.

CHANTEL CORBETT: But why not? Why would we want to not do that?

CYNTHIA BECKER: Right. If it's truly, if it's truly background and there's no radiation and you do the surveys properly, yeah.

CHANTEL CORBETT: Yeah. I mean, I guess that's the caveat in the whole thing is how you prevent that from being an issue. But it's the same kind of thing with outpatient iodine therapies. You know, you have to at some point you're going to trust your licensee and you're going to trust whoever you're giving a signed consent form, they're actually going to do what they say they're going to do?

MARK SEDDON: Isn't there a half-life requirement?

CHANTEL CORBETT: For decay and storage, that's currently 120 days. That prevents you from doing it.

ADAM WEAVER: One hundred twenty days.

CYNTHIA BECKER: Anything that's -- yeah, one hundred twenty days.

MARK SEDDON: For Cobalt, you can't do that. that's why you store Cobalt.

ADAM WEAVER: Some things are too long.

CYNTHIA BECKER: Yeah, there are some things you can't.

CHANTEL CORBETT: The Germanium rod sources.

ADAM WEAVER: And also, those have lead in them, too.

CHANTEL CORBETT: It depends on the source, you

know what I mean? We've got the flexible sheet that are completely different than the glass, plexiglass.

ADAM WEAVER: Yeah. Depending on the detectors.

CHANTEL CORBETT: Yeah, there's pros and cons, obviously. I think most of this comes from everybody -- social media these days. Like everybody has a alumni Facebook groups and, you know, things like that where they've got texts that they went to school with that are working in other states and they will say, hey, have you guys changed this yet, whatever. And they go, oh, no. You can do that? Oh, wait, wait.

So then, of course, then that hits me because everybody has me as their contact. So I get people who are not my clients, you know, because I'm also the Society of Nuclear Medicine advocacy contact for the State of Florida. And I'm also the NTC contact for the State of Florida and I'm also here. Basically, my name and number are the primary go to, I guess.

CYNTHIA BECKER: And you're hearing that. Well, that's exactly what came up at the OAS meeting and they didn't resolve anything except for saying that if different states, as soon as they heard from

enough people saying this is an issue, this is an issue, then they, then they made changes. And then when they did, they saw some things, but it's not going to be, you know, like that every time.

CHANTEL CORBETT: Yeah. The other thought I had was, you know, and it would probably prevent that issue, is you could have multiple locations -- I don't know who, you know, if it would be like an inspector hub kind of thing, where the client says, okay, I've got these five sources. They're completely dead. They meet the criteria. And I have to bring them to you or have you come to me and verify before we can dispose of them. You know, like during your state inspection, you can get, you know, that would maybe work, you know, during their normal state inspection.

MARK SEDDON: Didn't we do the amnesty day with Debbie Gillie a number --

CYNTHIA BECKER: The scatter program?

MARK SEDDON: Yeah, scatter program.

CHANTEL CORBETT: Similar to that. Even if you did it --

ADAM WEAVER: Those are still radioactive.

CHANTEL CORBETT: Where they did on their normal state inspection cycle, that's not going to

prevent -- I mean, that's not going to have extra, per se, trips for you guys. But I mean, as they go on site to the client, if the client says, I've got these five, can you please, you know, sign off saying that they really are dead and I can get rid of them. I mean, that might be a way to do it. So that you don't have that problem with them just, you know, chucking them and you find them in a landfill. I mean, if they don't have labels, you're not going to be able to track back to the clients.

CYNTHIA BECKER: You're not going to track it back.

CHANTEL CORBETT: Maybe that's the best way, just have them sign off on it during the inspection.

ADAM WEAVER: Some of these labels are hard to remove, too. They are permanent.

CHANTEL CORBETT: Some of them have the thermal labels on the Cesiums and that stuff and after a couple years, they disappear. Like, there is no labeling on those vials anymore. So if you don't write, like we've got masking tape and we've got all kinds of other things that we've handwritten them on.

Honestly, at that point, it's, you know, your word against whoever wrote it down like, I guess

that's really the source that matches. So -- it's an interesting game.

CYNTHIA BECKER: Okay. Well, so, the thought I'm supposed to bring from the materials licensing program is if you're collecting -- because they are calling you. If you're collecting those comments, if you could express those up to Charlie --

CHANTEL CORBETT: Okay.

