DATE: May 5, 2009

TIME: Beginning at 10:00 a.m.

PLACE: Tampa Airport Marriott
Santa Rosa Room
Tampa, Florida

REPORTER: Patricia K. Gough
Verbatim Reporter
Notary Public, State of Florida at Large

ADVISORY COUNCIL MEMBERS:

Chairman Warren Janowitz, MD, JD
Tim Richardson, RT (R)
Carol Bonanno, CNMT
Kathleen Drotar, M. Ed., RT (R)(N)(T)
Vice-Chairperson Randy Schenkman, MD
Paul Burress, CHP
Alberto Tineo, CNMT
Jerome Guidry, P.E., Q.E.P.
William (Bill) W. Atherton, DC
Albert V. Armstrong, Jr., DPM
Mark S. Seddon, M.P., DABR, DABMP
Timothy R. Williams, MD

DOH EMPLOYEES:

James Futch, Radiation Control
Terry Frady, Radiation Control
Janice Livingston, Radiation Control
Vicki Grant, MQA
Gail Curry, MQA

MEMBER OF THE PUBLIC:

Ray Dielman

P R O C E E D I N G S

CHAIRMAN JANOWITZ: I'm Warren Janowitz and is the current chairman with the – what happens – if anyone wants to run for chairman I won't feel insulted.

Why don't we go around the table and have everyone introduce themselves. I think we know almost everyone.

MR. TINEO: Start right here?

CHAIRMAN JANOWITZ: Sure.

MR. TINEO: I'm Albert Tineo, from Halifax Medical Center in Daytona Beach.

DR. ATHERTON: Bill Atherton, Bill Atherton, Chiropratic, Miami, Florida.

MR. BURRESS: I'm Paul Burress from Florida State University.

DR. SCHENKMAN: Randy Schenkman, Retired Radiologist from Miami.

MR. RICHARDSON: Tim Richardson, Marion County School of Radiologic Technology.

MR. FUTCH: James Futch from Health Radiation Control.

MR. JANOWITZ: Warren Janowitz, Baptist Hospital in Miami, Head of Nuclear Medicine.

MS. LIVINGSTON: Janice Livingston, Department of

Health Radiation Control.

MS. GRANT: Vicki Grant, Department of Health, MQA.

MS. CURRY: Gail Curry, Department of Health, MQA.

MR. FRADY: Terry Frady, Department of Health Radiation Control.

MR. GUIDRY: Jerome Guidry, Perigee Technical Services.

MR. ARMSTRONG: Albert Armstrong, Assistant Professor of Radiology, Barry University in Miami.

MR. SEDDON: Mark Seddon, Florida Hospital, Medical Physicist.

MS. DROTAR: Kathleen Drotar, Keiser University, Statewide Program Director.

MS. BONANNO: Carol Bonanno, Florida Nuclear Medicine Technologist and Diagnostics.

CHAIRMAN JANOWITZ: And has everyone seen the last meeting's minutes? Are there any corrections or comments?

MR. GUIDRY: We still don't know who said those words.

CHAIRMAN JANOWITZ: Nobody is owning up to it.

MR. GUIDRY: But I've been attributed as having said and I know I didn't and so I'll just leave it as it is. I don't think it hurts anything.

CHAIRMAN JANOWITZ: Change it to anonymous?

MR. GUIDRY: Right.

CHAIRMAN JANOWITZ: So we will officially strike Jerome's name.

MR. GUIDRY: Whatever.

MS. LIVINGSTON: We'll just strike it and put "unknown" in the minutes then.

CHAIRMAN JANOWITZ: Do we have a motion for approval of the minutes?

MS. DROTAR: So moved.

MS. BONANNO: Second.

CHAIRMAN JANOWITZ: Any opposed? (No response.) Approved.

(Timothy Williams, Terry Frady and Ray Dielman enter room.)

MR. FUTCH: Take a seat. Former radiation control employee (referring to Dielman) walking in here and assuming now, I forget exactly the company name or --

MR DIELMAN: Radio Physics Associates. Radiation Safety and Compliance Health Physics.

MS. LIVINGSTON: Did everybody get a parking validation ticket?

MR. FUTCH: Let me start out and just mention we've got a -- we did the introduction. We have two

new folks, Vicki and Gail, from the Department that handles the actual licensure, daily licensure of the radiologic technologists. We're happy to have you both with us today.

MS. GRANT: Thank you.

MR. FUTCH: And Bill sends his apologies but he could not attend today. I thought seriously about not telling you exactly why. I think I'll tell you why because, you know, I want you to know.

As you know, we spend a fair amount of time selecting the dates for the next meeting and vetting it with all of you and going through the rather long process. And we did all of this, of course, and we do it internally in the Department. And we went to Bill a couple of times and it was fine with everybody. And as we're sending the -- we were putting the final touches on the agenda and signed all the contracts for the room and he comes back to Janice and he says --

MS. LIVINGSTON: He says, "You know, there was something I thought about for that date that I had going on but I couldn't remember. I looked at my calendar and everything and I couldn't remember what it is. It just dawned on me. It's my thirtieth wedding anniversary."

ANONYMOUS: That doesn’t sound like a good excuse.

MS. BONNANO: Yeah, right. I would kill him.

MS. LIVINGSTON: I started laughing. Wait until I call your wife.

MS. BONANNO: Wait until she reads it in the minutes.

MS. LIVINGSTON: Before we get started let’s talk about the restaurants.

CHAIRMAN JANOWITZ: Okay.

MS. LIVINGSTON: The reason I want to talk about the restaurants now is I have to go down and make arrangements. We have a Carrabbas which is across the hall from TGI Fridays. And I don’t know if everybody wants to go to Carrabbas, TGI Fridays, if you want to go half-and-half. So if we could go ahead and I’ll go ahead and make arrangements.

MR. FUTCH: One Point. Carrabbas said they would reserve a table?

MS. LIVINGSTON: Uh-huh. They would go ahead and move the tables in the back and we could get in a big group.

MR. FUTCH: TGI Fridays, usual procedure?

MS. LIVINGSTON: We would have to split up into smaller groups.

ALL MEMBERS: Carrabbas.

MR. FUTCH: How many folks are going to go to Carrabbas? (Head count.) Anyone not going?

ANONYMOUS: And if you're not going to Carrabbas we have a long memory here.

MS. LIVINGSTON: Okay. I'll go down and I'll take care of that.

MR. FUTCH: Back to the business. We were running through the minutes and realized, of course, that we had extended the term for the chairperson by another year so he could have a two-year term. And they are up as of the middle of this year or something like that. So before we meet again we need to, I guess, have nominations from you folks, or re-nominations for the * chair and vice-chair, who I think have done an excellent job. But we will take a vote for that. So this is not really my part. This is y'all's part, so any thoughts?

MR. RICHARDSON: I think the chair and the vice-chair are doing an excellent job.

MS. BONNANO: Here, here.

MR. RICHARDSON: I re-nominate them.

CHAIRMAN JANOWITZ: The last time I wasn't here when this happened.

MS. DROTAR: We snuck you in.

MR. FUTCH: Any other nominations? (No response.) I'm perfectly happy with the nomination. Any discussion? Everybody wants to vote?

DR. ATHERTON: I'm ready to vote him.

MR. FUTCH: All in favor?

(All members say "Aye.")

CHAIRMAN JANOWITZ: Thank you. Okay. James, I guess you're up next, legislative.

MR. FUTCH: When I got notice that Bill wasn't going to be here today my name started appearing an awful lot in the right-hand column. But we have Vicki and Terry.

Let me start out with money matters. This is always fun. As you know, Florida is in a recession. Ha, ha, surprise. Who would've noticed. Right? And one of the things that happens in a state like Florida that relies very heavily on the sales tax for most of its general revenue programs is that we start having special sessions, and regular sessions, and things start getting tight and then people start looking for sources of money, et cetera, et cetera.

As you know, Radiation Control and MQA and the Rad Tech, all the rest of that are all state-supported

programs paid for by the people who pay the license fees, or the machine registration fees, et cetera, et cetera.

We are remarkably resilient and not terribly affected by the recession. We are not as affected by the recession although we are to a certain extent. However one of the interesting things that happens is our moneys are all deposited into trust funds. And those trust funds all have laws that say things, for example, like all the moneys collected and deposited into the trust fund shall only be used for the purposes for which they are collected, which, you know, basically sending the inspectors out to inspect machines, and licenses.

However, the other thing that happens in a recession is Legislators get to write laws. And so what they do is occasionally they will go through and sweep all the available cash out of the trust funds, which is what happened in this special session back in, what was it, February? Right. So they took about two-thirds of the cash out of the Radiation Protection trust fund and about three-fifths of the cash out of the Medical Quality Assurance trust fund, which is the place where either if you're a facility, your money

went to pay for the inspections, or if you're a licensed professional, your money went to pay for renewal of your license and examination and all that sort of stuff.

DR. SCHENKMAN: Where does that money go?

MR. FUTCH: Straight to the General Revenue Fund, which is the place where they are having the short fall because of the sales tax decrease and then they use that to fund, you know, all the stuff that was paid for out of General Revenue that doesn't have it's own dedicated funding source.

This is not a new thing that's happened whenever there is a severe recession. It happened back in '91, '92, the last big one.

And the other thing that has happened is that back, I believe it was in the middle of the Chiles administration, the trust funds had attached to them a surcharge of seven percent, which is an ongoing basically transfer of seven percent of all the funds that go into the trust fund to the general revenue. Now, that's kind of separate from the recession. That's been there since the middle of the Chiles administration. And that surcharge has always been set at seven percent. So in a way you can kind of

think of it sort of as a backdoor sales tax on the trust fund.

This particular session -- it's not final, of course; the budget hasn't quite been printed, I don't think, until today. But more than likely if it goes the way that we think it's going to go, that surcharge will increase from seven percent to eight percent, ongoing permanently.

So think of it this way. The economy goes south. The Legislators sweep available cash out of trust funds and this year increased the permanent ongoing every year amount of transfer that occurs from seven to eight percent.

All of that is a roundabout way of me saying that we will be looking quite hard at fee increases. Because of statutory caps -- and we will get into this in a second with some of the different programs, you can't really increase many fees in many places inside the areas that we deal with because we're at the limit that the law allows. So that means we will be looking at how else do we keep going. And we may be looking at legislation to reduce again the frequency of which we go out on the -- some of you were here back in the previous years back in the, I think the mid-nineties.

We used to inspect x-ray machines every year. By law there is a part of the statute that says we must do it at least this often. And one of the things we did is we had that law changed to at least every two years. And it's been that way since the mid-nineties.

It may be time to do it again which is, I think, a little unfortunate because, you know, at some point you can get to the point where: Okay, I go out every year, and I go out every two years, maybe I'll go out every three years. Maybe we'll do it every ten years. You know, at some point it really starts affecting, you know, oversight, and safety, and that kind of stuff.

Anyhow, I thought it was important to let you all know that, that that is kind of a backdrop for a lot of things that are going on right now. Because it leads into my next topic and also perhaps it may affect other decisions that -- or folks that you talk to who may wonder what's going on, you know. That's the background for all of this.

CHAIRMAN JANOWITZ: Are you to informing them for the x-ray machines?

MR. FUTCH: Yes. That's my next topic. A great segue. I appreciate that.

DR. ATHERTON: Did you say that -- so were you just telling us that they are decreasing the inspections or are you saying that may happen?

MR. FUTCH: No. That actually requires a change in the law.

DR. ATHERTON: Oh.

MR. FUTCH: What they were -- the last time we went through this, they were -- it was much easier to get a decrease in the frequency of inspections than it was to get an increase in the fee capital in the section in the law. They are both in the law. The amount of time we have to do them and the amount of money we can charge, or at least the limit on the amount of money we may charge.

DR. SCHENKMAN: But this limit is an old limit.

MR. FUTCH: Yeah. Let me transition to -- first, any questions about this part of it, funding, all of it? Think of the trust funds as kind of like mini balanced budget amendments that would work great except for the fact that the folks who write the laws can change them.

So you will recall we had some proposed legislation that you all voted on from I think the last meeting. Actually voted on a couple of times.

One of those was the specialty technologist which is the problem we have right now not being able to recognize post-primary certifications. And this was our mechanism for doing that. And I will go into that again in just a second.

But one of the things that we proposed this year was to change the x-ray machine statute. And this is actually the first thing in your packet. This is marked D-2, the little red tap on the top.

This is the actual x-ray machine statute. And because of all the background of things that were going on, you proposed this change to the radiation machine statute which basically, what this is, is an increase of getting rid of the existing frequencies and hard coated statutory caps, kind of collapsing them all down. We have several different types of caps for different kinds of machines and facilities. So what we did was we proposed to collapse it all into one big kind of super cap and super range with, of course, a larger amount of money that would be allowed to be charged.

And this was proposed for this legislative session which is drawing to a close as we talk. And this failed this year. So we will be trying something

along these lines again in the fall. I don't know if it will be exactly this.

MS. BONANNO: Is there a particular reason it failed?

MR. FUTCH: No. Actually, you know, it got farther than any of these kind of things have done over the years. I think because of all the -- everybody realized, you know, everything -- everyone is short, we need more money, we need sources of money, it actually got farther than it typically does.

We had some interest from one of the committees, I think it was in the House, from the chairman of the committee, to: Hey, if there is anything else there that is general revenue supported or is in an indirect way supporting things, you know, let me know how we can help support that.

So we were using that as a vehicle for trying to do this. And I won't get into the politics of it because I don't want to get fired. But the short story is that there is a lot of philosophical differences in the two different chambers on raising fees, is it a tax. Folks don't want to be associated with increasing taxes.

Nevertheless, there were a lot of things that did

get passed. You know, the cigarette tax, for example, I think it's going to go. But it kind of got caught up in all of that.

So, it was both a good thing and a bad thing. It was good because people were taking a look at it and saying: Oh, yeah, well you're right. We're using all these funds and we need to do something about it.

On the other side of it there were people who were opposed to it.

DR. SCHENKMAN: But, at least, when I read this or when we discussed it last, it seems to me like because these rules have been in place and are so old we are not covering the cost at all. So, maybe if it's re-presented to whomever again, you know, with the hard numbers of: Look, this is what it costs us to send somebody here, and this is what it costs us to send somebody there, and to inspect this machine and inspect that machine. I mean, maybe if they realize we aren't even covering the cost then at least something could get written in where it's not like adding a tax but it's just covering cost.

MR. FUTCH: Right. And we -- just to let you know, we have tried various creative and truthful, of course, ways of explaining this. You mentioned how

long it's been. These x-ray machines, these caps were set -- the caps, it's a range, right. You can start out in your department but you can't go any higher than this. That fee range was set in 1981 and we reached that cap in 1990, early nineties. I want to say 1991, somewhere in that range. So we actually -- I think it was set twenty-eight years ago and we reached it eighteen years ago. And since then, as the x-rays costs and everything has gone up, what has happened is inside our trust fund the costs of the x-ray machine program have, of course, gone beyond what it can recover so they are now being borne by other programs in that fund, like radioactive materials and so forth.

DR. SCHENKMAN: And also we're getting inspections every two years instead of every year.

MR. FUTCH: And that bought us a lot of time.

CHAIRMAN JANOWITZ: And the cost is the same whether it is a chest x-ray unit versus the –

MR. FUTCH: It's just the time that it takes, basically, to deal with it.

CHAIRMAN JANOWITZ: I just wonder if you might have a little more success if you increase the charges on the more expensive equipment.

DR. SCHENKMAN: But it probably takes longer to inspect them.

MR. FUTCH: Yeah. One of the problems we use as part of the rationale (for the proposed legislation), in addition to all of the money stuff that we talked about, the other part of the rationale is that this statute actually is internally inconsistent. This Section (5)(a) basically says that we're supposed to be charging basically what it costs to perform the inspections based upon the complexity of the inspection.

And then (5)(b) in the same statute kind of goes against (5)(a) and sets hard codes the cost of all these things, not really according to the complexity of the inspection but according to the kind of facility where the machine was used.

DR. SCHENKMAN: Would it be better just to try to get (5)(b) removed from the statute rather than trying to change the statute?

MR. FUTCH: Yeah. We used that actually as part of the rationale this time. I thought it was a pretty good rationale but it didn't really go any further. We will try again and one of the -- I don't -- did the MQA language go through this time?

MS. GRANT: No.

MR. FUTCH: One of the chairmen --

MS. GRANT: It didn't even get picked up.

MR. FUTCH: Really? That's odd. The chairman of one of the committees who was somewhat favorable to this actually, through his staff, apparently, suggested instead of going through here and directly changing caps, or eliminating caps and the rest of it, just putting in some wording somewhere in the statute -- and this appeared in some MQA language – that said something like: Notwithstanding any other law to the contrary, a program that is in a deficit shall increase its fees to overcome a deficit. Which, you know, is kind of a roundabout way of doing things. And lawyers sometimes use this notwithstanding language because they don't want to actually go and change the other law, because that's a little too visible and it may cause some hackles to be raised, but they stick another law in place in a different part in the statute that says: Notwithstanding that other law, you can do this.

That didn't go anywhere either, although I thought that was a pretty creative way of doing things.

So I don't know what form it will take. We will probably bring it back to you at the October meeting. But I wanted to make you aware that, you know, there are money issues. We were in our legislation to fix at least part of that. It didn't work out. And I don't know if it is the sense of the council perhaps it may be useful to take a vote that we continue to try and remedy this problem and fix the legislation so we actually recover the costs that we need to run the program.

DR. ATHERTON: This legislation moved everything to one year. Right? Because it was every two years, every three years, every five years. Everything is under one year now?

MR. FUTCH: This legislation, in addition to getting rid of the separate fee caps based upon kind of facility, gets rid of the frequency as well. So we will be able to set not only the fee by rule, we can set the frequency by rule.

DR. ATHERTON: Oh.

MS. DROTAR: The difference in the surcharge check charge, is that eight percent. We need to make up that funding as well.

MR. FUTCH: Yes. We'll throw that in, too, and

let them know that you are taking an extra one percent of the money that we were going to have. But we will try.

MR. FRADY: Is it forbidden to index any of these fees?

MR. FUTCH: To inflation?

MR. FRADY: Yeah.

MR. FUTCH: Yeah. In fact, that was kind of a rough rationale for this -- where did that number go -- on the front page, that $559 at the bottom of the very first page there. That's I think about where, if you took the highest previous cap, which was probably for medical accelerators, and you go back and look at the rate of inflation since '81, that's sort of where that $559 came from.

MR. GUIDRY: I think it would be high.

MR. FUTCH: It would be. If we went back –- I actually did the figuring and about a month after I did the figuring I went back and looked at it and realized I had dropped a decimal point someplace.