CYNTHIA BECKER: -- Hamilton, then we'll need to start looking at those and figure out if that's something we need to pursue or put in place something like you're saying where we change our inspection approach. Something that we could do to keep from having issues if it's changed.

CHANTEL CORBETT: Right. We've had inspectors mention to clients, you know, you guys really have a lot of, you know, old sources here. You really should get rid of them. And it's an ALARA issue. It's not an ALARA issue because they are dead. It's not that part, but it is a lot of sources.

And hurricanes, I mean, if you have twenty dead sources but a hurricane comes through and floods your department and they are all gone now, you have to go track them down because they were on your inventory, but they've been dead for years.

You know, that's an issue, too.

LISA GAVATHAS: Some of them are pages and pages long. What are these things? You start digging them out from under the cabinets.

CHANTEL CORBETT: Pulling them out of the cabinet.

LISA GAVATHAS: We have some up here and we have some down here.

CYNTHIA BECKER: Does it end up costing?

CHANTEL CORBETT: I think that might be the most streamlined way to do it, during an inspection and have them sign off, because it is already in their, their, you know, schedule cycle. And they're already checking inventory while they are there anyway.

CYNTHIA BECKER: Right. Okay. That's a good idea. Thank you.

CHANTEL CORBETT: Yeah. No problem.

CYNTHIA BECKER: All right.

RANDY SCHENKMAN, CHAIRPERSON: Anymore comments for this? Questions? Okay.

Next we go on to Brenda.

BRENDA ANDREWS: Okay. We have currently, two vacancies on the council. I know some of you remember Mary Bridget-Hart, who was in the Board

Certified Nuclear Medicine Physician position. And she submitted her resignation in February of this year due to her overload. She could not -- she could no longer continue on the council, so that position is still open.

And a little recently, Dr. Cognetta, his position expired in May. So he was unable to be here today, but he would've also not been a member at this point.

So I have sent an e-mail out to Dr. Cognetta and I'm waiting to hear back to see if he's interested in reapplying for another three-year term and I'm waiting to hear back from him. I'll probably give his office a call to see.

Also, shortly after Dr. Hart resigned, we did submit a letter to the society, but in the meantime of everything else going on, they have not responded. So we're definitely going to have to go back and do more due diligence in getting these positions filled. But in the meantime, if anyone on the council knows anyone that may be interested in the two vacancies.

I also put in your package a list of the current members and it shows those two vacancies. So if you know anyone that --

CHANTEL CORBETT: I'll contact the society.
BRENDA ANDREWS: -- would qualify.
CHANTEL CORBETT: See if I can get them to give us some --
BRENDA ANDREWS: Okay. That would be great.
CHANTEL CORBETT: They are having their annual southeast chapter meeting the 6th through the 8th of October they're actually meeting. That would be a good time. I'll reach out to them.
BRENDA ANDREWS: Great. Of course, Dr. Cognetta was in the lay position.
So we're looking to get those filled because the Department is always concerned about any vacancies we have on any of the councils or boards. So I've really got to step it up and get these filled pretty soon. Hopefully by the time we have the next meeting we'll have those filled.
ADAM WEAVER: What's the requirements for the open position?
BRENDA ANDREWS: James, you can probably speak more to that than I can.
ADAM WEAVER: Is that the one you were trying to look to fill with the vet?
BRENDA ANDREWS: One of the lay positions.
JAMES FUTCH: No, Dr. Cognetta's position we

kind of call it the lay position. It's just -- it can't be one that is a member of any of the certified radiation positions or closely related positions. The attorneys -- Dr. Cognetta, actually, is a dermatologist and he performs radiation therapy, superficial. We actually had to run that one by the general counsel's office last time and they said that's not close enough to worry about.

So if that's still what they say this time, you can actually be a cardiologist using fluoro or a vet using x-ray and that would be fine, judging by the previous guidance. Really, anybody. It's a very wide-open spot. I think -- who's the other one?

BRENDA ANDREWS: I'm sorry?

JAMES FUTCH: Who's the other one?

BRENDA ANDREWS: Matt Walser.

JAMES FUTCH: So give us ideas.

ALBERTO TINEO: I have a question. I know the last time I was up for renewal, which is going to be next year, there was a lot of push to change members or to -- I don't know if that was from the Department or if that was from, what was the impetus for that?

BRENDA ANDREWS: That was more so from the

Department at that time.