MR. GUIDRY: I looked at the number and I was amazed at how big it was. And then you told me 1981 and then I'm now amazed how small it is.

MR. FUTCH: Yeah. I think it should've gone up

like 120 percent or 130 percent or something like that. But --

CHAIRMAN JANOWITZ: Let me ask you a question. How much was in the trust fund before the state did the sweep?

MR. FUTCH: The cash balance was about -- in our fund the cash balance was about $6 million. And unfortunately, the other thing that happens is the x-ray program collects its fees once a year and it sends it out in, what, September-October. And pretty much everybody has puts their money in by like December. And then the special session happened. And so the cash balance goes up and down during the year, according to the revenue coming in from the people, from the programs. So they hit it right when it was at its peak.

CHAIRMAN JANOWITZ: So are you running in an actual deficit?

MR. FUTCH: This particular program is. I would have to get Janet (Cooksey) to give you the technical details on the money but they’re telling me that something has to happen this next year or we’re going to have a real problem. So they took $4 million out of the $6 million*. And I think MQA was like, what?

Thirty-somewhat-million?

MS. GRANT: Thirty million.

MR. FUTCH: Oh, and the interesting thing about this, if you think about it. The dentist, for example, we take an annual fee for five years and then we go out and inspect them in the fifth year. So all the dentist who had all their money in the trust fund who had paid for four years and was just about ready, they were especially hit hard. You know, that's the way it is. We go on.

MR. BURRESS: James, is this the same trust fund that is for clean up of sites, that materials license fees go into?

MR. FUTCH: No. But the same thing happened to them. There's a couple different funds. There is Reclamation trust fund; A pre and post Mining trust fund. I can't remember all of them.

CHAIRMAN JANOWITZ: Technologist fees goes into it?

MR. FUTCH: Yes, they do. They go through this fund and then they go over MQA fund. Everybody is affected.

MR. FRADY: James, I don't know if it is of

interest or not, but as an inspector I interact with many, many different people. One of the questions that I've asked on occasion is: "Do you think we charge too much? Do we charge enough?"

And surprisingly the majority of the people say, "I'm surprise there hasn't been an increase." So that's what the majority of the community is saying. Of course, there's always people who would think we charged too much if we did it for free.

MR. GUIDRY: Their fees are not at all out of line compared to other fees that I'm familiar with for permitting, and environmental permitting, and things of that sort. In fact, I think they might be a little low.

CHAIRMAN JANOWITZ: Does someone want to propose a motion that we support the Department's --

DR. ATHERTON: May I make a comment when it is appropriate?

CHAIRMAN JANOWITZ: -- the Department's goal of maintaining -- how would you put it? The Department's trust fund?

MR. FUTCH: Yes. I would say to make sure that the trust fund at least it didn't operate at a deficit.

DR. SCHENKMAN: I'll make the motion.

MS. BONANNO: I'll second.

CHAIRMAN JANOWITZ: Any discussion?

DR. ATHERTON: I would like, you know, to make up the deficit. The only thing I don't like about it is it takes away the mandate of the number of inspections. So you could probably have virtually no inspections eventually, which I think is, again, kind of what we're here for.

MR. FUTCH: I think the intention is to not only necessarily change the frequency of the inspections, but to move it from --

DR. ATHERTON: Yes, I just see the negative side effects.

MR. FUTCH: Sure. There's two arguments in this. One of them is the money argument. Been picketed I might say. The other one is this business of the Legislature telling us: You need to base everything, including the frequency of inspections, on the complexity, and the risk, and all that kind of stuff, which is why we go to dentists offices once every five years and we go to, you know, hospitals, I guess, every year?

MR. GUIDRY: Every two.

MR. FUTCH: We have no intention of changing any of that. We don't want to upset any apple carts and people are used to having things done at this particular point in time. It's just a -- we were trying to follow through on the original mandate of the first part of the statute which says: Yeah, you should have the ability to set these things according to complexity, and risk, and safety. Does anybody think we need to put in a floor and say, you know?

DR. SCHENKMAN: Well, you can put in there, according to the complexity of the machine not more frequently than annually, or less frequently than every five years.

CHAIRMAN JANOWITZ: I think we should just limit this to the solvency –

DR. SCHENKMAN: Yeah. That's a different issue than the money issue.

CHAIRMAN JANOWITZ: Ray, you had a question?

MR. DIELMAN: I'm an optimist of this process but it has been talked about for years, and years, and years. You know, it's got to be now. But there is a risk of bringing this subject up at all in the Legislature. And that risk is it can be associated with significant changes in the entire program covered

by the Legislature, not by the Bureau. And also, significant out-sourcing could also impact the Bureau. So the wording should be carefully considered and chosen as DR. Janowitz sort of alluded to. I think you have to be really careful in what you say and what you ask for. Because you can really open up the whole process for significant changes.

MR. FUTCH: Ray raises a point. Whenever you propose to change the statute you're opening it up. This is Chapter 404 and this is Section 404.22. In essence, this year we proposed opening it up, and you do run the risk of when it gets downtown someone who, for example, works at a facility that has a diametrically opposite opinion or somebody who just wants to put something on top of it: Hey, you know, this is about money and x-ray machines; I think we need to put in a requirement for national standards for badging personnel at facilities who work in radiation. It's sort of kind of related.

But, you know, at this point the points are all noted. And we may have to run the risk of doing it and we will do it in the most effective way with the least amount of risk that we can.

DR. SCHENKMAN: I think with this motion, though,

it’s limiting very -- you know, the wording is very limiting. It is the money issue.

MR. FUTCH: Which is basically as DR. Janowitz stated it before.

CHAIRMAN JANOWITZ: Any other comments? (No response.) All in favor? (All members say "aye.") Any opposed? (No response.)

MR. FUTCH: Okay. The next thing on the agenda was the Specialty Technologist. This language, this thing is marked D-3 with a red tab. This is the language at I believe it was the last meeting. If not the last meeting, the one before. Which we presented to you. This was proposed for discussion and what this does, this allows the Department to issue post-primary certifications to technologists on their licenses. The status right now is we have three types of certifications we can grant to radiologic technologist, for radiologic technologists. That is Radiographer, Nuclear Med-Tech, or Radiation Therapy Tech,, ARRT. And everybody calls those primary certifications. And we also have a basic, but that’s not really what we’re talking about right here.

And then we have the Radiologist Assistant, but that’s a higher level than a technologist. We have

three types of primary Rad. Tech. certification: Nuclear, Radiographer, and Therapist.

The problem we have -- and we've discussed these before and I don't want to go back through all the details -- is that when Nuclear Med. Techs, for example, want to get post-primary certifications in an area like CT, which is not part of their primary pathway, they go to ARRT, they do the prerequisites, they take the exam, they become certified in CT, they come back to Florida and they want to practice CT, not just the limited PET CT that they can do, but full CT, which is what the credential requires. And we can't give that to them in Florida. We have no way of giving that to them in Florida. We can't give them the full radiographer because they haven't qualified for the full radiographer and they have no credentials for full radiographer.

So we came up with this mechanism of fixing that, not just for the Nuclear Med Techs, but for all the technologists who are starting to do this business of like, for example, General Radiographers who want to go to NMTCB and get the PET certification which is a much tougher row to hoe. And I don't know if anyone really has successfully done that.

MS. BONANNO: Two.

MR. FUTCH: Two of them.

MS. BONANNO: In the whole country.

MR. FUTCH: But this fixes it by sticking a new kind of technologist into the Rad Tech Certification Act called a Speciality Technologist. In past years we've called it Advanced Technologist or Post-Primary Technologist. And it basically says to the Department: You can issue a license to someone who has got one of those post-primary certifications from a national registry by endorsement. You will not be able to grant this by examination so we're not re-creating the wheel, we're not trying to become another pathway for it. We're simply saying people who are already certified and have this from a national registry and they come to Florida and they want to practice, we can put that on a Florida license and they will have the same scope that they do nationally for that particular area.

Previously you voted unanimously to support this. I really propose no changes to what we submitted last year and what you previously voted on but I just wanted to make you aware of it. And perhaps get a vote that we try again this year for this exact same

legislation.

MR. RICHARDSON: Did this die in committee?

MR. FUTCH: This one? I don't even know if it made it downtown. The Department has, as a state agency, Florida Department of Health, in addition to 20,000-plus people, responsibilities for things like swine flu, and Chinese drywall, and, you know, all these other things that -- what happens at legislative time is the Governor's staff typically will say: You have five issues that you can propose, or ten issues that you can propose, or whatever. So come show them to us and we will come to some sort of agreement on which ones will proceed downtown. And typically there is something much bigger that needs to be fixed than this. And so this doesn't really make it anywhere. And that's what happened to it.

DR. SCHENKMAN: Are they going to have on their certificate, on their license, a separate designation?

MR. FUTCH: No.

DR. SCHENKMAN: Do they get two licenses? How does it work?

MR. FUTCH: This legislation allows us to come up with additional initials. I think it says we are supposed to pay attention to what the initials are

from the national registry. And if there is no conflict with any other Florida initials, use those.

So, for example, what it would do is, if you are a Radiographer in Florida or a Nuclear Medicine Tech, and you have CT from ARRT on your Florida license, after it says Certified Rad. Tech. General Radiographer, it will say CT. It will just be another set of initials to apply to your Florida license.

MR. RICHARDSON: I think this is important in legislature because it brings Florida in line with the National Certification Board.

MR. FUTCH: And the longer things go the more and more this seems to be a problem for more and more technologists.

DR. SCHENKMAN: Yes. Very frustrating for them. Very frustrating to them.

CHAIRMAN JANOWITZ: We have more and more hybrid machines. I talked to someone --

MS. BONANNO: It saves the radiologists a ton of money. You don’t have to have two tests.

MR. FUTCH: The Nuclear Medicine Techs especially are frustrated by this.

DR. SCHENKMAN: Very.

MR. FUTCH: It’s been, oh, I don’t know how many

years, three years, probably longer that we've been trying to do something about this. And every year we have this conversation: Oh, we're going to submit this to the Legislature, there's hope for you. And every year it doesn't go anywhere. But there are a lot of folks out there -- this is my fear.

DR. SCHENKMAN: Well, can we get support from the Nuclear Medicine Society and from ARRT to help get it in front of somebody?

MR. FUTCH: Any society, interest group that you folks know or that we can approach, let us know.

DR. SCHENKMAN: I mean, any lobbying group.

MS. BONANNO: We need a state lobbying group.

DR. SCHENKMAN: To push it, yes.

MR. FUTCH: The state ones would have more effect.

MS. BONANNO: Yeah, than the national. The national supports, but they don't have a lobbyist that will come to Florida.

DR. SCHENKMAN: It needs to be the Radiologists, really.

CHAIRMAN JANOWITZ: I don't think there is a functioning nuclear medicine physician on there.

MS. BONANNO: But there is a Radiologist.

DR. SCHENKMAN: But I think, you know, that might

be the way to get it in front of committee instead of just, I mean, it hanging around.

MR. FUTCH: I think it is important that we have the support of the council behind this specific piece of legislation so we can say to folks: Look, this is our council, this is how it is configured, and we talked about this until we are blue in the face and this is what we think would be good. We could try something else but this is something we've all agreed to.

It's probably not going to get official -- I mean, because of all the things I just described and all the different issues, it may not ever be one of the things the Department is able to go and try and seek a legislative sponsor for. I'm not saying that they will oppose it. They will probably tell us: If you can go find a sponsor, go ahead.

So, in order for this to actually ever happen, it is probably going to take us finding -- and when I say "us," I mean you a group out there, FMA, Florida Hospital Association, you would think they would have some interest in this, Florida Radiological Society, whoever cares enough about this --

MS. DROTAR: Radiology Technology Schools.

MR. FUTCH: Yeah. -- who cares enough about this to go and try and get it sponsored. But that's another point. At this point I think if we can get at least a vote on it, that would good.

MS. BONANNO: Now, you know I support this so I support this. So I move that we support this again next year and try real hard to find somebody to introduce it to the Legislature.

MR. FUTCH: Maybe you should repeat that because somebody's phone was going off and I'm not sure everybody heard it.

MS. BONANNO: I move that this Council again support this action to allow advanced practice nuclear medicine, or Radiologic Technologist to be certified in the state of Florida.

MS. DROTAR: Second.

CHAIRMAN JANOWITZ: Any discussion? (No response.) All in favor? (All members say "aye.")

MS. DROTAR: If we are at the Department level, and this is at the Department level, can you get us copies of these so that we could maybe look for support?

MR. FUTCH: Yes.

MS. DROTAR: Because if we don't have these

things, it's a moot point.

MR. FUTCH: Well, one of the points -- one of the reasons that we're handing this out and we're talking about at this meeting is so you have it as part of this official meeting. We will be -- typically they ask us for new legislation in July, August, sometime around then. And then it officially gets decided upon and submitted later on in the year, October, in that time frame.

But yes, this is a public meeting and these documents are public records. Anybody who wants to can request this and you've all got copies of this. This is what exactly, as far as I can tell, unless somebody tells me otherwise, what I am going to be submitting again this year. You've got it, Kathy.

MS. DROTAR: Uh-huh.

MR. TINEO: If you know, is this part of the e-mail or –

MS. LIVINGSTON: Yes, I did send it.

MR. FUTCH: And if not, I can send it to you. I've got it.

MR. TINEO: I've got it.

MR. FUTCH: Future issues. I'm drawing a blank actually right now. Is there anything else?

CHAIRMAN JANOWITZ: I'm just wondering. I think everyone here is aware of the Care Bill in Congress.

MR. FUTCH: Maybe. Some folks aren't; I don't know Vicki is.

CHAIRMAN JANOWITZ: Well, the Care Bill is a bill to set some national licensure standard, standards for radiologic technology. Currently I would have to say there are no requirements for basic x-ray technologists. So this is something the technologists have been working on for years. Last year I think it got close and Congress did not pass and I know there's another big push this year to get it passed. I think eventually it will get passed and I'm just wondering how that's going to affect things like basic machine operators.

MR. FUTCH: Well, I haven't looked at this current legislation but last year or the year before we looked at it. And I think, if I remember right, what it does is it directs the Secretary of Health and Human Services to write regulations to specify minimum standards, basically.

I have to go and research it again to figure out the exact. My impression was there were still some loopholes that would allow states that had basics to

continue with them as they had been, but I think they are still going to have -- the key for Florida, as you know, for Florida basics are not required to attend a formal educational program. They do a -- they can, but they also can do a self review of about a 400 page study guide from Elsevier called Radiography Essentials for Limited Practice. And when they review that then they can go ahead and sit for the test.

That's the key part and my recollection was there was still some sort of delayed implementation time frames in the draft set of rules that I saw. But the key would be what does the Secretary of Health and Human Services write into the regulations. The law directs he or she to write something. What comes out will probably be the result of some big lobbying between the states that don't have anything and the states that have something and so forth. Where that ends up only politics knows.

But I think it would put a pressure on Florida to impose some sort of minimum educational requirement. And I think that ASRT has on their website for -- and you can correct me on this if I'm wrong -- ASRT has recommended limited scope program and I think it was a -- I want to say a 400 hour, 600

hour program, somewhere in that neighborhood.

You know, if it was up to me I would, you know, write it to the ASRT standards and see if we could get it passed in Florida with whatever pressure is coming from the Federal Rules, once they get written.

Does anyone think there would be any reason --

DR. SCHENKMAN: And this is only for basic?

MR. FUTCH: No.

DR. SCHENKMAN: No. Is it still --

CHAIRMAN JANOWITZ: For everything.

MR. FUTCH: It's for everything but it wouldn't affect us because we're pretty close to national registry standards for all the other areas. It's just the limited scope that there is the biggest divergence.

Of course, now the states to the north of us that have absolutely no requirements for imaging at all, it would affect them also more directly.

MR. RICHARDSON: I think that there needs to be some sort of education. Originally when Florida's law was written, wasn't it written into the law that the physician provider was supposed to provide the person with some training?

MR. FUTCH: I've never seen anything in a

regulation or a statute that explicitly said that. But the institutional knowledge, from my predecessors and my colleagues, is that it was essentially that was supposed to happen. The Medical Association lobby wanted the DR.s to be able to go and take a Medical Assistant, for example, give them the study guide, have them review it, do all the didactic learning, so to speak, in that fashion, sit and pass the test, and then the DR. would show them the hands-on clinical, you know, here's what you do with, you know, positioning.

That's my understanding of it. I can't point to anything, Tim, that says that.

MR. RICHARDSON: I think ethically it would have to be that way.

MR. FUTCH: Well, you know, but I don't know close we are to that standard anymore. There's a wide variety of backgrounds of folks who come to take the basic exam. And I tell this to people when they call up, a small hospital or somebody wants to use a basic machine operator. They inevitably make the assumption that there is this uniform educational background of the person. And I explain to them there is a couple of different ways you can do this and here is the one

that’s required by the state.

MR. RICHARDSON: I get probably two or three calls a month from DR.’s offices in Marion County asking me to be able to train somebody in their office. And I say, "Well, you can enroll for the first 650 hours of our two-year program.” And if I remember correctly, that was the original amount of education that was supposed to be provided, was 650 hours.

DR. SCHENKMAN: Is that with the --

MR. RICHARDSON: It can’t be done in a two week seminar.

MR. FUTCH: Yeah, that’s like several months.

DR. SCHENKMAN: That would be ASRT requirements are? Do you know?

MR. RICHARDSON: That was Florida’s requirement out of the Department of Education when they first wrote the particular framework.

MS. BONANNO: I was involved in that lobbying.

MR. FUTCH: Kathleen, do you remember the ASRT’s limited scope number of hours for the program?

MS. DROTAR: I don’t remember the specific number of hours there; however, the book that we used or that was recommended was the Essentials that had in each chapter a specific number of hours that should be used

for didactic purposes. And that was one of the things that we had looked at previously that we use the recommended number of hours in the text because the book written by Bruce Long was consistent with the ASRT limited scope curriculum.

MR. FUTCH: I want to say somewhere -- it was either the ASRT website or maybe it was the book -- I went through and added up a bunch of hours and I think it came to like a four-to-six month program. Something like that.

MS. DROTAR: I think that's what we looked at, a possible six months program with training and some other having the physician that they worked with or were working with also determining the competency level.

MR. FUTCH: There is another issue to this and that is that there is kind of a chicken and egg thing, I think, my personal opinion. Because we don't have a requirement for a formal educational program there really aren't any public ones. There used to be one. Every once in a while like a new one will kind of come into existence and then it will fade up and the number stays around, zero. For public programs. There are a few -- I can't remember the total -- ten, fifteen

private programs, I think, around the state.

MR. RICHARDSON: Isn't the number of rural hospitals down? It used to be fourteen rural hospitals that would hire BMO's.

MR. FUTCH: I couldn't tell you. I don't know.

MR. RICHARDSON: I think that is much fewer now. There's not that much of a demand for them.

MR. FUTCH: So, are we heading someplace in particular with this discussion. Do you want to try to get a vote or something as far as Care bill? Do we know enough about it?

MR. ARMSTRONG: Before we go on --

MR. FUTCH: I'm sorry.

MR. ARMSTRONG: Before we go on with this bill how would this affect the limited provisory x-ray?

MR. FUTCH: Well, we would still -- well, ours, I would assume, since the sub-category of the full limited basic. We have the basic and then we have a more limited version, which is the limited basic podiatric medicine. I would assume that whatever happens with the Care Bill, Health and Human Services would eventually affect that.

The question for me is, you know, in Florida, podiatric medical lobby several years ago created its

own certified podiatric -- Assistant Certified Podiatric Medical Assistant, something like that. And the number of people who have been applying have really been mostly going to that pathway for the past several years. You haven't seen probably hardly any (basic)podiatric.

MS. GRANT: I haven't seen --

MS. CURRY: I've had a couple in the last six months.

MR. FUTCH: I would assume they would be also affected by the Federal Regulations in the Podiatric Assistants that's underneath the Board of Podiatry. However, that is not our purview and we would not have anything to do with what happens with the Board of Podiatry certification.

I'm actually kind of confused or surprised that when that one was created (the podiatric assistant) they didn't just do away with the other one (the basic podiatric) and give everybody who had that certification that certification, but that hasn't happened. So we actually have two certification if you want to become licensed to do podiatric x-rays in Florida.

CHAIRMAN JANOWITZ: Do we want to pass a motion

supporting the passage of the Care Act?

MS. BONANNO: I move that we support the passage of the Care Act.

MS. DROTAR: I second it.

CHAIRMAN JANOWITZ: Any other discussion? (No response.) All in favor? (All members say "aye.") Any opposed? (No response.)

MS. BONANNO: It has not been introduced yet?

CHAIRMAN JANOWITZ: No. But I was in (Washington) DC two weeks ago.

MS. BONANNO: Were you at the RC weekend?

CHAIRMAN JANOWITZ: What?

MS. BONANNO: Were you at the RC weekend?

CHAIRMAN JANOWITZ: No. This was the SNM had a lobbying group.

MS. DROTAR: Just a side note on that. There are several senators and representatives that have come out and supported the bill in different states and Florida, one of the largest care givers, doesn’t have anybody that has come out in support of it.

DR. SCHENKMAN: Would it be possible to have a meeting, maybe later. I mean, just so we know what’s in it?

MR. FUTCH: We could try and –

MS. DROTAR: It’s on the ASRT website.

MR. FUTCH: The ASRT website?

MS. DROTAR: The ASRT website and there’s a link to that and also to the Image Gently web site.

MR. RICHARDSON: I think you have to go under government regulations and then there is a whole section to the Care Bill.

MS. BONANNO: You can go SNM.org also and can instantly write a letter. All you do is put in your zip code and it pulls up **

DR. SCHENKMAN: No, I’m just saying see what’s exactly in the bill.

MR. FUTCH: The current inclinations. And you never know what the regulations are going to look like either.

MS. BONANNO: Last year they took out that part where they wouldn’t get the Medicare funds if they didn’t comply.

MR. FUTCH: Well, I believe that’s it for the legislative issues. And with your permission we will move on to E. which is the MQA program update and Vicki Grant. Vicki?

MS. GRANT: Just a little background about our office. We currently have radiologic technologists.

We also license EMT's, paramedics, and medical physicists. We are pretty busy. So just to give you a couple of numbers that come through our office, from the last -- from January the 1st through April the 27th, we received 845 Rad Tech. applications and of that 845, 809 have been scheduled or have received a license. So we're pretty busy.

We have also received within that same period of time 3200 renewals and we really, really encourage the on-line process. It is a very self-gratifying, pay your fees. That's why it is important that you get your CEU's. They get dumped into our system so you can see that on-line application.

We have also processed about 1900 miscellaneous transactions. That is request for duplicate, someone has moved or changed their name, and we're issuing a duplicate license for that.

I'm going to defer the fee increase discussion after we talk about the applications, if that's okay with you.

MR. FUTCH: I would like to talk about the ASRT business, too.*

MS. GRANT: Yeah. The only other information I think that -- we sent out a letter to all of our

educators explaining the new ARRT application process which now ties with our process. There has been a little confusion so we did put a little screen shot, how you do it, where you go, what you do when you get there in the packet.

And the most discouraging that I will have to say today is that we had planned to have the Rad Tech application on line by February. During the last session the Board of Pharmacy was given the task to license 30,000 pharmacy techs by on line application by January. So we kind of got bumped to the back. As long as we can keep our business processes going I think we're doing it within an incredibly small amount of time. But when we get to on-line applications, that is going to be fabulous.

We are going to be having our on-line application status check within the next six months. You apply; you will be given a password and ID; you can follow the status of your application through the entire process.

And this is Gail Curry. Gail is the supervisor and actually runs our Rad. Tech. program. So if anybody ever has any questions you can call Gail or myself.

MS. CURRY: Do you want to make mention that they can get their results on line?

MS. GRANT: That process also does show you a link where your students can go to get their actual exam results. James is working with me to make sure our site is accurate and cleaned up. And I think that will happen in the next couple of days.

And other than that I don't have anything else for you.

DR. SCHENKMAN: Is this third page which says "Sample Only," does that come from whatever Rad. school they come from?

MS. CURRY: Yes. That will be the graduation letter. And we are asking now that instead of letters that they use them -- I mean, instead of lists of graduates that they send us individual letters so that we can place those letters in the individual spot.

MR. FUTCH: You discussed that, I think, last time.

DR. SCHENKMAN: Great. So this is going to come from -- this sample letter, or whatever the final letter is, would come from the school directly to you but not through the student?

MS. GRANT: Correct.

MS. CURRY: Correct. And it is just a sample. I mean, they can format it any way they want to. And I did place in there just the information that we need on the letter. They can do it however they want to. I don't have a problem with the format.

DR. SCHENKMAN: Wouldn't it be easier just to have a form letter?

MS. CURRY: Sure.

DR. SCHENKMAN: I mean, easier for you and easier for them.

MR. RICHARDSON: This is my form letter.

DR. SCHENKMAN: I mean, then you have what you need and you're not getting ten pages written by somebody about somebody that you're going to have to go through and pick everything out.

MS. GRANT: Correct.

MS. CURRY: Well, in the past it's been a very simple format for the providers. They'll just send me the little blip that says: This is the date they graduated; this is the date they took the mandatory course. And they would just give me a list of names.

MR. FUTCH: So really what is changing is you just don't want the list. You want it per person.

MS. CURRY: Uh-huh.

MS. GRANT: We want to be able to include in each licensure file a copy to indicate that person truly completed the course. A list, it makes too much work for the staff to have to redact everybody's name other than that one person, if there's fifteen or twenty.

MR. RICHARDSON: Can I send these to you electronically?

MS. CURRY: Yes. In here the letter that -- this letter that's in your packet, it does have the ZZZ (email) box that you need to send those to. That way if I don't happen to be in the office for some reason, Vicki or Bessie has access to that box so they can pull those on that same day that you sent them.

MS. DROTAR: I just went through that process with Gail because I had fifteen students who graduated in April. And it is not a big deal with the letter because it is the same letter. It is just changing the student's information. I like the idea of individual letters because it becomes an issue of student's confidentiality again where we don't have birthdays and Social Security numbers involved. And that way, when they copy them I can e-mail the whole document. I had fifteen letters together, e-mailed those documents to Gail and it was a smooth

transition. She e-mailed me. I got a response the same day that they had received it and was beginning to process them.

So, to me, as Program Director, it worked as planned. It was the same thing I had been doing except that it was mailed for each individual and was targeting each.

MS. CURRY: We appreciate that.

MS. DROTAR: And then the next part, how long is that part of the process?

MS. CURRY: That's okay. Are you talking about the temporary part, how long does it take?

MS. DROTAR: Yes.

MS. CURRY: If the application is approved up to the point of waiting for the validation of graduation, they will be approved the same day as of this letter. They will be approved for a temporary the same day.

MS. DROTAR: Okay. So how long of a lead would you need for them sending in the application ahead of time in all that process and then when they get the letter, how much of a lead time would you need for processing an application?

MS. CURRY: I would send it in a month. A month, ahead of time. Now, be aware that they are going to

get that letter that says: Your application is incomplete because we've not received proof of graduation. That's a letter that goes out automatically because it is a new application. They don't need to panic because as soon as you guys send us those letters we're going to go ahead and take care of it.

DR. SCHENKMAN: Do they take the examination before they graduate?

MR. RICHARDSON: They have to complete the program first.

DR. SCHENKMAN: And then if they pass the examination then you send the letter?

MS. CURRY: No.

MR. RICHARDSON: I send the letter the day they actually complete the program.

MR. FUTCH: And that allows Gail to release things so they can go take the exam.

MS. CURRY: Right.

MR. RICHARDSON: We've got to hold up the application until the last piece comes in, basically, which they are allowed to temporarily work until they pass.

MS. CURRY: Yes, get a temporary license.

MS. DROTAR: There's two different mechanisms because one they apply for a temporary license. The other is by endorsement after they've got the registry, after the results in, then they can apply for it. If they want to work then they have to select a different mechanism.

MS. GRANT: That's all I have.

MR. FUTCH: Thank you.

MR. RICHARDSON: Did you say there was a specific drop box that I could send this? I do not see it.

MS. CURRY: If you will look at the second page. It is the last, under number three, second line would say MQA under score Rad Tech that's where you're going to send it

MR. RICHARDSON: So I could make one file or PDF, scanned into a PDF?

MS. CURRY: Uh-huh. Actually it's better that way because I've been getting individual files, individual documents for each person. I have to go in and save each person's document one at a time to an electronic file. So if I can get it as one document with all the letters in it, it saves me a lot of time.

DR. SCHENKMAN: That CD is something you might want to send out to, you know, references.

MR. RICHARDSON: I'm not sure my server will handle all of that. We'll see. We've got twenty-five students.

MS. CURRY: And if it doesn't, just keep doing it the way you're doing it. That's perfectly fine.

DR. SCHENKMAN: And were you going to go over the fees?

MR. FUTCH: Let me just make -- Vicki wanted to talk about the fees, which are the last thing in Section E here. In combination with the new forms which are down in the second bullet in, Item F. So what I'm going to do is why don't we just take these forms out of order and combine them with your discussion of the fees and let's doing them now.

CHAIRMAN JANOWITZ: You have plenty of time before lunch.

MS. GRANT: It seems that I've been working on these applications for a while. So I think the applications are the way we want them. But while we're looking at them we need to talk about the fees.

This profession is in a deficit to MQA. MQA receives the application and the money and the money is deposited into the Environmental Health trust fund. So MQA is the one that pays for the initial and then

they send us a check in the end. Unfortunately, the amount that we're charging for our current application is not enough to pay for the actual process.

So James was kind enough to sit down with me and Les* and discuss it and we have some proposed fee increases. It does take it to the cap in several of these instances.

We would like to move the Rad Tech application fee from $50 to $100. Any subsequent exams -- these are re-takes -- it takes the same amount of time to process a re-take application as it does to process a new application. And we would like to raise it to $75. The endorsement application is $45, the cap is $50. We would like to raise it to that. And our current renewal is $55 and we would like to raise that to $75.

DR. ATHERTON: Is there anything that is not at a cap?

MR. GRANT: Yes.

MR. FUTCH: You mean in a separate proposing increase?

DR. ATHERTON: These are all up to the cap. Right?

MR. FUTCH: They would be with these changes, yes.

These changes take all these to the cap.

DR. ATHERTON: Doesn't that mean that with these changes there are some fees that won't be taken to the cap?

MR. FUTCH: Well, we're not proposing to change some of the other fees. For example, there is a fee, currently a fee of $40 to set your current active license to an inactive status. We're not proposing any changes to that. There are a couple of others.

MS. GRANT: An additional certification, when you renew with additional speciality.

MR. FUTCH: On the renewal fee, the $55 is just for the first certificate. Those people who were certified in three areas, such as Ms. Drotar down there, we're not --

MS. DROTAR: $135.

MR. FUTCH: The second certificate is always -- the way it is right now it is $55 for the first and I think it is $40 for each additional.

MS. GRANT: $40.

MR. FUTCH: And we're proposing only changing the initial, the one certificate going from $55 to $75. The additional would still be $40 so we're not proposing any changes for that. So, yes. To answer

your question there would still be some that are not at the cap. It's just not these.

I'll be honest with you. Let me give you a breakdown in dollars and cents. It costs us between the pieces in radiation control, like to do the CE, and our inspectors to go out and check things in the field, in Vicki's portion in MQA, it costs us about $1.3 million a year total to run the program. I forget exactly how much we are bringing in right now but I think it's about, I want to say $800,000 or $900,000.

MS. GRANT: Right.

MR. FUTCH: These changes which take these things to the cap still would not completely eliminate that deficit. It would still be like $100,000, $150,000, give or take, deficit. We can't eliminate it.

DR. ATHERTON: Why don't you just take everything up to cap?

MR. FUTCH: Well, to be quite honest with you, although there are lots of separate fees, almost all the revenue comes in from the renewal fee. There's a multiplier of about 10,000 on the renewal fee. The multiplier on the rest of these are in the couple hundreds.

MS. GRANT: Right.

MR. FUTCH: So, it really almost doesn't matter what you do with any fee except for the renewal fee. That's where you get most of your money from. And, unfortunately, the cap is not that -- it's only a $20 increase before we are at the cap for the renewal fee.

MS. GRANT: Every $20 helps when you're in a deficit.

MR. FUTCH: I was trying to look and see when the last time we increased fees were. And if I'm reading this right, I think the last time we changed these fees was in about '94. We made some changes to the fee section of the rule when I took over in '99, '98. But that was to -- that was when ARRT starting doing the on-line computer based testing and their fees started going up.

The Legislature changed the law so that the fee that the person pays for the testing organization is separate from all these caps; it's not counted underneath these caps. And actually, these days, it doesn't even come to us. They go straight to ARRT with that.

CHAIRMAN JANOWITZ: I'm a little concerned that the people least able to afford these, who are the Rad

Tech's initial applications, are the ones, they were the biggest increase. I just wonder if there was a way to make it a little more gradual than a 100 percent increase?

MS. GRANT: MQA is open to work with raising the fees however you see fit. It's just I think part of the concern is the rule process takes so long. Once we start this process it could be six months before it ever comes to fruition. Something could've happened in that time that makes us do something different that increases the cost that MQA has to spend.

MR. FUTCH: And actually if you look at the initial application fee -- and Vicki, you could probably help me out with this. But I did this about six months ago and looked at the initial application fee for this particular profession and compared it to the other thirty-nine professions that you guys took care of, including the nurses and the rest of them, we worked -- and even with this increase I think we're still on the lower end of what they charge for most of the other professions. The nurses I think are -- do you remember what the nurses are?

MS. GRANT: I think the nurses raised theirs this past year, too. It's very low. I know EMT's and

paramedics are low, also.

MS. DROTAR: I think it was a 2.5 increase.

MR. FUTCH: So even after -- the sense I'm trying to give you is even after all this -- although DR. Janowitz is completely correct, honestly it's a 100 percent increase -- we still end up not anywhere near the middle of the pack in terms of all the different professions, at least in Florida. And I have no idea what it would be compared to the other states.

DR. SCHENKMAN: What does it take to change the cap without legislative?

MR. FUTCH: Well, we haven't actually proposed that. It is something to think about, I guess.

MR. GUIDRY: Your low application fee is by design intended to be financed by your renewal fee. This is a low application fee.

MS. GRANT: Very low.

MR. GUIDRY: For an exam to practice a profession. That's something that is by design. You wanted it to be that way.

DR. SCHENKMAN: But that's not the exam. That's the application fee. The exam is separate.

MR. FUTCH: The exam is separate. The exam is another --

CHAIRMAN JANOWITZ: The exam is separate.

MR. FUTCH: There is the exam fee to ARRT of $100. That is in addition to this application fee to the Department.

MS. GRANT: Right.

MR. FUTCH: ARRT – basically they're paying the subcontractor directly $100 on top of whatever we charge. So right now the total cost to the person is $150 and it would go to $200 if you count also the actual exam fee to ARRT.

MS. GRANT: This profession doesn't charge a licensure fee either. I mean, the majority of the MQA professions charge an application fee that is non-refundable. They charge an application -- I mean, a license fee as well as part of the application and you probably remember that very well.

MR. GUIDRY: The renewal fee is annual?

MR. FUTCH: It's every two years.

MR. GUIDRY: Every two years.

MS. DROTAR: When they first get their -- when they get certified by DOH, to begin with their first initial can be longer than two years. If it's after –

MS. GRANT: No longer than twenty-four months.

MS. DROTAR: The fact it is just a $100, it's $75

to renew it and that's only $25 different.

MR. FUTCH: What Kathleen is saying, is their first license, if they catch it right, depending upon if they apply just after their birthday, it will be up to twenty-four months before they have to renew. And it has to be at least twelve months, the first license.

DR. SCHENKMAN: What does the license fee do?

MS. GRANT: The license fee for MQA actually pays for the maintenance of our COMPAS database system. That's a huge cost that each of the boards share. There are other fees for investigation cost.

MR. FUTCH: Unlicensed activity,.

MS. GRANT: Unlicensed activity. For MQA we collect an additional $5 for the unlicensed activity.

MR. FUTCH: I should mention that. All the other health professions, except for EMT, too. They're not doing it either, are they? Have several other kinds of fees that don't apply to this simply because of where these folks reside in the statutes. They are kind of off by themselves. EMT's and Paramedics are off by themselves and everybody else is underneath MQA's explicit statue Chapter 456, which provides among other things, for a fee of $5 per license that

they use to fund all the people who are investigating with the law enforcement, the unlicensed activity that goes on in the state of Florida. I don't know if you've ever -- we get these --

MS. GRANT: We've seen the billboards around the state, we're talking about unlicensed activity.

MR. FUTCH: We see it a lot because we are inside the Department. But we get I don't know how many e-mails a day, a week, press releases from the Department of Health: "Department of Health announces arrest of So-and-So for practicing dentistry without a license in Miami."

CHAIRMAN JANOWITZ: No, that never happens.

MS. GRANT: A lot with the massage.