ALBERTO TINEO: At that time.

BRENDA ANDREWS: Of course, each person in that position may take a -- someone else may take a different stance on that. But I think the main thing, the main focus during that time was to renew the council so that the same members were not on there for years on end, but give other people opportunity --

ALBERTO TINEO: Okay.

BRENDA ANDREWS: -- to apply for it. Of course, this is a unique council, so it's not like you don't have an abundance of people that would even qualify or be interested, everything lining up for them to be a part of this council. So I think they began to recognize that. And I'm not sure if that's still going to be the case now. We are under a new Surgeon General as well.

ALBERTO TINEO: I see that as a lot of --

JAMES FUTCH: By my count, ten next year.

ALBERTO TINEO: Yeah, next year.

JAMES FUTCH: Not counting the two we were just talking about.

CHANTEL CORBETT: How far ahead do the societies nominate for these renewal positions?

BRENDA ANDREWS: Well, we're the one that initiates that. So when there's a vacancy, we submit the letters to them, letting them know that we have a vacancy and that they nominated someone. We give them that information before.

We also let them know if that person is interested in renewing, we let them know that. Or if the person is actually resigning from the position, we let them know that as well. So they can decide if they want to reappoint that person or renominate that person or if they want to give us a new nominee.

CHANTEL CORBETT: Okay.

BRENDA ANDREWS: But it starts with us.

CHANTEL CORBETT: How far ahead does it happen, do you know?

BRENDA ANDREWS: Well, in the case with Mary, Mary Hart's position, we did it short -- about a month after she resigned.

CHANTEL CORBETT: I mean for, like, the renewals. That we know the date.

RANDY SCHENKMAN, CHAIRPERSON: We had ten. Ten for next year.

BRENDA ANDREWS: Yes.

CHANTEL CORBETT: If your term is ending in

July, does the notice go out in July or does it go out in May?

BRENDA ANDREWS: The notice to the person -- they like to give them at least thirty days once we have chosen someone. So I would say about two months out -- three months, three months out would be a nice range for us to do a solicitation --

CHANTEL CORBETT: Okay.

BRENDA ANDREWS: -- and get a nominee back in, do all the vetting that has to be done with the person and then submit our paperwork through, giving them the thirty-day window.

CHANTEL CORBETT: Yeah. The reason I ask, some of the societies only meet so many times a year. I wasn't sure how that would fall into their meetings cycle.

JAMES FUTCH: Brenda, we would probably prefer wouldn't we, if they're having their society meetings in May, April, March, spring meeting, right? If, if they were to go ahead and talk to the society that nominated them and maybe get the ball rolling so we don't have to go after the fact and send something out. We can get something from them.

CHANTEL CORBETT: That's why I --

BRENDA ANDREWS: Right now we're pretty much

after the fact.

JAMES FUTCH: We don't want to be.

BRENDA ANDREWS: We don't want to be.

CHANTEL CORBETT: It's not easy. I know.

BRENDA ANDREWS: We really need to go ahead and get some nominees in at this point.

CHANTEL CORBETT: Like FNMT, we have our meeting the 30th of this month. Council meeting. Our annual meeting is in May. We have another council meeting at the beginning of the meeting in May, so at that point, we can make sure we have a decision or whatever.

BRENDA ANDREWS: I'm pretty sure the Department is going to want us to have something before the end of this year. Some decision made.

CHANTEL CORBETT: We'll talk about it.

BRENDA ANDREWS: Because we have one that will be open, well, from February and May.

CHANTEL CORBETT: FNMT will be a good guide --

BRENDA ANDREWS: I appreciate that, too.

CHANTEL CORBETT: -- Society both and see if we can come up with a nuclear med position for you --

BRENDA ANDREWS: I would really appreciate that.

CHANTEL CORBETT: Because they are harder.

BRENDA ANDREWS: Right. It's the keeping up with letters going out --

CHANTEL CORBETT: Right.

BRENDA ANDREWS: -- responses coming back and e-mails and sometimes, you know, you don't know whether someone has responded back to you or not for a while because you've got other things going on.

CHANTEL CORBETT: Right.

BRENDA ANDREWS: Before they start asking me a whole lot of questions, I have already been contacted that we have positions vacant. So I know they want them to be filled pretty soon. So I'm thinking at least by the end of this year those positions will need to be filled. At least by January.