MR. FUTCH: Massage/prostitution. All of that is paid for by a dedicated fee for all the other professions but us. We pay for it out of this, out of these moneys, basically, because we don't have any way of charging a separate unlicensed activity fee for that. So when they go and do the investigation for *Ad tax, or when Radiation Control does it, that has to come out of this pot of funds.

DR. SCHENKMAN: Are we getting near the point now where we should re-look at eventually bringing these

caps up by legislation or putting everything under MQA instead of having it separate? I mean, maybe it's getting to the point where we should start looking into that in the future.

MR. FUTCH: You know, one of the things that we'll probably be doing this July-August, is looking at whether we should be increasing those caps or doing something like that for Rad Tech. I don't think we've talked about it yet but --

MS. GRANT: Well, we haven't talked about merging.

MR. FUTCH: You'll see it.

DR. ATHERTON: We're going to have to, I think.

DR. SCHENKMAN: I mean, it just seems like it is getting to the point --

MR. FUTCH: I like the notwithstanding little blurb myself. You know, directly attacking caps. We could say: Notwithstanding any other law to the contrary but the deficit we've incurred –

MS. GRANT: This is just allowed for a lot of the MQA professions to, for example, I had the Chiropractic Board for about eighteen years. And they recently, in the last three or four years, said that you will charge the cost to examine each candidate. So exam fees may have gone from $200 to $600 or $700

because it actually costs that much because at the time it was Department-generated examination. So we had -- like a nutrition an entire testing unit so we had to absorb those costs for the Chiropractic profession. And it did significantly raise their fee. That's what (Chapter) 456 does allow. If this group were under 456 then we would be able to more closely collect what it actually costs to license and manage this profession.

MR. FUTCH: Does anyone have any questions on the forms? I should mention the current Rad. Tech application form is a single form. It is DH Form 1005. And the overall summary of what is happening is we are splitting the basics off into their own application, which is Form 1006, which is the one up at the top that says: Application for Basic X-ray Machine Operator. This is at Tab F-2, Blue F-2. So that's the biggest change and why we are holding two applications in our hands, so that one is for basics and one is for everyone else.

Of course now if the Care bill passes and we go back to actually requiring education for some point and so forth in the future then a lot of the reasons for separating these two will be gone and we'll be

back to one application.

MS. BONNANO: Isn’t the fee increases – they will be the safe?

MS. GRANT: Yes.

MR. FUTCH: And the other -- what else did we do. Oh, because of the laws on confidentiality and Social Security numbers, the current Rad. Tech application has the Social Security number actually right on the front of the form with all the other personal data. The MQA, if you go to page three of I think either one of these applications, it looks like this. They basically just separate on a separate sheet of paper the Social Security number information so they can separate it out from the file and treat it in a more secure manner so it doesn’t actually gets mixed in with something and ends up on line. Because you can look up this stuff on line.

MS. GRANT: Correct.

MR. FUTCH: Any other major changes?

MS. GRANT: I think that’s it other than the directions on how to apply to the ARRT.

MR. FUTCH: Yes.

MS. GRANT: For state licensure.

CHAIRMAN JANOWITZ: Do you need a resolution about

the fees?

MR. FUTCH: Yeah. You want one?

MS. GRANT: I would like one.

MR. FUTCH: How do you want it said? Compose, please.

MS. GRANT: Somebody could move to accept the proposed fee increase. That would be fabulous.

DR. ATHERTON: I so move.

MR. FUTCH: And the forms.

MS. GRANT: And the application form. That would be great.

DR. ATHERTON: And the application forms.

DR. SCHENKMAN: Second.

CHAIRMAN JANOWITZ: Any other discussion? (No response.) All in favor? (All members say "aye.") Any opposed? (No response.)

MR. FUTCH: And the last thing I have in this general vicinity is I wanted to tell you about a project we've been working on with ASRT. First of all, right now it is about 11:20. And, Janice, are we going to leave about 11:40? Is that enough time?

MS. LIVINGSTON: We've got it at 11:45 but I can go down and ask them if we can get it earlier.

MR. FUTCH: I think we will be wrapping this up a

little bit early.

A lot of the technologist don't renew on line even though for a couple of years now I guess it's been available to them that they can renew their licenses through the automated mechanisms. The Department loves the automated mechanisms. It's a lot less staff time; it's much more efficient; it costs less for us to handle the on-line that way.

We're not really sure why the technologists don't renew in great numbers on line. I forget the percentages. But we get this warning message from one of the communications people about the middle of each month that says -- it goes out to everybody that's on the distribution list I think which is like all the educators, and all the societies, you know, FSRT and everybody else. This warning goes out and it says: Please, not enough people have renewed for the month of whatever it is, you know, May. If you know someone who hasn't renewed, please encourage them to renew on line.

And the percentages are something like twenty to thirty-five percent currently renew on line at the middle of the month. In other words, they are expiring in another two weeks from that point, from

the time this is generated.

My own personal thought is a lot of the technologist, we did it this way for twenty-some-odd years and I think there is just a lot of inertia. They are just used to doing it on paper form and they can't get away from the paper form. They just fill it out and send it in.

And the other things is that they can't renew on line if -- excuse me. They can't renew on line unless they meet certain requirements. And one of the requirements is they have to have enough (continuing education) hours to renew. Makes sense. Right?

So to reduce the impediment from not having enough hours to renew, twelve hours to renew in Florida, one of the things that we've started as a project in the ASRT, actually almost a year ago, to transfer some of the technologists ASRT CE courses that are being tracked underneath the ASRT system for national registry purposes into the Florida system to boost the number of hours they are rightfully entitled to to renew, because we accept the national CE hours, to try to get the people up to the magic number.

We started this a long time ago. Through a series of fits and starts, and the ASRT had a lot of

other projects they were working on, we finally got the first to download. There are something like 21,000 CE records waiting to be input into the Florida system, each one of which represents at least a one or two hour CE course. We're starting out with directed readings. I don't know if everybody is familiar with those. But in the ASRT journal, there's a certain amount of CE that's actually contained in the journal that a person reads and they fill out a form and they send it in.

We're starting out with that. In fact, directed readings makes up like ninety-seven percent of the total CE that's being tracked for technologists in Florida. So it's mostly going to be directed readings, no matter what.

We're still doing some testing with the Florida COMPAS system. It's not underneath our direct control. It is a big major data base with all the usual security protections and hoops to jump through from IT and all this other kind of stuff. But we're working through that and we hope certainly by the end of May to have all of those 21,000 CE records loaded into the system.

The technologists will then be able to not only

renew if, of course they have enough hours, but they will be able to go on line with a license verification, as they can today, and click their CE tab and see the CE from ASRT reflected in their Florida license on the on-line licensing system in Florida. And it will be indicated -- I think we're calling it ASRT directed readings and then we use the individual course numbers from the national system in the Florida system. So you can directly -- if you're looking at your ASRT printout as a technologist and you're looking at all your CE courses and you see the numbers of each course, you can then go on line in the Florida system and see that exact number and it should match the number of hours you've been credited nationally. That was complicated, wasn't it. Sorry about that.

Any questions about that?

MS. BONANNO: Will you be able to do that with SNM?

MR. FUTCH: We haven't gotten as far with them. I see no reason that it's not possible to do that.

MS. BONANNO: They have affirmed to NMTCB. They should be able to affirm to individual states.

MR. FUTCH: We just haven't gotten to that stage

with those folks but it should be possible to do this.

MS. DROTAR: I went on in January you could do it on line but the incentive was because it showed 15 credits for a course that I had taken, which I had forgotten about. So it was not that difficult to do. It was pretty quick and easy. But I think your assumption is right that you just are not used to having that and being familiar with it and that you want to make sure that you do it right the first time.

MS. BONANNO: Well, I renew my NMTCB dues and SNM dues on line, FNMT dues on line, but that's because I get an e-mail blast from both of them as a reminder. So then I go pull out the credit card and do it. So that might be something if we have e-mail addresses down the road, that's somebody else inputting a lot of e-mail addresses.

MR. FUTCH: There is a spot on the form now. Right?

MS. GRANT: There is.

DR. ATHERTON: Can you create an incentive to make it like $5 or $10 cheaper on line or --

DR. SCHENKMAN: The incentive is you don't have to pay postage.

DR. ATHERTON: Or stop sending them paperwork and

make them go on line to get the paperwork to mail in.

MS. CURRY: Another incentive also is as you know we have a lot of people that wait until the very day of expiration. And they renew but they --

MS. CURRY: They renew but they can also print out the receipt and that acts as a temporary certificate so they can continue working until they get their actual certificate.

MS. DROTAR: And you print it out you can also get reimbursement from licensing fees for your employer, which you need to get reimbursed quicker and you can use that to get reimbursement.

DR. SCHENKMAN: Transfer R&O CE credits into the state.

MR. FUTCH: And this is from which?

DR. SCHENKMAN: From AMA. As long as it is an AMA accredited credit through Net CE, it’s transferred to CE Broker and it comes up on your -- you know, showing how many credits you have, what courses you took, how many you still need and whatever for your Florida license.

MR. FUTCH: The Net CE system is a national system specific to your profession, right, or do you know?

DR. SCHENKMAN: I’m not really sure because I’m

only in it for the physician side. But it is part of CE broker. Yes, CENC broker.

MS. GRANT: Well, this profession out of the ones that we do have is the only profession that requires a hundred percent audit at renewal. The other MQA professions do not. They get downloaded; they get licensed; and then they get audited. So what James is working on for us will help us tremendously to get to ASRT dumped and any others that we can work with and do that would be fabulous.

DR. SCHENKMAN: I can check and see if Net CENC.

MR. RICHARDSON: How many licensed Radiographers or ASRT members?

MR. FUTCH: The number is about half of them.

MR. RICHARDSON: I'm amazed.

MR. FUTCH: Somewhere in the course of this year long project we asked them and it was 7,000.

MS. GRANT: It was a pretty good number.

CHAIRMAN JANOWITZ: Do basic operators have to get CE's?

MR. FUTCH: Yes, they do. And they're probably, if you look at percentages, it's a little harder for them to get CE's because they don't have as many avenues, people talking about it.

They’re kind of on the periphery of everything, really. I can’t remember if they are part of -- are they part of the -- can they join (ASRT), with limited book work?

MS. DROTAR: I think they might be able to join but they are not a member. They might not be certified. I’m not a hundred percent sure.

MR. FUTCH: I wonder if their CE’s --

MS. DROTAR: If there are a lot of other –

MR. FUTCH: I was just wondering how many of those people are, how many in the system are basics. I didn’t think to check that.

MS. DROTAR: Didn’t we get an e-mail about a year or so ago that the general or the basic machine operators they were in a downturn of their re-applications?

MR. FUTCH: That may have been this thing from Gail Curry, our communications person. We get it every month.

MS. DROTAR: Oh, okay.

MR. FUTCH: I’ll start forwarding that to you all if you want to see it.

MS. BONNANO: They just did that as like that last ditch effort to keep people because it’s more

difficult to have to turn around and send us a lot of documentation.

MR. FUTCH: Yeah, he's a great guy. I mean, I don't know for doing, so he's got to be a --

MS. GRANT: Well, they ask me every month do you want them to send that, sure*.

DR. SCHENKMAN: Well, would it help you -- I don't know if they do this but if ASRT would somehow send, if they're allowed to send e-mails of the people who are tested in the state of Florida. At least you would have those people that you could send e-mails out to when their applications were, needed to be renewed.

MR. FUTCH: Yes. I could ask him.

DR. SCHENKMAN: It would make -- or any others that would have e-mails already so you don't have to wait for another two or three years to get all those e-mails.

MS. GRANT: Yes. That would be something that we would look at or ask IT to look with James and probably whomever he's been talking to.

MS. BONANNO: Make you a monthly, a list by month and send an e-mail blast to everybody who is due to renew.

DR. SCHENKMAN: Say it’s due in June, you send it the month before.

MS. BONANNO: Right. And they can answer -- they can renew by answering that e-mail and make things easier.

MR. FUTCH: Do you know what percentage of e-mails we have right now for the techs?

MS. GRANT: Probably -- well, I’m not aware that people had collected them before you and I, e-mail addresses, no.

MS. CURRY: We had no place to --

MS. GRANT: Put that on the application.

MS. CURRY: -- require it on the application.

MS. GRANT: Oh, well.

DR. SCHENKMAN: Maybe you need to add it now.

MR. FUTCH: It’s on the new ones.

MR. RICHARDSON: I haven’t found e-mail to be very consistent and people change their e-mail addresses like --

MS. BONANNO: Yes, but it is one more --

MR. RICHARDSON: When you send out your notices for renewal, do you send them bulk rate or do you get them back if they are undeliverable?

MS. GRANT: We send out a postcard, the postcard

is a paper renewal.

MS. CURRY: For this profession it's paper.

MS. GRANT: Yes, we get them back. But to answer your question about bulk. Yes, we do modern mailers to rapidly mail them out.

MR. RICHARDSON: I've had a number of people say they never received their renewal notice.

MS. GRANT: And a lot of that comes because they don't change their addresses. And if they don't change their address, of course, it comes back to us and we don't change their address based on that yellow sticker that's on the envelope.

MS. CURRY: But we would send that renewal form back to them based on that yellow but we would not make it an address change.

DR. ATHERTON: If you want to be really progressive you could just stop offering paper renewal and just do on-line.

MS. BONNANO: A lot of MQA.

MS. GRANT: Well, MQA has gone that direction because people --

MS. BONANNO: Do you know there are still people with no computers.

DR. ATHERTON: They'll get one if they have to.

MS. CURRY: They can go to the library.

MS. BONANNO: They can go to the library. That's what some of them do.

MR. SEDDON: That's what some of them do.

MS. BONNANO: Very helpful.

MR. GUIDRY: Excuse me, but I didn't get the answer to the question of why we don't offer a monetary incentive to renew on line.

MS. BONANNO: Because we're in a deficit and it just helps reduce the deficit if they renew on line.

MR. GUIDRY: Well, perhaps they're in a deficit because they're spending too much time on renewals not having them on line. Perhaps they should consider raising slightly -- I don't know. It seems like an on-line renewal would save a substantial amount of that fee. I mean, thirty, maybe forty percent.

MS. GRANT: You're absolutely correct.

MR. GUIDRY: So why not offer them a twenty percent discount and you will still come out ahead.

DR. ATHERTON: You could keep that fee the same and charge a fee for the mail, like an administration fee, but I don't think we can do that?

MS. BONANNO: Like the airlines do for a paper ticket.

CHAIRMAN JANOWITZ: No. If we do away with the fees maybe we could give them a five dollar --

DR. ATHERTON: If you want to do it by mail it's going to cost you $10 more.

MS. GRANT: I'm know that we looked to getting the 9-1-1 operators in our office last year. And the bill that passed this year to make that, change that from a may to a shall register, does include an incentive that you are required to do it by on line. But if you choose you will pay $25 extra to do paper. And that's great. But that was put in the statute and that language did pass. I don't know that we could offer discounts because I don't think that our project --

DR. ATHERTON: I think that's a good idea.

MR. FUTCH: That's a good idea.

DR. ATHERTON: It's a great idea.

MR. FUTCH: The problem we have is that we're coming at it from the position of already being, having a rather lower renewal fee and not enough money -- and that being the biggest place of the revenue generation.

MS. GRANT: This profession, I think, just makes it sound right. I think on-line would be great and I don't think it would be that difficult. But everybody

is not diligent enough to do the fees and get it there in time. That's what prevents lots of people who go on line, they don't have their continuing education in there. And then it becomes a paper issue. They have that option. They have the same option MQA does, to go on and do an on-line renewal. And it was at this lower price.

DR. ATHERTON: And the CE issue was what you are working on now to change?

MS. GRANT: Right. And that will help for that rule.

MS. DROTAR: But again, the technologists have to do it in a timely manner in order to get it on line, and for CE to do it and instantaneous that it gets there. So it may be one true mechanism and probably, I would think there's a large majority of people don't wait until the very last minute to do it, and that that would require mailing in the documentation for CE's.

MR. FUTCH: They're giving them to us on the 10th and your folks send the renewal stuff out, printed on the 15th, or request the data on the 15th which then it is printed a little bit later.

MR. GRANT: So if they run into the course on the

9th, it may not be on that 10th download, so we're still looking at are the licensees having to assume a little more responsibility as far as the renewal process.

DR. SCHENKMAN: I think if we wanted to charge a fee for doing a paper application that has to go through legislation as well?

MR. FUTCH: A separate fee, yeah. The only thing we have the authority to do right now is charge a single fee for renewal. It's a great point and we'll probably be talking about it some more to see, talking with the attorneys to see what kind of wiggle room we have.

MR. GUIDRY: The only reason people aren't doing an on-line renewal is because they don't have an electronic version of their CE's. Can't you have an incomplete on-line renewal application where you have to submit something in later? That still would save you thirty percent of the labor.

DR. SCHENKMAN: You can fax in paperwork.

MR. GUIDRY: Is there a way to do that?

MR. FUTCH: The alternative is essentially what you do now. It's a paperwork method.

MS. GRANT: Correct. Out of the 1200 that are mailed -- that's an approximate number -- monthly, we

probably handle 700 what we consider dirty renewals.

MR. FUTCH: Yeah. I think -- we don't know exactly what the rationale is for the technologists. We have a lot of assumptions. We're about to rule out one of them because the CE will be in the system. It could just be that 24,000 people have been doing it this way for twenty years and that's just they way they want to do it.

DR. SCHENKMAN: Is ASRT the only place that they can get renewal credits from?

MR. FUTCH: No, there is a whole -- well, yeah. I should mention this. The whole system is already set up so that if they are using a Florida CE provider that information is already given into the system. The provider is getting with us and we're putting it into the system. It is basically that ASRT is just like --

MS. GRANT: It's just like when they go to a national meeting or whatever.

MR. FUTCH: Right. So all the Florida societies, they're already going to be there. But ASRT is kind of like a super provider and we actually talked to them years ago about doing this. I don't know why they didn't want to do it back then. Now they want to

do it because it is part of this process, taking information about technologists so they use it for marketing, or they will be using it to market stuff to them like ASRT membership.

MS. DROTAR: I don't think years ago they had the ability, the technical ability to do it.

MR. FUTCH: Yeah. Now actually the initial part of this project they wanted to charge us to do this like I think $1,000 per transfer, something like that. And, you know, for any private business it probably would've been no problem but, you know, for us. So we've been talking for several months and they eventually figured out that: Hey, we're getting a lot of information, you know, it was publically available information, but we're getting a lot of information about folks who may not already be ASRT members because we've got to match up the Florida folks with the national folks. So then they kind of figured out, I guess: Oh, what do you know. Another pool of people who might get into ASRT.

That's it.

CHAIRMAN JANOWITZ: So why don't we adjourn for lunch?

(Lunch recess from 11:45 a.m. to 1:15 p.m.)

CHAIRMAN JANOWITZ: Shall we get started? I think we're doing pretty good in terms of time though we may have a few controversial things coming up. It looks like we're still with Jim.

MR. FUTCH: Thank you. We're on Item F for the first bullet. And this is just basically a wrap-up issue for me but I wanted to bring closure to this.

As you know, we worked, with your assistance over a long period of time to get the electronic brachytherapy regulations written. Those were implemented earlier in the year. There is a letter in the packet from ASTRO. This is at Tab F-1. Which basically is a letter in support during the rule-making process, saying that they like the regulations.

I'm sorry Debbie (Gilley) couldn't be with us. She is plugged into lots of other organization on this issue and a couple of others. But my understanding is that I think we were the first state.

DR. WILLIAMS : We're the first state.

MR. FUTCH: So that just makes the company coming back and telling us what we did wrong or somebody will find it. But I wanted to say thanks for the assistance, and show you the letter, and that's basically all I wanted to say about this.

Any questions? Anybody have any opinions? (No response.)

All right. We did the radiological personnel forms before so that means we're down now to the medical use draft rules, which Terry Frady is going to talk to us about. These are changes to Chapter 64E-5 affecting radioactive materials users in a couple different parts of 64E-5.

In your pamphlets here you have I think it is three documents that pertain to this section. The first one is labeled F-3, blue tab F-3. That's the summary document. You were e-mailed a couple of these. This summary is the one that you were e-mailed before. And then there is a single double-sided page with USNRC on the top of it. I'll let Terry explain what that is. And then the last thing is the big thick actual draft rules dated 4/8/2009. And I'm sure you've all been through this and have all the corrections.

So we have a committee who has been working for awhile to draft these changes. It affects a large number of licensees. The internal committee put together this document and summary. I think this is the first public appearance of them and e-mailed to

you and also a meeting that Terry did this past week.

I will stop talking now and Terry give it over to you.

MR. FRADY: Thank you, James. This rule change process has been very educational for me. I found out just a little bit of some of the stuff that James has dealt with over the years. And it is really about moving a very stubborn mountain sometimes.

As the handout you got said, the NRC has made significant changes to the medical regulations. And based on those significant changes, we were tasked with bringing our rules into alignment with them so we remain in an agreement state. Some of the rules that they gave us, we had to adopt the way they expressed the stated rule. Others we could alter to some degree. Others we could change more. So this was a process that went on for just about a year we've worked on it and gotten it to this point. And as it gets further approved then it will be published where we ask anybody who sees the publishing to please comment on it as well because we want everybody to have as much input as they can into what we've done. And if they feel it will make it better or something we have not seen -- and that happens. And I think you

have a copy of the drafted rules. Is that in there, James?

MR. FUTCH: Yes.

MR. FRADY: Yes. That 156 pages. And don't read it late at night. It might take a long time. But that's it. And there's things that we could possibly have changed and you say: Gee, you shouldn't have changed that. And you can tell us why. We will listen to that. If we can change it back, maybe we will. If we can't -- there are some things that we just cannot changed. The NRC doesn't allow that.

They've changed the medical things and Carol had to hear this the other day and so did Ray. Mis administration has been changed to a "Medical Event." And that is in Part 1. I'm just going over the major ones. You have them right there.

Notification requirements for reciprocity has been changed from 365 to 180 days so they can be able to stay in the state without having to reapply or re-pay.

We've changed decay in storage. That is just one that they gave us which was an option. From ninety days for a short-lived isotopes to 120 days or less.

Back with the medical event reporting, they've

now included that if a child, an embryo/fetus or nursing child receives 50 Millisieverts (5 rem) or the nursing child has an unintended permanent functional damage to an organ or physiological system (as determined by a physician) it must be recorded.

This was something we didn't have before. And that's specifically to do with radioactive material. In other words, if they get around a dose somehow by CT accelerator, or anything else. No, it has to be radioactive material related, not.

And in Part 6, which is the biggest part, one of the first changes is the RSO will now have to sign, agree in writing to the responsibilities as RSO. Before we've always had a signed RSO and as inspector sometimes you realize that you're not on the same page with the RSO because an RSO is neutral and * accepted. Because some people, unfortunately either the DR. will make him the RSO and it doesn't work so now they have to be responsible for that.

Radiation Safety Committees may be required for outpatient facilities. Currently they are not.

No longer will we have written directives required for I-123. This makes a lot of people happy.

We have the current category Visiting Authorized

Users and it's been expanded to include Visiting Authorized Medical Physicist, Radiation Safety Officer, and I also believe Visiting Nuclear Pharmacist. And the reason for that is that sometimes we need somebody to replace an RSO who is on vacation or something like that. And there is no real clear way. We don't have Deputy RSO's so this is going to be the answer to that. You can have a Visiting RSO just as though they are a visiting authorized user for the same sixty days per calendar year.

We went and clarified the requirement mobile medical licenses must perform both fixed and removable contamination radiation surveys at a clients' facility before leaving to verify the facility is clean.

And here is another one that they found very exciting at the SNM team meeting. Dose Calibrators are not required (or an assay) if the radio pharmaceutical is in a unit dose and does not require a written directive. A lot of dissension about that.

MS. BONANNO: Do we want to discuss that here now or when you are through.

MR. FRADY: We can discuss it now.

MS. BONANNO: Yes. I was directed by the (Florida) Nuclear Medicine Technologist Society to

encourage us to -- we can be stricter than these rules. Right? We don't have to -- we can follow the NRC but we can be stricter. We can say that you still have to have one (dose calibrator) in the state of Florida. That's my understanding.

MR. FRADY: Direct compatibility is required.

MS. BONANNO: Right. Because there were all but one person in that whole room just went nuts over this. It's a liability issue. Radiopharmacies make mistakes. They are not perfect. You get the wrong size dose, you get the wrong radioactive material from Radiopharmacies. It's happened to me, both, and there is no way to tell is you don't use those calibrators until you inject it in the patient and now you've got a medical event that you have to report in writing to the physician, to the patient, as well as to the state.

And I don't think that it's a lot to ask for anybody that's dealing with radioactive materials and they've spent $250,000 on a nuclear medicine camera system, to have a $5,000 dose calibrator sitting in the complex, period.

CHAIRMAN JANOWITZ: I agree with Carol. You know, I think it is for patient safety to make a second

check just to make sure the pharmacy did not make a mistake. And it would be good for the pharmacy. They would probably much rather know ahead of time that the patient was going to be injected with the wrong dose or the wrong isotope.

MS. BONANNO: They're ultimately liable. The pharmacy would be ultimately liable.

CHAIRMAN JANOWITZ: You're talking about a minor investment and a minute of time to check the dose in the calibrator.

MR. FUTCH: We appreciate your comments very much.

MR. FRADY: Yeah. Great input. I do want to say this. Remember, even if this law changes, you don't have to do this. You can do the greater extent. You can continue to use the dose calibrator.

MR. FUTCH: We will forward those comments back to the --

MR. FRADY: Yes. All of them are very valuable. As I said the other day, any input as you read the entire document and you find something, please let us know.

MR. FUTCH: That's the whole purpose. We provide this thing because we want to hear these kinds of

things, the parts where we didn't get it right or the parts where something else needs to be done.

It's really early, you know. It's not too late. It's not written in stone yet.

MS. BONANNO: But there's only thirty days once it is printed, right, for comment?

MR. FUTCH: We have twenty-one or thirty. I can't remember exactly. I believe it is thirty.

MR. RICHARDSON: I'm sure no one will complain about the I-123.

MS. BONANNO: No. There were cheers.

ANONYMOUS: Including the inspectors, yeah.

MR. FUTCH: You want to keep on going.

MR. FRADY: Transmission sources that are used to calibrate imaging equipment have been, prior to this, 15 millicurie, and it is going to be raised to thirty millicurie. That's when the PET scan is internal. That's what the maximum total has been changed to. And that's so that people don't run into a problem because they have several systems and now they have too much REM.

Brachytherapy sources, the inventory has been changed from three months to six months.

There is new additional training and experience

requirements for Medical Physicist, Authorized Pharmacist, Radiation Safety Officer, Authorized user physicians in the use of Brachytherapy Procedures, Remote Afterloaders, Gamma knife, et cetera.

As that's changed, there are reasons for it. You have to create alternate pathways to be able to be user, or for people who had not at the time chosen to be on a license as a Medical Physicist. Now they have to find an alternative pathway to do that. The training and experience requirements are in the new document as well. And you will find some of that attached to this.

CHAIRMAN JANOWITZ: I have a couple of questions about this section.

MR. FRADY: Sure.

CHAIRMAN JANOWITZ: I guess first of all it says grandfathering existing RSO's.

MR. FRADY: Correct. If you are an RSO now and for whatever reason the training requirements that you need looks like it is more extensive than what someone has had in the past, because by virtue of being an RSO they remain an RSO.

CHAIRMAN JANOWITZ: If you were then to switch to a new facility would you still be an RSO or would you

have to meet the new requirements.

MR. FRADY: You know, I meant to ask that question and I didn't because we were busy at the time with so many different things. I can't answer that question.

MR. DIELMAN: Was the question -- excuse me. Was the question if you moved to a new facility?

MR. FRADY: Transfer from license to license.

CHAIRMAN JANOWITZ: A new facility.

MR. DIELMAN: Can you be an RSO at the new facility? I don't know the answer to this question for this group, but I know by precedent, what Part 35 is doing now is you can do that in the existing NRC system.

MR. FUTCH: I think the choice was if you were recognized on a license --

MR. FRADY: Yes, I think that's where it remains because otherwise --

MR. DIELMAN: And therefore you could go to another license and do it.

MR. FUTCH: And also on the NRC paper, the (specialty) Boards recognize it says: Training for the oral administration sodium iodides under 32 millicurie, American Board of Nuclear Medicine is not in there. On the back of the paper on 35.392. On 394

I guess none of the boards are recognized for greater than 33 millicurie. And what are the requirements?

MR. FRADY: Well, I can answer the required amount. You will see that on the next page that they have here several of the requirements. It talks about 200 didactic, 500 supervised clinical, hours documented in clinical experience.

MR. FUTCH: Which one are you on, Terry?

MR. FRADY: I don't have page numbers on here.

MR. FUTCH: Hold it up. Okay. And I know in the past American Board of Nuclear Medicine has always been recognized.

MR. FRADY: This list is taken from the NRC, as I understand it. It's not something we put together. Okay? It's their current list subject to change. Maybe it is an oversight on their part. It is not a list that will never change again. They've had additions and subtractions over the years and that's where this is at right now. Why it is that way I don't know because if I had seen it I would've asked. I didn't see it until today, to tell you the truth.

ANONYMOUS: You have to apply, the different education that applies to have a we have * to be recognized. So when they first did this a lot of them

were kind of left out. They start with a zero boards recognized and then --

MR. FRADY: And I look here and I see Wednesday, February 6, 2008, so I'm sure it's updated from then No, I'm not sure. It's possibly updated since. February of '08.

MR. FUTCH: On this paper it says 4/8/09.

MR. FRADY: Okay. I apologize.

MR. FUTCH: Well, we will certainly run that up there to Mike and Bill, the NRCO of the committee, and see if we can get an answer on that, see if they know or if it is, as Terry indicated, just NRC's own.

ANONYMOUS: Actually, if you look also, all these other certifications, they have a date as when the first counted them like 2005, 2007, so that's where we reflect the date you asked about and these are being recognized as far as '08 and '09. So anything before that still wouldn't count either.

MR. FUTCH: I think it is safe to say that the training and experience parts of this is one of the bigger parts.

MR. FRADY: Yes. We have an overview of that. There is more of that and it is a brief description of how these changes, what they are and how they have

changed. There's things that I've disagreed with I didn't see. I'm just trying to give you a brief overview of things.

And if you want to jump to under gases and aerosols. We have changed the requirement for collection systems to be checked during the months of use instead of every month. Well, in a hospital it is a monthly -- they are used daily. In a clinic somewhere they may be used two or three times a year, but I'm still not comfortable personally with them only being checked in the month of use, and what part of the month do you check it, when used, prior to use. I don't know how the verbiage is on it.

Also I see here the section on calibration. They have calibration of -- calibration of manual brachytherapy sources under 64E-5.632 and also a new section for decay corrections of Sr-90 eye applicators to assure source of specific data is correct.

This is like an overview, when you get into the meat of it, some of its far longer and but essentially what they tried to do is build a program that is compatible with what NRC was requiring of us, to have something that would not create impact financially was the key consideration, and to get this done in a

reasonable amount of time. Some of our rules are advanced from what the NRC may even want because we anticipate our next change and we want to be ready for it before it happens. Not like with this rule change where we kind of have to catch up or try to get ahead of the curve on that.

I'll take any questions you have about what we've done. We've done this over a period of about a year. We've taken one rule at a time, literally, and went through it. And all I was asked to do on the committee was can I inspect this when they changed the rule. And the other people really have put a lot of work far more. Mike Stephens comes to mind as doing a tremendous job. Of course, Debbie Gilley was often involved in so much of what we do and the rest of the people on the committee have done a heck of a job trying to bring us up to speed, get it to this time of year so that we can go on forward with it.

Are there any questions?

MS. BONANNO: Well, is there going to be a chance for -- for the nuclear med tech stuff, you hear a lot of this this week. But what about the radiology tech? What about the other people that are affected by this? How are they going to know and are they going to have

a chance to comment and is there going to be somebody to explain this to them?

MR. FRADY: Anything you can comment on. Tampa can go through the same process once it is posted. The only thing if it is, is we don't know that day that that's going to be posted.

MS. BONANNO: And are these groups aware that there is a new rule and it is going to be posted, or they have any time?

MR. FUTCH: There is a notice of proposed rule -- the process we have to go through, Florida Administrative Code, any modifications, the initial notice is given to the Florida Administrative Weekly and basically what it says is that we are starting the process of developing the rule. I don't remember the exact date for that, but that was done several months back, before Mike started putting this stuff together and the committee started meeting.

If we don't complete and get to the final stages of that we will have to do it again at the end of the first year, which is what happened to the electronicbrachytherapy. We got started with that process and didn't get far enough and had to do it again.

The second notice after the proposed rule development is the actual publication of the rule and the proposed rule making. That's the time when you were talking before you get the public comment period and you get thirty days and the rest of it.

We're before that. That hasn't happened yet. So there's always that at the end. But what we're trying to do with this is to get this out to groups like last weekend or whenever it was.

MS. BONANNO: Right. Are the other groups going to have time before –

MR. FUTCH: And the advisory counsel. I think --

MS. BONANNO: They don't read the Florida Public Administrative Weekly, you know.

MR. FRADY: Well, and the thing is, Carol, you guys asked us to come speak and this is what is occurring and what would impact you. I have not personally been asked to speak in a group like that other than for the FNMT because of the level of you guys have. But we have to go everywhere and tell everybody because we don't know where they are.

MS. BONANNO: Do you ever do a public hearing with a notice of a Webinar or something like that?

MR. FUTCH: We cannot -- there's a couple of ways

to go about it. We can do a workshop. We can do lots of different things. I think this is kind of --

MS. BONANNO: Because these are a lot of changes, you know. And so the people that come to the FNMT are mostly from this part of Florida, the whole South Florida group, there are only three or four people from South Florida. So they are wholly unaware, I'm sure.

MR. FUTCH: I think Mike has got plans but I wanted to give you guys kind of the first chance to say: Look, it's, you know, coming out of the internal department, and now it is coming through the Council, and into the -- there's one group a little bit ahead of you but that's because they had the meeting.

MS. BONANNO: Two days ahead of us.

MR. FUTCH: I wanted to kind of get a chance to see what you all thought about it first and then tell us, you know, take a look at this area again, or, you know, where we have the most concerns, as you've done so far with the comments that you've made. We'll probably make some adaptations and changes to that before we come out to, you know, the rest of the state of Florida. But, you know, this is a public document that you're holding in your hands so you guys can do

whatever you want with the public documents.

MR. DIELMAN: May I make a brief comment?

MR. FUTCH: Sure.

MR. DIELMAN: The first is, although with a strong background in nuclear medicine, I'm really inclined to believe that those calibrators should continue to be used in the diagnostic assessment radio pharmaceutical. With that in mind, there is also I recognize that when you receive any dose of any other medication in an institution or an outpatient facility, it is not checked by the institution or the outpatient facility. You know, it arrived from a pharmacy, came into the pharmacy and it is dispensed. It is not rechecked but by assay. I can see a parallel there.

MS. BONANNO: But it is labeled by the manufacturer.

MR. DIELMAN: I know but these would be labeled by the radio pharmacy.

MS. BONANNO: Yeah.

MR. DIELMAN: So that's number one but I think the other reasoning is, let's try to look at both sides of it. My advocacy is for the -- my initial statement. The other one is the liability issue. When Part 35

was adopted by the Feds five years ago. So this has been a long process. And five years ago I may recall, and James, you may recall better than I and others here. Florida Hospital Association at that time when Part 35 was first distributed, I'm not sure if they did it as an association or if there was someone representing the Florida Hospital Association, but nevertheless, they took a position at that time of concern about liability. They felt it was important to them to be on the side of having a dose calibrator for a whole, obviously for therapeutic, but also for diagnostic because it would contain their liability.

So relative to Carol's point, you know, how are people going to know? Where there are people from the Florida Hospital Association that will read everything that ever appears in a Florida Administrative Weekly. On the other hand, there are others who won't.

But that's just the point. There are people in the past who have been very strong advocates of the dose calibrator, continuing the dose calibrator project, i.e., the Florida Hospital Association.

MR. FRADY: I think Carol brought up the one point that's very relevant. The medical event as we are now calling it. If you give the wrong radio

pharmaceutical even for the six month period it becomes a medical impact. And that is a part of the problem now. Even with those calibrators will that ever happen? Well I don't think its going to happen. I suppose. I don't know that there is a guarantee on that. I don't know what even prompted this. I know it comes from the NRC. I know it's option. I don't understand it. It's part of the thing you do as a Nuclear Tech every day of your life you should calibrate your dose. And a life begins by evaluating generators.

MS. BONANNO: Me, too, honey. Me, too.

MR. FRADY: And it went downhill from there.

MS. BONANNO: Before.

MR. FRADY: And so I was very surprised when I first about it.

DR. ATHERTON: Well, it sounds to me like most of the facilities will still maintain doing this despite what the law would say.

MS. BONANNO: But if you have a new place opening up, yeah. But it gives an opportunity for somebody who is opening new facilities to not make that purchase, and it is not a big purchase.