CHANTEL CORBETT: Okay. I'll see what we can do in the next couple weeks.

BRENDA ANDREWS: Okay. That would be great. Thank you so much.

RANDY SCHENKMAN, CHAIRPERSON: What I was just saying is because we have so many positions that are going to be opening up in July, that maybe letters to all the members of the board to see if they want to return maybe should go out in April or beginning of May, so that that gives everybody time to -- that

would give time for the spots to be re-filled.

BRENDA ANDREWS: And probably before that, I'm thinking.

RANDY SCHENKMAN, CHAIRPERSON: Or before that.

BRENDA ANDREWS: It will have to be. Because if I -- if they are in -- if their terms are going to end, well, July, a lot them will end -- let's see here. Yeah. Those that are ending in July. Let's see. Yeah, April will probably be a good time. April, May, June. Yeah, April would be a good time to put those notices out. Okay. That would be great.

RANDY SCHENKMAN, CHAIRPERSON: So most of us be looking for your notices in April.

BRENDA ANDREWS: I will definitely put that in my Outlook.

RANDY SCHENKMAN, CHAIRPERSON: Okay. Is there anymore discussion on this? Should we go on?

Okay. The next thing we have is old business. Is there anything anybody wants to bring up about old business?

(No Response)

RANDY SCHENKMAN, CHAIRPERSON: Nope? Okay. So now we're going to move on.

Our next meeting --

BRENDA ANDREWS: There's calendars.

RANDY SCHENKMAN, CHAIRPERSON: There's a calendar in the back.

BRENDA ANDREWS: Yeah, in the back.

RANDY SCHENKMAN, CHAIRPERSON: So give us an idea what we're thinking when the next meeting should be.

BRENDA ANDREWS: I printed three of them, March, April and May. That was just to have something to look at because we generally go around the May time frame. If you all want to continue to stick with that with May, that will narrow it down to that month.

JAMES FUTCH: When is CRCPD, do you know? I hear you.

KATHY DROTAR: May would put us after the session ends. The legislative.

JAMES FUTCH: Oh, it's January, February this year, right? It's the early year.

RANDY SCHENKMAN, CHAIRPERSON: So is May okay with everybody?

JAMES FUTCH: So we need to avoid the week of May 20th, 21st.

BRENDA ANDREWS: Okay. What's during that week?

JAMES FUTCH: CRCPD. Any other societies we know of now meeting?

CHANTEL CORBETT: ARRT is the first weekend. That won't affect the Tuesday.

RANDY SCHENKMAN, CHAIRPERSON: So the -- we have to avoid the 21st -- the 22nd you're saying?

JAMES FUTCH: Yep.

RANDY SCHENKMAN, CHAIRPERSON: Okay.

STRATIS LAGOUTARIS: One second. This calendar is incorrect. May -- this is May 18th, I'm sorry, like May 16th is actually a Wednesday, not a Tuesday.

BILL ATHERTON: Well, there's two 16's.

BRENDA ANDREWS: I think it's the way it looks.

STRATIS LAGOUTARIS: I picked one day with two 16s. Got it. Never mind everybody.

CHANTEL CORBETT: Those numbers are really blurred.

BRENDA ANDREWS: The fives look like sixes. The fives look like sixes.

KATHY DROTAR: The 15th?

RANDY SCHENKMAN, CHAIRPERSON: So our choices are the 1st, the 8th, the 15th and probably the 29th is not good. It's right after Memorial Day.

So anybody have a preference for any of the

first three weeks? First three Tuesdays?

KATHY DROTAR: The 15th.

CHRISTINE CRANE-AMORES: The 15th.

RANDY SCHENKMAN, CHAIRPERSON: Okay. Is the 15th good for everybody so far?

JAMES FUTCH: Any complications with schools, colleges, children's schools?

KATHY DROTAR: Not as of today at 3 o'clock.

CHANTEL CORBETT: Usually May is Memorial Day.

RANDY SCHENKMAN, CHAIRPERSON: So May 15th it is.

BRENDA ANDREWS: Okay. And the location?

KATHY DROTAR: Here.

RANDY SCHENKMAN, CHAIRPERSON: Does everybody like it here? We have here and we've done Orlando.

BRENDA ANDREWS: Yes.

MARK SEDDON: This is fine.

JAMES FUTCH: All the east coast folks would like to go back to Orlando. No. We're agnostic in Tallahassee. It's the same time frame either way.