ANONYMOUS: A lot of this is good advice for

cardiology groups because they are -- you know, they are only using one radio nuclei, usually, possibly two, and that's $5,000 they didn't want to spend, quite frankly.

MS. BONANNO: You're absolutely right.

DR. SCHENKMAN: Are these prepackaged doses? In other words, they are packaged at the manufacturer?

MS. BONANNO: No, no, no, they are not. They are made up at the radio pharmacy.

MR. FRADY: Cardinal, whoever your pharmacy of choice is, makes the unit does for you. And that's the only thing that's applicable to you. You can't buy bulk tech and make a kit. That would not be allowed. But the individual dose, like the cardiologist would use. Either as ten or twenty millicurie doses. That's --

MS. BONANNO: It comes in a syringe, ready to inject. But they have absolutely compounded it.

MR. DIELMAN: With a label on it and with the amount. They are taking the liability in the circumstances. You know, they take the sole liability. In the past the hospital has been taking it but it seems to, at least historically, seemed to want it. I don't know where they are today.

MR. FRADY: Yes. Because once you break the rule it does become a risk.

MS. BONANNO: I can see hospitals never changing but the technologist, you know, what if they come in and you want a job and they say, "Where's the equipment? There's no dose calibrator." Well, you have the choice of not taking that job. I wouldn't take that job and I don't think most people would, but people are desperate for jobs so they might take the job without that. It is a form -- you know, it is the suspenders and the belt. I don't want my pants to fall down.

ANONYMOUS: That's one way you have of paying the bills.

MS. BONANNO: And we don't even talk about 797, right?

MR. FUTCH: Any other thoughts or points on this? I know it is rather complicated.

ANONYMOUS: Wait until they see the training requirements for diagnostic imaging went to 200 to 80 hours, 700 supervised clinical hours.

MR. FUTCH: It's been redacted from, it looks like supervised clinical hours.

MR. BURRESS: Who is qualified to do the

supervision of this?

MR. FUTCH: Terry, would that be the --

MR. FRADY: On the training, that’s another thing. On the training, all training when completed it has to be signed by the person who has done the training that they do meet levels of competency by a qualified user in that category, just as it is now. I mean, you can’t teach somebody in a category you aren’t already certified in.

MR. FUTCH: So any qualified user can do it. It doesn’t have to be a training program or --

MR. FRADY: Right. And the reason for that is so it is offering a pathway so more people can become authorized users, say, in small clinics. And again we go back to cardiology with this where they didn’t -- they couldn’t -- they had to go away to learn. Now if you have an authorized user for 620, 6620.7, you can teach that person and have to get to 200 didactic but they have 700 supervised hours with him. But it allows people to have an alternative pathway, become an authorized user for that type of rem without having to leave or to go away for a turn.

ANONYMOUS: I guess the real question is how do you document the hours that is spent? Is it just

based on the signature of the authorized user who is signing off?

MR. FRADY: Insofar as I know, yes, they have to --

MS. BONANNO: That's a lot of trust.

MR. DIELMAN: Are you talking about the preceptor process?

MR. FRADY: Yes, still. But I don't know because I don't have that part of the rule in front of me. But it has to be someone in the category can teach the category.

MR. DIELMAN: Competency.

MR. FRADY: Right. And then they have to have a letter. No matter what happens, they have to have a letter attesting to the competency when they're done, as well. Not just a certificate. The same way that a person was qualified before to do that. In other words, by virtue of being in that category, that they can teach that *.

MR. FUTCH: I understand. I don't know the details of it, but I'm sure Ray either you or Terry, NRC is actually in its own rule process right now to fix some aspect of what they do, how they handle the preceptors.

MR. FRADY: Right.

MR. FUTCH: Maybe somebody who is knowledgeable about that can explain.

MR. FRADY: Well, it came out about a month ago, I think -- a month, six weeks ago -- that they started talking about changing, reviewing that and doing that. And they said very little and what they said we're not supposed to discuss because they haven't decided how they are going to do that. That was six weeks ago. They just knew that they were behind the curve on that and they needed to address it.

MR. FUTCH: The substance of it, though, was in their changes to Part 35 they kind of painted themselves into a corner --

MR. FRADY: Yes.

MR. FUTCH: -- in terms of the number of people who could be preceptors. The limited the pool down to --

MR. FRADY: They made it too tiny.

MR. FUTCH: Too tiny. And that was something that -- I remember Bill and Mike talking about this. We were forced into -- we could be a hundred percent in compliance with something that we know they are trying to change because it is wrong. Or we can

target it toward where we think they are going to end up in their rule making and go straight to that and be noncompliant. And when they come and ask us, you know, "Why are you noncompliant?" we will say, "Because you did it wrong." So they have made allowances for that.

ANONYMOUS: Which they have become aware of.

MR. FRADY: Right. I understand. And then we will -- it's not just that one rule because we have others like that.

MR. DIELMAN: T and E are training and experience requirements. They dealt with that the Department, correct me if I am wrong, they actually worked on that. This whole process of Part 35 has been going on for at least twenty years. And this T and E was the last to be approved, was it not? And then they still, at you just pointed out, James, have a problem with.

MR. FUTCH: And the cardiologist have been trying to get this changed for many, many years.

MR. DIELMAN: And get it diluted, if they possibly can where it allows more people to be used one for department pharmaceutical which is how the old thing, the whole mix about that, in my personal opinion.

MS. BONANNO: My concern is that there has got to

be a way to track those hours. Because just because they are a partner in this practice that does nuclear medicine every day, eight hours a day, he's off seeing patients, he's at the hospital. That shouldn't count as his eight hours, you know, towards this 400, or 700. There's got to be a way to really getting that training and not just sitting in on the reading most of the day for an hour. I don't know how to control that.

MR. DIELMAN: Well, the only mechanism we currently have is the supervision requirements in which you create the criteria. You, meaning the licensee, creates the criteria in advance and the institution gets it approved by the Radiation Safety Committee, the Radiation Safety Committee guides it.

MS. BONANNO: Unless you're outpatient and you don't have a Radiation Safety Committee.

MR. DIELMAN: Exactly.

MR. FRADY: Currently.

MS. BONANNO: Currently. You won't unless you have aerosols anyway, will you? The way I understood it. Maybe it's more strict than that.

MR. FRADY: Yeah. That's another change is the Radiation Safety Committees are not in 5-C's or in

clinics at this point. But if you have -- and that's one example. If you have aerosols and gases on a license for a small clinic they are going to require a Radiation Safety Committee, and also if you're doing diagnostic and therapy they're going to be required to do that. If they're just a therapy place then that's not the same. But once you have add the other imaging to it or vice versa, then they're going to be required a Radiation Safety Committee. And the makeup will be essentially the same as the Radiation Safety Committee now, so you have to have one person from each category of user, the RSO management.

MR. DIELMAN: Most of those places oftentimes the RSO is (inaudible).

MS. BONANNO: Yeah. It is going to be a meeting of one or two people, the technologist and the RSO. They better serve lunch.

MR. FUTCH: Any other thoughts on the medical use? All right. If you get back to your offices and colleagues and begin to discuss this and other things occur to you, please e-mail it to me. Individually, of course. And we will feed all this up the chain and see if we can get it corrected if it needs to be corrected.

ANONYMOUS: I have a simple question. Child embryo/fetus calculation, is that something that's already done and it's just a matter of reporting a * 5 rem or are people going to have to come up with standard assumptions before it is finalized?

MR. FUTCH: I actually asked that question myself for the first draft. The summary must be like four or five drafts. They gave this to us and we opened it up and said great. So that was the genesis of the summary. And then the summary went through three or four revisions. I could somewhat understand it because this is not my area. And I asked that exact question and this is the answer that I got, what you see. I don't know. Do you guys know? How is it done currently? If you have a child who is exposed, receiving more than this, are they not required to report it now? That's the implication, I guess.

MR. FRADY: Received less than. I don't like the way that this is even written but I have heard it written worse before we got to this point. I guess this is as much as anybody could agree on at the time. It does leave things kind of open even if you identify that it is less than.

MR. BURRESS: You have to do it as the mother's

milk, it seems like.

MR. FRADY: You know, clearly you would.

MR. DIELMAN: Can we suggest that --

MS. BONANNO: No, you can’t volunteer.

MR. DIELMAN: I missed something while you were talking. Would you be so kind as to perhaps take that back to the committee, that change, and discuss that point. Because I had a college professor once that had the big rubber stamp that stood about that high and about that long in college. And it said "Vague and Incomplete." That’s exactly what that section appears to me to be.

DR. SCHENKMAN: It also doesn’t give a time frame.

MR. FRADY: No.

DR. SCHENKMAN: Terry, this doesn’t give a time frame for when this unintended permanent functional damage to an organ or --

MR. FRADY: That’s the point I disagree with strongly, definitely. So they come back when they are twenty years old and say, "I’m this way because."

DR. SCHENKMAN: Right.

MR. FUTCH: And how do you determine the cause.

DR. SCHENKMAN: Right.

DR. ATHERTON: Why is the other radiation

excluded? I mean, isn't fifty millisievents --

MR. FRADY: Because the part that we're working with is about radioactive material as opposed to being the radiation --

DR. ATHERTON: Oh, I see.

CHAIRMAN JANOWITZ: But when you look at this, the only time I could foresee this ever happening is probably if it is hydrosradioiodine therapy if someone is pregnant.

MS. BONANNO: And someone is pregnant.

CHAIRMAN JANOWITZ: I can't imagine any other diagnostic procedure that would cause fifty millisieverts to a fetus. And actually, if you look at the literature, there isn't literature on women who were given thyroid cancer therapy doses 100 millicurie or more who were later found to be pregnant. And the data shows no significant increase in birth defects. So I'm not -- I don't know what the rationale is.

MR. FRADY: But there's a part that bothers me and it probably has got something to do with the NRC's actual rule and how far we can stretch this rule.

The question that you brought up. At what point can this person come forward and say, "This happened to me –

ANONYMOUS: -- my mother nursed and I automatically got radiation then."

MR. FRADY: This is a problem and the kind of medical liability I don't know and I obviously don't like that one. The rest of them I can live with and I know how to inspect that. That's what we know. But the rationale behind it, I don't know. It is too vague.

MR. BURRESS: I just would think that if you proposed the rule people might think they have to do assays to prove that they didn't exceed the 5 rem.

DR. SCHENKMAN: Or any time any woman with a uterus is going to get a significant dose of radiation they are going to make sure that they have a very current pregnancy test.

MS. BONANNO: That's what you do anyway.

DR. SCHENKMAN: Even still, sometimes, you know, they get pregnant that night and has a dose.

MR. FRADY: Not if she follows the instructions given to her. And that's why I don't like her to read the instructions.

MS. BONANNO: Follow these instructions. You could keep them in the hospital for three days you have a chance.

MR. FRADY: We often get patients we know are pregnant and we have them sign a waiver we usually use a low dose but they are no where near 50 Millisieverts.

MR. FUTCH: Going once, going twice. I apologize for the amount of material but --

MR. FRADY: It’s a two-day project.

MR. FUTCH: Yeah.

MR. FRADY: The overview is as good as can be for this afternoon.

DR. SCHENKMAN: Would you kindly, when you know it is going to be published, since I may forget to check that present day, call --

MR. FRADY: That’s special treatment for you. We can’t do that.

DR. SCHENKMAN: Ms. Committee, would you let us know so that we can sound the alarm. Or Terry can call me.

MR. BURRESS: And your input, what we take back –

MR. FUTCH: You know, actually you can go -- you can go to the Department of State’s website and, if I remember right, asked to be e-mailed when there is a change made to a particular part of the state’s regulations. I know this because people do this to

me. "Oh, I see you did this." I go, "What? Who are you?"

Are we moving on?

MR. BURRESS: I think we're done with this.

MR. TINEO: Just a pause, might I suggest -- Terry, thank you very much. Thank the committee and all these guys I know.

MR. FUTCH: Terry has to leave and we appreciate you coming, Terry, and thank you for your --

MR. FRADY: Yes. I appreciate everybody's input. If you do get a chance to read that when you are not really sleepy. It's a lot to read and there are some changes. I think most of it is livable. There are in particular things, again, about the calibrators. It reflects a change from the very beginning. And if you don't know anything else, you know about those calibrators.

And it was a lot of work. We hope we've done some -- if we've missed anything, we want to know. I told somebody the other day. We've gone over this endless times. Every inspector has read that. Okay? And then my boss comes over to me and he says, "What do you think this means?" And something was written one paragraph one way and one paragraph the other way.

Had to do with assay at injection time. And, nobody caught that. And I was on the committee. Nobody on the committee caught it. Thirty other inspectors didn't catch it. There's a lot in there and that's, unfortunately, what happens, especially when we do a lot at one time.

MR. FUTCH: There are NRC points sometimes you don't catch it for years.

MR. FRADY: Thank you all very much.

MR. FUTCH: Part G you may recall -- I don't remember exactly how many council meetings ago it was, but we had a presentation from one of Debbie's colleagues on the NCRP 160 committee about increased doses to the public. And that report has now come out, at least they're taking orders. This is a pre-publication copy. And has anybody seen one? Have we actually gotten delivery on this yet?

DR. ATHERTON: No.

MR. FUTCH: All right. I just checked with Debbie and it has been finalized and it is supposed to be printed and being forwarded soon. This is Debbie's copy. If anybody wants to see it, here it is.

But we had talked about when this happened, trying to do something at the Department. Maybe

getting the Surgeon General to send a letter to the State's physicians. Oh, I should back up. The main thrust of this, for people who haven't seen this, is that there is a type of organization which looks at the dose, average dose to the public from all sources. And they last did this I think twenty years ago and they have now updated it. And they found that the average dose to the public have more than doubled. That makes you feel real good, doesn't it? All the entire framework of licensing techs, and regulating machines, and trying to have as low as reasonably achievable of your dose to the average person doubles in twenty years, which is not a good thing in and of itself.

So the thrust of the report is where did the increase come from. And so the thrust of the report is the increase came from increased use of medical procedures primarily two different kinds -- CT and nuclear medicine cardiac procedures.

And that accounted for the vast majority of the increase. Medical use went from I think -- oh, I forget what it was, eleven percent, something like that to now medical use is more than fifty percent, if I'm right.

So the trick to all this is that, nobody wants to frighten people away from getting medical procedures. But there is a lot of national organizations who have come out. ACR has come out and made some pronouncements. Health Physics Society, I was just reading a two or three page summary of NCRP Report 160. AAPM has some pronouncements.

And everybody is kind of taking the approach of trying to better educate referring physicians on a few points which is that, you know, these procedures have dose and does doesn't cause illness. It can increase one's risk of things like cancer. And to think about it before you send somebody to a CT procedure. Maybe check into, you know, have they had something before. Some folks are talking about trying to track exposures, with your own personal tracking card, keep track of your CT dose exposure.

All this is being talked about. And the committee last time I think they gave some support through trying to get interviewer Monte Ross to come up with a letter that would go to the DR.s in the state and talk about these issues. Tie in to the *Image Gently* campaign that ACR and some of the other organizations have for paying attention to pediatric

doses especially.

And what you've got here in your packet I hope to actually be a draft letter from us on behalf of Surgeon General Viamonte Ros but it hasn't quite gelled and come together yet. So what you have instead is essentially the same type of letter from the state of New York, Medical Commissioner of Health to their physicians in New York. This one specifically talks about CT. I don't think it really mentions nuclear medicine. And it ties into the fact that the NCRP was working on this report.

But I wanted to put it in your hands because I think this is the direction that we're heading with our letter. And I wanted to see, since it's actually been done, what you thought of this direction and if you thought the tone of this was right, the direction and the topics were in the right vein for Florida.

Okay. I'll stop talking now.

CHAIRMAN JANOWITZ: I have two comments. I think there should be a letter to all physicians, but I think you need a letter also to every licensee physician, because they are the ones that control the settings of the machine, they are the ones that could do the most to limit the radiation. They don't need

the same letter necessarily, but I think pointing out these things that I feel are very important, just as important as sending it to the physicians.

MR. DIELMAN: I would certainly advocate that very position, that Florida receive a letter similar to this. I think there are places where it could be enhanced. As you suggested, in addition to CT, nuclear medicine reference, not to mention fluoroscopy, conventional cases. I think on the last page they referred to only one accrediting group, but there are several accrediting groups out there. It would be really hard only mentioning one of them.

MR. FUTCH: * is one of them.

MR. DIELMAN: Joint Commission is now very active in going back in diagnostic imaging accreditations. That's being actively pursued by Joint Commission now. So that's not a complete process but where it is at. So I would just be very broad, you know, in who does what to whom. But I think it is a good idea.

MR. FUTCH: All right. Thank you.

DR. SCHENKMAN: Does any other place publish a letter like this for Florida physicians? Because a lot of them are never going to open their mail.

MR. FUTCH: I should ask you folks that. The

suggestion was made to put it into the Board of Medicine newsletter. I'm not sure about the space limitations. I've never actually seen but one issue of that, eight years ago, on another issue I was involved in. What do physicians read? How does one get their attention?

CHAIRMAN: JANOWITZ: People will probably hate me for staying this, but, you know, we have special CE requirements for domestic violence and AIDS. Why not have one created for radiation safety?

MR. FUTCH: That's an excellent idea.

DR. SCHENKMAN: Great idea. That will get everybody's attention. Trade out HIV for that.

MS. BONANNO: Been beat over the head by HIV so much. Every other year, every other.

MR. FUTCH: Stepping into the lovely area of things required by the Legislature and law, you know, like increased caps for x-ray and all of those things. Certain people have ideas on what everyone should do and things. You know how that happens. But I appreciate that, and we pursue that.

MR. GUIDRY: What is you dose range for a CT?

CHAIRMAN JANOWITZ: Up to about -- prior CTA is the current culprit about -- well, it used to be about

twelve to fourteen millisieverts and newer dose reduction has it down to about three or four. But --

MR. GUIDRY: Three or four millisieverts?

CHAIRMAN JANOWITZ: Yes. Dual isotope cardiac studies would be twenty-four millisieverts.

MS. DROTAR: They are supposed to be under five a year, right, for any person?

MR. FUTCH: That’s occupational. It doesn’t apply to the patient.

DR. SCHENKMAN: But then you also get a lot of patients, cancer patients who routinely have multiple CAT scans every other month.

MR. FUTCH: They are probably driving it up.

DR. SCHENKMAN: And it is additive.

MS. BONANNO: They are driving it up.

MR. FUTCH: Oh, year, you can’t walk into an ER these days and not get a CAT scan or something.

DR. SCHENKMAN: Right.

MR. TINEO: The other groups are likely to go after are physician assistants and nurse practitioners. The Physician Assistants are in no particular group because they are operating under the license of the physicians and they are basically the ones ordering a lot of these procedures under those

physician's guidance. We just need to bring them to their attention also because this is an issue.

CHAIRMAN JANOWITZ: This is something a little bit different (holds up small packet). Most of you haven't seen this yet but it is related to this issue of the radiation. This is actually from a fellow I've known for many years who started off doing EBT. But this is Bioshield-Radiation Formula Two, Multiple Antioxidant Micronutrients to address Radiation Exposure. And this company would like every patient going for the x-ray exam to take these pills prior to the exam to reduce radiation exposure.

If anyone would like to see that, I'll pass it around.

ANONYMOUS: If you just eat a portion of a bar of dial soap.

CHAIRMAN JANOWITZ: It is Vitamin A, Vitamin C, Vitamin E, and Alpha-lipoic.

MS. BONNANO: It reduce free radicals.

CHAIRMAN JANOWITZ: N-Acelyl-L-Cysteine.

ANONYMOUS: Stop breathing and you will reduce free radicals right away.

MS. BONANNO: For how long? Forever.

MR. FUTCH: Jerome, you had asked about doses

from some of these procedures. I've got this printout from the Health Physic's Society's website that I keep with me. Once in a while somebody asks questions like that. They've got CT abdomen, effective dose, 1 Rem. CT bones the same thing. I don't know what that stands for but --

DR. WILLIAMS: Per cutaneous Coronary Angina.

MR. FUTCH: Heart study. It says 750 millirem to 5.7 Rem. So these are higher dose procedures that are singled out.

MR. GUIDRY: And those are upper bound, I would presume.

MR. FUTCH: Well, they give a range on a couple. On the rest of them they give like an average based upon different amounts of images that they've measured.

MR. GUIDRY: So they are total body then?

MR. FUTCH: Yes.

MR. *: Now, one of the things that is stated in this letter has to do with children.

MS. BONANNO: Right.

MR. GUIDRY: You would presume that a physician giving a CT scan to someone my age would, it's not the same as giving a dose to a child that's got seventy

years of life ahead of them. But what is the children? Why are children getting these?

CHAIRMAN JANOWITZ: ER.

DR. WILLIAMS: They walk in with abdominal pain, rule out appendicitis.

MS BONANNO: ER injuries, everybody gets it. They have a head injury they get a CT. Called protecting yourself from malpractice.

MR. GUIDRY: They're doing it defensively.

DR. SCHENKMAN: Yes. You bet.

MR. FUTCH: Well, a lot of it is defensively and some of it --

DR. SCHENKMAN: Not all of it but for sure if you have a kid with a head injury you do a CT.

MR. FUTCH: The implication from reading a lot of these letters from states and so forth is that while there are some knowledgeable people, such as the tech, and a nuclear medicine physician, and the oncologist, radiologist, the remainder of the ordering and referring medical community doesn't, I guess, think of or see the difference between a diagnostic radiograph of the chest versus a CT of the abdomen and pelvis. To them it is about the same thing.

CHAIRMAN JANOWITZ: They are looking at the

benefit, not the risk factor.

MS. BONANNO: Right.

CHAIRMAN JANOWITZ: You know, when I was in medical school it was acceptable to have a positive appendectomy rate of ten percent. That was nine out of ten appendectomies turned out to have a normal appendix. Nowadays it is probably reversed.

DR. SCHENKMAN: It is reversed.

CHAIRMAN JANOWITZ: Ninety percent have a normal appendix. So your diagnostic accuracy need for * surgery has gone down tremendously but at a cost of radiation.

MR. GUIDRY: Now, these exposures, apparently no of this has happened -- I think the last NCRP report was ‘80?

MR. FUTCH: Yes.

MR. GUIDRY: When did kids start getting these? Ten years ago? Fifteen years ago? When did this really --

DR. SCHENKMAN: Twenty years ago.

MR. DIELMAN: Twenty.

Dr. WILLIAMS: But it’s become much more common in the last five years.

MS. BONANNO: But now it is faster and easier to

do a kid. You put them in the kids' well.

MR. GUIDRY: Are we seeing any effects? Has anyone noted --

CHAIRMAN JANOWITZ: There's a study going in England right now but there's been no study that's shown any definitive effects that I'm aware of.

DR. SCHENKMAN: And it's also -- you also have to realize that in the last seven years, five to seven years, the technology has gotten better for CT. Many, many more CT's are being done on adults and children. So --

MR. GUIDRY: So it's geometric.

DR. SCHENKMAN: Yes. So even if they do a study now it may not reflect what the current practice of radiation exposure is.

CHAIRMAN JANOWITZ: Five to ten years ago it was unusual for radiologists to have to come in at night to read a CT scan. Now we do them twenty-four hours a day. We've got -- we just * probably 70 or 100 CAT scans done overnight from midnight to 7:00 a.m.

MR. GUIDRY: That's incredible.

MS. BONANNO: It is, isn't it.

MR. BURRESS: This was written in September '08. And March '09 press releases came out from the ACR

(and others) that cover a lot of the issues that were swept out of this one. They have the age issues in there; they have the kids. Eight to ten percent of CT's are done on children.

Most of them says over fifty-four percent are done on adults over age fifty-five, and they've been increasing at ten percent per year over the last decade, the number of CT exams. So the collective dose is increasing even though the individual patient dose has actually dropped over the same time period. So a lot of these are addressed and the ACR does a real good job about saying what we should do, if anything, and what does this mean. They have a risk benefit paper. So the resources I think are already in place on line.

MR. FUTCH: One of the things you want to do is, if it's not done is point out those more recent resources and tie them into the letter and give them ways to get a hold of that from the internet, I guess.

MR. BURRESS: Yeah. They're written for a lot of different groups, too. AAPM reports quite technical. Obviously not, I don't think, for lay people.

CHAIRMAN JANOWITZ: I would rather do that than domestic violence.

DR. SCHENKMAN: You might also be able to get the letter into the separate Florida Medical Speciality Journal that come out.

CHAIRMAN JANOWITZ: Again, they won’t be read. Okay.

DR. SCHENKMAN: Make a big announcement.

CHAIRMAN JANOWITZ: All right. This is always the fun part. We have -- I always like to give you a little window into the questions that we get.

MS. BONANNO: It’s always amusing.

MR. FUTCH: This time we actually had one this time that came from, not from people calling up and asking questions but from one of our cases that came before the discipline panel at the Department. We were asked to, something along basically the hospital, Diagnostic Imaging Center, had a patient who was undergoing an MRI with Gadolinium contrast.

MS. BONANNO: NSF.

MR. FUTCH: And it goes through the whole scenario but it goes something like this. The patient comes in, they go through all the normal prepatory steps and consents and the rest of it. And the fill all the forms out, and "Are you allergic to contrast? Do you have kidney problems?" and so forth and so on.

To make a long story short, the technologist appeared to do everything correctly in giving the contrast but the person had some type of reaction -- it wasn't specified in any of the literature we saw. Started foaming at the mouth, airways blocked off. They called for an ambulance -- because there was no physician, or physician assistant, or anyone else in the facility; this was a free-standing diagnostic imaging center -- to provide emergency life saving care. And by the time the ambulance got there the person basically expired on the way to the hospital.

So this -- I brought this one up because it kind of gels with a lot of the questions we used to get which are -- from technologists who work in free-standing diagnostic imaging centers who say that they are giving contrast and they don't feel comfortable giving the contrast in that setting because there is no one there who can help out in just this kind of situation when it occurs.

So I just wanted to run the whole thing by you so you knew that both the questions continue and there is at least one case, probably more. And ask you if we need to do anything differently from our end and what that might be.

I think one of the attorneys on the panel who is going to initiate a communication with the Board of Medication staff and try and clarify what authority, regulatory authority they have over these kind of tests being performed in the free-standing centers. You know, could someone, for example, write a regulation to require that the contrast only be given if there are certain types of personnel available, and then what does that mean, what kind of personnel, and how available is available, and all that.

What is the sense of --

MR. BONANNO: I call on PET centers every day of my life and those that do CT never inject contrast without a physician present in the building. So I -- now, as to Gadolinium, that’s a whole different thing because I had not heard of allergic reactions to Gadolinium.

DR. WILLIAMS: A lot of additional risk.

MR. FUTCH: As far as I knew, I thought a physician was required to be on premises.

MS. BONANNO: For contrast.

DR. SCHENKMAN: I thought it was required, too.

MR. FUTCH: Part of the paperwork that was developed for the case was a printout of the

information of the FDA approval for Gadolinium. And they said that I think about two years ago there was a revision. And in the FDA paperwork it says they recommend only doing it when there are physicians present or available, whatever term they used for that.

So, I don't know if this was just on the periphery of --

MS. BONANNO: I wonder if there is a Medicare requirement like that for stress --

MR. FUTCH: Does anyone know of a requirement.

MR. DIELMAN: May I just address that, Carol? It's purely all about standards of practice and not legality. And there is a source. The American College of Radiology has a book that looks like a Sears and Roebuck catalog. It's called the Standards of Practice. All right? And they address that very issue. And you can also get it, by the way, on disk. And the American College of Radiology in Virginia, call them, readily available.

MR. FUTCH: But those are not legally --

MR. DIELMAN: No. They are standards of practice but they are not legal in the sense of a regulation or a statute. But in a court of law they are precedent

and they are used as precedent briefly.

CHAIRMAN JANOWITZ: If you look at the beginning, though, it says: These standards are not meant to be used --

MR. DIELMAN: Exactly. Because the standards of practice is just that. It is the standard of practice. You can argue the standard of practice changes from place to place, so if you're in a rural hospital you could argue there is no physician available, you know, such and such. But the point is that and a myriad of other subjects of a similar nature are covered in that document.

Mr. FUTCH: Yes. I'll take a look at that.

MS. BONANNO: Some of the Medicare requirements for certain tests require the presence, direct supervision and the physician has to be there. But that's the stress testing.

MR. DIELMAN: That's for payment, though, but it doesn't -- none of them that I'm aware of, Carol --

MS. BONANNO: Yeah, that's for payment, yeah.

MR. DIELMAN: -- have anything to do with the injection or things like that.

CHAIRMAN JANOWITZ: Actually the requirement for Gadolinium has got much tougher restrictions.

MS. BONANNO: Because of NSF, but --

MR. DIELMAN: Exactly. There's been a lot of issues with that.

MS. BONANNO: But that doesn't happen right away while you're under the camera. It's two or three days later when your --

DR. SCHENKMAN: Your kidneys shut down.

MS. BONANNO: -- your kidneys shut down and then you get -- so do your lungs.

MS. DROTAR: Contrast in these outpatient facilities and there are many physicians who interpret that very loosely about how close they need to be when contrast is given. Because there are some because I get questions from technologists about that.

CHAIRMAN JANOWITZ: There is another issue that's also which I've had some arguments with administrators. Their feeling is if there is a reaction their response is to call 9-1-1 as opposed to being prepared to handle severe reactions in a facility. And we've gotten them to the point where they have basic drugs available for some of this but in an outpatient setting do we want to permit contrast injections with allergic possibilities and relying upon 9-1-1?

MS. BONANNO: No.

DR. WILLIAMS: But that's the standard. I mean, we operate a free-standing center, the hospital does, as soon as you open the front door of the hospital and it is operated as an outpatient center. And if somebody has an allergic reaction we have a full-blown imaging center and the procedure is to call 9-1-1. I mean, if you want to go to ACLS, that's drips and strips, you know, and you've got to be certified for that. That's a whole different level of competence that very few radiologists or radiation technologists have. We're BCLS, you know, and we can handle --

CHAIRMAN JANOWITZ: Well, I think every radiologist should be able to give an antihistamines, maybe some steroids or adrenalin, if necessary.

DR. WILLIAMS: I guess as simple as that, yeah. But there is no halfway as far as the regulatory language goes. It is either BCLS or ACLS, and so you can't just say: Well, I'll get some Benedryl. You know, that won't cut it from the standpoint of the competence and the skill set required to manage the case. So --

DR. SCHENKMAN: Yes, but it may keep the patient around long enough for your 9-1-1 call to make a

difference.

DR. WILLIAMS: Well, the problem is, is that that's not the way the regulatory authorities look at it. I mean, I'm all for saving patients and everything, and we have patients once or twice a week, you know, that get issues that we have to, you know, deal with. So I'm right there with you on that. But, you know, I'm a BCLS certified physician and if a patient has a reaction we're going to call 9-1-1. That is the policy and I guarantee you that almost all outpatient facilities imaging centers in the state recognize that and operate that way.

CHAIRMAN JANOWITZ: Well then probably there's no requirement to have a DR. in there because you just call 9-1-1.

DR. WILLIAMS: That I don't know about, you know. Our policy is if you use contrast to have a physician on site immediately available no matter what the contrast agent is. I thought that was the state requirement.

MS. BONANNO: I thought it was, too, because I've never gone in one with -- you know, I've seen them sitting there waiting for the DR. to show up before they inject the patient. I've seen that.

Technologists don't want to inject it themselves. I had rather have an EMT resuscitate than you.

ANONYMOUS: There is nothing funny about radiologist and a code.

MS. BONANNO: They do it all the time.

CHAIRMAN JANOWITZ: The point is to keep it from getting to that.

MS. BONANNO: Right, right.

MS. DROTAR: Part of it is just having that other person there that can say yes, you know, if there is a minor reaction, if you're the technologist, if you're there by yourself, you can't really evaluate that patient to give that. I mean, it is an emergency but, you know, it is stepping outside of your scope of practice. And then the technologist is being required to act on this level of a physician or a nurse and that's outside the standard of practice. So, it's not going to --

CHAIRMAN JANOWITZ: I'm sorry. I'm not advocating not having a physician.

MS. DROTAR: Oh, okay.

DR. SCHENKMAN: No. He's advocating having one there.

MS. BONANNO: You would still call 9-1-1, though.

DR. ATHERTON: But the physician should call 9-1-1.

MS. DROTAR: If a physician is there --

MS. BONANNO: Hey, call 9-1-1. But I ran into a technologist who called me up and said: I'm working for a cardiologist, single practice cardiologist, with a nuclear camera in his office. And he wanted that technologist to stress the patients when he wasn't in the office.

DR. WILLIAMS: That's his liability.

MS. BONANNO: I said: Quit that job and run.

MR. TINEO: Most facilities are with hospitals, associated with hospitals. They probably follow the general commission guidelines which then are strict and you do have to have certain physician supervision. So the problem you have is that there are some outpatient facilities that are not associated with hospitals, so they are not joint commission accredited. And those are the ones that are, like Carol says, they do the very minimum to follow.

MS. BONANNO: Yes. There are PET centers where the only physician affiliated with that PET center is somebody who reads in Miami and this is in Jacksonville. There are places like that. It's very

scary.

MR. FUTCH: Well, in the case -- in the instance of the one case that we were just talking about before we closed it with no action recommended, it appeared to us that the technologist did everything they were supposed to do. I mean, the only thing we even have jurisdiction over anyway is the technologist and their scopes and what they do. And I don't really know how to get at this, or if it is get-at-able. But I thank you for your comments.

The next issue -- I took these out of order, actually. Sorry about that. The next issue was we have had a couple of facilities with nuclear med techs who called. And their question was -- I wasn't really sure how to answer this. Their question was: How many patients can a nuclear medicine tech monitor in multiple rooms, in multiple facilities while they're being scanned. And I asked them for more information. And, as I understand it, it sounded like he was saying there are at least multiple rooms in the same facility and perhaps even one room in an adjacent facility where a single technologist is, of course, giving the radioisotope and sending folks to be imaged on a machine and is, quote, responsible for this, according

to the facility, for the scan. So, you know, they are signing off on all these scans. They are the ones who did all the scans. But they are physically, of course, in one place at a time and they have multiple patients undergoing multiple scans at the same time that they are responsible for.

MR. TINEO: Who is watching the patient?

MR. FUTCH: They are.

MS. BONANNO: How can they look at two scans at the same time, though?

MR. FUTCH: They put one on and they start it going and then they go do the next one. Then they come back and check the first one and then --

MS. BONANNO: That would be a cardiology office.

MR. TINEO: I would recommend that that tech would find another job.

MS. BONANNO: Yeah.

MR. FUTCH: That’s been many of my recommendations.

MS. BONANNO: Yeah. That’s crazy.

MR. FUTCH: That’s crazy, I guess.

MS. BONANNO: The liability there, if a patient fell off a bed, if a patient stood up or had a reaction.

MR. TINEO: The patient could fall out of the bed when you are in the room.

MR. BONANNO: Yeah.

MR. TINEO: Never mind not being in the room.

MR. DIELMAN: You've got two options there. For example, the American College of Radiology standard of practice covers that type thing, Again they are not legal but they are standards of practice. But the other source that you have is the Joint Commission Standards for hospitals, institutions, and for outpatient facilities. And they are not prescriptive any more. Many of us think of the Joint Commission as being very prescriptive as it was 2000, somebody got it prior to that. Now they are very global so there is no specific requirements.

But what they do, as was stated over here, is they put the responsibility onto the institution to create a procedure to address that issue so it becomes institutional.

MS. BONANNO: Yes. They want to see your procedures, how you're handling that.

MR. TINEO: Risk Management also takes in a big part of that. I mean, I don't know if that facility has any Risk Management Department, but that's another

area that you can refer them to because that would be a Risk Management issue.

CHAIRMAN JANOWITZ: I'm on several of the ACRNS and M Practice and Standards committees and I don't think we've ever even thought that we would have to put in there that technologist should be assigned one --

MS. BONANNO: One per camera.

CHAIRMAN JANOWITZ: -- one for one. And I think that's generally been understood by everybody --

DR. SCHENKMAN: If they have any common sense.

CHAIRMAN JANOWITZ: -- the technologist is responsible for one patient at a time. They can't do it. They need to write in the standards that it is --

MR. TINEO: But when you've got the independent practice.

CHAIRMAN JANOWITZ: I doubt if it is even in there because probably no one ever thought of it.

ANONYMOUS: Look under 12 don't recall seeing it but that's where I thought.

CHAIRMAN JANOWITZ: It never says anything about how many technologists would --

MS. BONANNO: You could probably help people avoid that when you're helping them write their procedure

manuals.

ANONYMOUS: And we do. That's where you write it in when you are creating it.

MS. BONANNO: Right.

MR. BURRESS: That's why radiation -- why you are all so important because radiation safety and practices are extraordinarily important and compliance issues in terms of actual functional operations. So take yourselves seriously.

MS. BONANNO: Find another job and call Ray.

MS. DROTAR: I just want to double back for a second because the facilities that are going to use standards or create policies aren't the facilities that we're talking about. Those are people that go in and establish, you know, they need this person, and that's the person that's there, and they've got three machines. And here, you can run them all because you're licensed to do so and you can do this number of procedures.