RANDY SCHENKMAN, CHAIRPERSON: So if it's okay with everybody, why don't we just do it here? This was very easy. Is that okay? Does somebody have a preference for Orlando?

STRATIS LAGOUTARIS: It doesn't matter.

RANDY SCHENKMAN, CHAIRPERSON: Is this good for you?

ADAM WEAVER: May 15th?

RANDY SCHENKMAN, CHAIRPERSON: May 15th, here.

BRENDA ANDREWS: So that's that.

RANDY SCHENKMAN, CHAIRPERSON: So does anybody else have anything else before we adjourn?

BRENDA ANDREWS: I want to say one more thing about the travel.

RANDY SCHENKMAN, CHAIRPERSON: Ah, yes.

BRENDA ANDREWS: The dirty words.

JAMES FUTCH: We'll start with "we apologize".

BRENDA ANDREWS: Yes, we apologize all around. Some of you got in very easily this time, but we still have glitches in that system. My plan is to, since we now know the date of the next meeting, to go ahead and do the Go Travel electronic system and try and get your travel through. That gives us about six months or more to get everybody approved through their preferred system.

So you can look for an e-mail that's going to say, do not reply from this -- DOH, very shortly. Probably within a month because I'm going to go ahead and try and get these done this time and not be at the last minute.

No matter how soon I started, it seemed to wind up at the last day trying to get travel done. And we don't want to keep doing that. So we're going to give this another try. We'll give it more time.

RANDY SCHENKMAN, CHAIRPERSON: Are there any receipts or anything you need from us for that might not have gone through or --

BRENDA ANDREWS: If you -- well, everybody's went through. I actually -- this is my fault. I messed up and didn't know that Alberto was coming, so I've got to go back and actually do travel for him. So if you have receipts, like tolls or your hotel receipts and anything, you can all send those back to me or e-mail me copies. Make it easy for yourselves. Okay.

RANDY SCHENKMAN, CHAIRPERSON: But if we've already had the approval, do we still need to do that?

BRENDA ANDREWS: If you've already had the approval, you still need to e-mail me receipts because I need to attach those to your reimbursement.

RANDY SCHENKMAN, CHAIRPERSON: Okay.

BRENDA ANDREWS: And you don't have to mail

them back. You can scan those in and e-mail them to me. That will be fine.

BILL ATHERTON: And then fill in the exact times and stuff on -- is that online now or --

BRENDA ANDREWS: If your times are different from what was on the authorization, just in your e-mail, tell me what your times were.

BILL ATHERTON: Gotcha.

BRENDA ANDREWS: Your exact times. And if your mileage was different, tell me what your exact mileage was and I'll adjust it. Of course, you know that the way the state works is I have to do the rental car based on their criteria as opposed to the actual mileage at the 0.445 cents per mile. And they give what is the most economical for the state, of course.

CHANTEL CORBETT: What?

BRENDA ANDREWS: Yes, I'm sorry.

RANDY SCHENKMAN, CHAIRPERSON: Gee, what a surprise.

CHANTEL CORBETT: Shocking.

BRENDA ANDREWS: Yeah. It makes my heart break to even say some of these things. That's the way they do it. That's the way it is. So anyway, that's how it's figured. So any receipts, you can

just e-mail those back to me and that will be fine.

RANDY SCHENKMAN, CHAIRPERSON: Any other questions? Comments? Okay. I think we're adjourned. And we'll see each other again in May.

(Proceedings recessed at 2:19 p.m.)

CERTIFICATE OF REPORTER

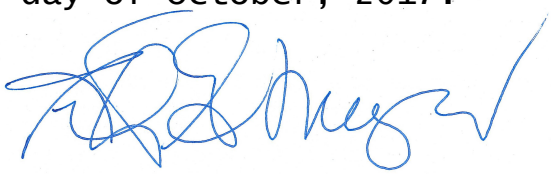
STATE OF FLORIDA:

COUNTY OF HILLSBOROUGH:

I, RITA G. MEYER, RDR, CRR, CRC, do hereby certify that I was authorized to and did stenographically report the foregoing proceedings and that the foregoing transcript is a true and correct record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties, attorneys or counsel connected with the action, nor am I financially interested in the outcome of the action.

DATED this 10th day of October, 2017.



RITA G. MEYER, RDR, CRR, CRC

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