We're not talking about our usual standard and the standards that you all have. And I think that there are areas out there that need to protect -- you know, our job is to protect people in the state of Florida, but also technologists that are asked to do

those procedures and perform those procedures. And as much as we would like to all think that, you know, you would have that altruistic attitude that you can, you know, run and fly and you're not going to do it, they will find someone else who will.

So where do we have the wherewithal to stand there and say, "I cannot do this." Do we have anything? I think that's what you were trying to get at. Where can we or can we in any way put something in there that will protect technologists so that they don't have to do something that is not what they would want to do and not the way that they would want to perform procedures?

MR. FUTCH: In other words, write a regulation.

MS. BONANNO: A rule, a rule.

DR. ATHERTON: Profit versus patient care and that's the thing that --

MS. BONANNO: Yeah.

MR. DIELMAN: That's an excellent idea. I'm wondering in practice --

CHAIRMAN JANOWITZ: Well, look what happens to --

MS. BONANNO: Yeah.

CHAIRMAN JANOWITZ: Look what happens when the nurses try to go to the Legislature and get staffing

ratios.

MR. DIELMAN: Exactly. That's exactly where I'm going to go. That will not go anywhere.

DR. SCHENKMAN: Is there a way to not do it through the legislation but --

Mr. FUTCH: Yeah. Try to write a regulation with the authority that we have and see where the chips fall. It is clearly a patient safety issue.

MS. BONANNO: Right.

MR. FUTCH: Well, let me ask you this. Would you feel comfortable if we were to attempt to write a regulation that said a nuclear medicine tech can only monitor one patient being scanned at a time? Would that be unduly restrictive upon --

MS. BONANNO: They could do two if they were in one room right there. It would be possible.

ANONYMOUS: But if the rooms are configured appropriately, then you could do four. You see where I'm going.

MS. BONANNO: Yeah, yeah. So there you go and you don't want that either.

MR. FUTCH: What if they use electronic means and set up a camera and watch sixteen rooms at a time.

MS. BONANNO: Yeah.

MR. FUTCH: All the rings in a circle around me.

MR. DIELMAN: And that's the -- your own target. That's exactly the issue. I don't think there's an answer there. I think it would be an exercise in futility.

DR. ATHERTON: And is nuclear medicine the only modality that's an issue with?

Mr. FUTCH: I think it's the time factor.

MS. BONANNO: It probably is because in x-ray you're only using MR, yeah. Those scanners are not that --

MR. FUTCH: Multiple rooms. Which I feel obliged to remind all of you it's just not the statutes.

MS. BONANNO: Oh, you're right.

CHAIRMAN JANOWITZ: It's either the machine statute or the licensing statute.

MR. FUTCH: I appreciate the comments.

CHAIRMAN JANOWITZ: I had a procedure a couple of weeks ago and I got claustrophobic in there.

MS. BONANNO: Did you?

CHAIRMAN JANOWITZ: And I was looking for the tech. I'm head of this department. I would be very upset if the tech was not immediately available.

MS. BONANNO: Yeah, yeah. Well, I know when we

were on --

DR. SCHENKMAN: We could try writing the regulation and see where it goes.

MS. DROTAR: A little bit of something is a lot better than nothing at all. At least there's a way -- there's something and then that sets kind of a precedent if something else is needed. We might not need anything more than just yeah, it is like that.

Mr. FUTCH: Does anyone know of a state out there that does this or anything that I can copy?

(Inaudible)

CHAIRMAN JANOWITZ: Well, I'll tell you one thing. I'll try and get it entered in all of the SNM standards. You know, that actually is quite useful. A lot of times in a conversation on the phone I get a long way with turning it around to the legal side of things. And starting to talk -- not that I'm giving legal advice or anything, but just saying, you know, there is this standard out there and this is what it says. It is not explicit Florida statute or regulation but it is available for any enterprising attorney who wants to come sue you people if you do this and someone dies, for example, or falls off the table and breaks their neck, whatever happens.

CHAIRMAN JANOWITZ: It should probably be a separate patient care standard that applies to all of the procedure standards especially in nuclear medicine. I don't think we have that.

MR. FUTCH: I will look into it. And then last but not least in this particular area, I wrote the verbal orders. I'm not rally why it didn't have anything to do with it. This one came back to us. One of the manufacturers asked us this question. I guess it is coming back to them from their facilities or through their continuing education or something like that. But anyway, it came from the manufacturer and they wanted to know, they were using basic machine operators to do things that are prohibited by our regulations for basic machine operators like mobile imaging and some other things like that. And we pointed out the regulation and pointed -- actually had a regulation, actually had a statute. Pointed out the regulation, pointed out the statute and then they wanted to come back and basically what they are trying to do is kind of a partial practice of technology and figure out which part is okay for basic.

They wanted to know, for example, could they at least print the film. It's funny that you mentioned

that today about digital images and how important it is to print the film properly. Can the film be printed by someone who is either not certified or someone who is a basic doing the procedure that they're not supposed to do by regulation. Could they turn the unit on? Not turn the beam on but turn the power on.

And usually at this point I just kind of stop and say: I've given you the statute. I've given you the regulation. Go figure it out. We're not in the business of picking things apart.

MR. FUTCH: But I just wanted to run it by you and see what you thought about this. To me, again, it looks like trying to kind of parse apart all the different parts that go into making the practice of technology into: Well, how much skill does it really take to turn on an x-ray machine, and how much skill does it really take to print an image from whatever system you're using?

Thoughts, comments. Am I being too restrictive. Should we just let that happen or am I on the right track?

MS. DROTAR: That's bizarre.

DR. WILLIAMS: I mean, plenty of folks actually

work in the hospital setting. And so, are you talking about the OR, that's a common question we have like, or can the physician have a nurse come in and bring it and set it up and then wait for the DR. to show up. We get that question a lot in that one particular area, who is allowed to actually touch the equipment. The physicians are allowed to operate it so can they supervise a nurse set up the equipment in a similar vein as this. Do the QA in the morning be first one to turn on the use CT. Got some small clinic they turn on the CT scanner get, do the automatic QA on the phone. What is the calibrations.

And so yeah, we see that a lot in actual practice.

MR. TINEO: You've got a mini-CR operated by the physicians and the nurse in the OR, no x-ray tech possibly can't be the nurse.

MS. BONANNO: Can't be the nurse.

MR. TINEO: Possibly the physician is operating it.

(Many talking at once.)

MR. RICHARDSON: But there is several data on that. I don't want to necessarily complicate things because there are what you just pointed out lots of

different aspects to --

MS. BONANNO: This is a multiple-

Mr. FUTCH: No, they didn't specify. A manufacturer so they kind of asked me a global question.

MR. FUTCH: In the case of the physician being in the room, I think there's always been that argument of: Okay. Well, he's actually using the foot pedal and he's simply asking someone to move the head around, turn a knob on a machine. Is it him doing the practice or is it the other person doing the practice. I don't want to try to fall into that. I don't know where you draw the line on that one.

MR. DIELMAN: James, if I may, years ago I believe you authored a document and I think --

MR. FUTCH: Now don't go bringing back stuff that I wrote long ago.

MR. DIELMAN: You authored a document that I thought was very good and I think, especially the inspectors in this case and many physicists as well who have dealt with it for a long time, and essentially what you said -- and I'm paraphrasing it -- is that a person could move the piece of equipment from Point A to Point B and plug it into the wall.

But they couldn’t position the patient and they could not set the techniques. That answers your question, Mark. They can’t push any buttons in order to start anything to do with the technique. And I think there was a third element. But that sort of answers your question. In other words, when it comes to the scope of practice on setting the techniques it is a scope of practice issue. You know, doing QA on the scope of practice, that type of thing.

But moving it and plugging it in, is not, or positioning a patient.

MR. FUTCH: Maybe we should just --

DR. SCHENKMAN: Take that back up.

MR. FUTCH: -- find the memo again. It’s in here someplace.

DR. SCHENKMAN: Well, I mean, I don’t really think that turning a machine on necessarily has to be done by somebody who is a basic operator, or licensed, or whatever. But I think everything else that ends up as part of the decisions you’re making for a patient should be done by qualified people.

DR. ATHERTON: Or if the patient is in the room there has to be a qualified person present. Because if the patient is not there then we don’t really have

to protect them.

MR. FUTCH: Any other thoughts?

MR. BURRESS: We use x-ray machines all the time on campus, not on people. And you do the same thing all the way up to actually administering ionizing radiation to a patient. That's something that most people can figure out. Athletic trainers is another group we don't even talk about here but they do the same thing with injured football players and then the radiologist comes in and administers the dose, we're told. They are there. They have sports DR.s that are there. But I don't see -- I wouldn't see a problem with it as long -- I mean, the button has to have the warning, right, that it produces x-rays when energized and that's where the qualifications kick in when you actually hit the switch, or turn on the button, or it go on the computer to run protocol.

MR. FUTCH: How many sometimes when you print the film.

DR. SCHENKMAN: I mean if the film is your only thing if you don't have any other original but the film then it needs to be done by somebody who is qualified to look at the film and make sure it is okay.

CHAIRMAN JANOWITZ: No, I think that's pushing it a little bit.

DR. SCHENKMAN: What? In --

CHAIRMAN JANOWITZ: I don't think you need a technologist to develop film. Nobody develops film anymore anyway. It's all automatic processes. You don't need a certified tech to put a film in the processor.

MS. BONANNO: Oh, are they talking about the machine itself produces the picture.

DR. SCHENKMAN: No. But what I'm saying is you need somebody to be able to look at it when it is processed and say: Yes, this is decent quality, this is readable. I mean, look at how many things come out of a processor that the temperature is wrong or whatever. That's what I'm talking about. The quality of the film, not processing of it itself. Somebody needs to get a look at it. That's your only document.

CHAIRMAN JANOWITZ: Right. Okay. Surely a technologist should do that, look at it, yes, if not the DR..

DR. SCHENKMAN: If there is a DR. there. If it is a facility that does contrast, not a DR., you only have two in the facility.

MS. DROTAR: Were you are talking about a facility that would have a DR. and MDO?

THE FUTCH: They didn't specify so we would have to to assume the worse case, no DR..

Well, that's it for that one. Okay. Do we have any further items? Okay. Are there any issues that any of the members of the council want to bring up? Hearing none --

MR. DIELMAN: May I open one up, please? First of all, I guess a little background information. I'm a liaison for scientists to the Joint Commission on radiation issues and the CRCPD and a couple of other groups. In particular as most people know here, the Joint Commission established that a dose to a patient at 1500 rad in fluoroscopy really here -- 1500 rads to a patient in single field in fluoroscopy as a secular even and DR.s in in therapy, factors in therapy we're all well aware of.

This state, Florida, years ago was very much involved, along with FDA and lots of other people, of raising this issue of fluoroscopy and the need for training of the operator, whoever they were. And appropriate use of the equipment related to a patient.

It would seem to me, from the point of your

radiation protection, that Florida through this board or other means should readdress that, that whole scenario.

The Joint Commission has established, you know, that type of circumstances and special events. It would seem to me that there should be some regulation, perhaps, or something more than the standard of practice related to the use of fluoroscopy in Florida by persons who are untrained and/or circumstances where the equipment is used inappropriately.

And I will give you just a couple of examples. And you will find parts of this in your literature again, technique groups, interventional radiology groups, National Cancer Institute, et cetera. If you don't have it I would be happy to give you the links to those locations.

But this happens frequently particularly in interventional circumstances. It does not happen terribly often in the radiology, traditional radiology department now doing CR's. But it certainly does happen elsewhere.

The other day, at one of the hospitals that the provider deals with, we received a call. The patient -- well, first of all, the procedure lasted six hours.

And we figured up that there was 600 -- I'm sorry -- 168 minutes of fluor time to the patient.

This hospital has taken the position that anything over thirty minutes of fluor, it is argued that -- it is not equivalent but arguably equivalent to about 2 gray, 200 rad. which is where you see erythema and so forth.

But they have an internal mechanism -- and they're doing this to meet Drug Commission requirements -- that they will have a follow up mechanism of that patient to be sure that the referring physician is aware that the patient had greater than thirty minutes. Some facilities have used sixty minutes and so forth.

There is the physicist which all the physicist know here by the name of Wagner in Texas who has written extensively on this and he uses the sixty minutes in that criteria.

But nevertheless, in this particular case there was 168 minutes fluor time using the -- we determined off of the DAP, the DAP monitor. Are you familiar with that term, the dose area monitors on the pieces of equipment which are essentially accurate up to fifty or a hundred percent radio emit. In any event,

a patient essentially received 730 rads off the monitor. So this does happen. And then what you see in the literature is examples of patients who have had skin grafts after they have been -- have ulcers identified.

They will have a procedure. Six months later, literally six months later in some cases, they go to the referring physicians, back to their primary care physician or referring physician, and find that they have this ulcer that requires then a skin graft. It kind of runs all over the place. But FDA has accumulated data about this and so forth.

I would just like to suggest that this group actively consider, if not in this meeting perhaps in future meetings, the prospect of having at least perhaps a registry of the number of cases or some -- there be some monitoring. Or should there be an endorsement by this advisory committee today that you support the Joint Commission efforts, et cetera.

It seems to me that something should take place in that. I think most of the physicist in here will agree, not excluding the physicians or technologists, but we see a lot of this, a great deal of it. And it is one of the big contributors, of course, to the

increase in radiation dose.

CHAIRMAN JANOWITZ: Would that be reported under our current regs to Don’s office?

MR. DIELMAN: No, because it is x-ray oriented predominantly. And, you know, most of our reporting requirements, generalizing here, most of our reporting requirements have to do with radioactive materials.

MR. SEDDON: There is an FDA reporting requirement on radio action. It’s been around for a long time. They don’t have that much communication but a written advisory that went out in like ‘92, ‘94 when this all first came to light. Lot of objection out there, too. And there is currently still on the books a requirement radio action procedures supposed to report it to the FDA.

MR. DIELMAN: That’s kind of ironic that people -- that’s a good point, Mark and you mentioned that not a lot of participated in it.. Joint Commission, we were receiving commentary about it and we started pushing to, you know, taking their position, in addition to their own thoughts, by CRPPD and the FDA. They introduced this at December of 2005 as part of the Drug Commission issues.

Prior to that time they were receiving three or

four reports a year of that happening in hospitals. Since they introduced the central DAP criteria, they have not had one response. People are usually not going to report it. Enough said already. Perhaps a serious public health, radiation public health problem, I think.

Thank you for allowing me to - -

MR. FUTCH: Ray, if you want to write that up. And if you have any more would you forward it to us?

MR. DIELMAN: Oh, absolutely. I would be happy to. I will send it to you.

Mr. FUTCH: And we will see if we can get it on the calendar for next time and we'll talk about it.

Also, the JRC, do you have any recommended language?

MR. DIELMAN: Yes, they do. Drafted and also required by Florida our own bureau. And so yes, we has that available, There is recommended language, recommended training, and so forth.

MR. FUTCH: Thank you, Ray.

MS. DROTAR: Something else we could look at, too, is California has separate requirements for fluoroscopy training for technologists, and for DR.s and physicians

MR. FUTCH: The only state in the nation, I believe, that does.

MS. DROTAR: And it’s not that intense but it is a - - it is specified out for the - -

MR. FUTCH: How do you think that would go over in Florida?

CHAIRMAN JANOWITZ: Don’t hold your breath.

MR. DIELMAN: Well, that’s why I’m bringing it up.

MR. FUTCH: Okay.

MS. DROTAR: Dr. Libby Brateman talked to us about that a long time ago when she did the - - when first she started attending the meetings. She had done work at UF and had done measurements that actually went to, I think, the part of what form at DDC.

DR. WILLIAMS: Jim, does it make any sense to invite a cardiologist to join the advisory council. They seem to be part of the problem.

CHAIRMAN JANOWITZ: We can certainly ask one to come talk to us.

MR. FUTCH: We did have vacancies on the council. I don’t know.

ANONYMOUS: Actually that’s an excellent idea.

MS. BONANNO: I think that’s a great idea.

Mr. FUTCH: I don’t know if we actually have a

position where we could - - We're always looking for a licensed practitioner who is employed as a basic machine operator. And then we have two lay person positions which we can never fill. The problem with those is they can't be techs or a member of any closely related profession. Do you consider cardiology to be --

MR. RICHARDSON: No.

Mr. FUTCH: Any more thought or discussion on that? We're actually - - I think we stop at three o'clock right now.

MS. BONANNO: I think that's a really good idea.

CHAIRMAN JANOWITZ: So why don't we focus on time for the next meeting. The suggested dates are in October. Are these Tuesdays or - -

MS. LIVINGSTON: Those are all Tuesdays.

CHAIRMAN JANOWITZ: The 13th, 6/20th or 27th. Does anyone have any preference or know that they cannot make those dates?

MR. GUIDRY: The later the better.

CHAIRMAN JANOWITZ: Why don't we consider the 13th or 20th. And maybe you can check your schedules when you get back and if you have a conflict get back to Janice.

MS. LIVINGSTON: Yes. Send it to me.

CHAIRMAN JANOWITZ: Any other business? (No response.)

MR. FUTCH: We wanted to let you know that several members' terms are up in June or is going to be up in June of this year. And we went through and put the paperwork in, got all the recommended letters and the status now is - -

MS. LIVINGSTON: They are approved and I've got the letters and I'm going to send them out.

MR. FUTCH: So you should be seeing something soon. Those of you who I think was Kathy, and Tim, and DR. Janowitz. And we appreciate everyone who serves. Obviously, I don't say that enough but I should.

MS. LIVINGSTON: And the travel reimbursements are in your packet. If you want to go ahead and get the receipts to me, or if you want to send them to me, I've also got self-addressed envelopes with me.

ANONYMOUS: Move for adjournment?

CHAIRMAN J: Okay. We're adjourned.

CERTIFICATE OF NOTARY PUBLIC

STATE OF FLORIDA

COUNTY OF HILLSBOROUGH

I, Patricia K. Gough, a Notary Public in and for the State of Florida at Large, do hereby certify that the foregoing proceedings were taken before me in the cause, at the time and place, and in the presence of counsel as set out in the caption hereto, at Page 1 hereof; and that the foregoing typewritten transcript consisting of pages contained herein, inclusive, is a true record of the proceedings had at said session.

I FURTHER CERTIFY that I am neither an attorney or counsel of any of the parties in this cause, nor a relative or employee of any attorney or counsel employed by the parties hereto, nor financially interested in the event of said cause.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my seal this 17th day of May, 2009.

NOTARY PUBLIC, STATE OF FLORIDA AT LARGE

My Commission expires May 22, 2011