

ADVISORY COUNCIL ON RADIATION PROTECTION

Bureau of Radiation Control

Hampton Inn & Suites

Tampa Airport Avion Park Westshore

Tampa, Florida 33607 05/23/2019



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**CERTIFIED
TRANSCRIPT**

Bureau of Radiation Control
Hampton Inn & Suites
Tampa Airport Avion Park westshore
Tampa, Florida 33607

Thursday, May 23, 2019
10:04 a.m. - 3:03 p.m

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

1 ADVISORY COUNCIL MEMBERS PRESENT:

2 Randy Schenkman, M.D., Retired (Chairman)
3 Mark S. Seddon, M.P., DABR, DABMP (Vice-Chairman)
4 Kathleen Drotar, Ph.D., M.Ed., RT. (R)(N)(T)
5 Christen Crane-Amores, RRA, RTCR
6 Rebecca McFadden, RT(R)
7 Mark wroblewski
8 Armand Cognetta, M.D.
9 William (Bill) W. Atherton, DC, DACBR, CCSP
10 Chantel Corbett, AS, CNMT, RT(N), RSO
11 Matthew Walser, PA-C, ATC
12 Nicholas Plaxton, M.D.
13 Adam Weaver, MS, CHP

14 FLORIDA DEPARTMENT OF HEALTH STAFF

15 Cynthia Becker, Bureau of Radiation Control
16 James Futch, Bureau of Radiation Control
17 Brenda Andrews, Bureau of Radiation Control
18 Douglass Cooke, Bureau of Radiation Control
19 Jorge Laguna, Bureau of Radiation Control
20 Kevin Kunder, Bureau of Radiation Control
21 Clark Eldredge, Bureau of Radiation Control
22 David O'Hara, Bureau of Radiation Control
23 Leo Bakersmith, Bureau of Radiation Control
24 Gail Curry, Medical Quality Assurance

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1 RANDY SCHENKMAN, CHAIRPERSON: Good morning
2 everybody.

3 MEMBERS: Good morning.

4 RANDY SCHENKMAN, CHAIRPERSON: Welcome to our
5 first meeting of the year. My name is Dr. Randy
6 Schenkman. I am retired now, but I'm a Board
7 Certified radiologist and I specialize in women's
8 imaging and breast imaging, for those of you who
9 don't know me, and I've been on this committee for
10 quite a while. I want to welcome everybody and
11 should we start with new members or the agenda?

12 JAMES FUTCH: I think if we do the minutes --

13 BRENDA ANDREWS: Here's Mark.

14 RANDY SCHENKMAN, CHAIRPERSON: We'll wait just
15 a minute and then we'll get settled and then we'll
16 get going.

17 (Stood at Ease)

18 RANDY SCHENKMAN, CHAIRPERSON: Okay. So we'd
19 like to welcome everybody, but we'd like to go
20 through and have the new people on our committee
21 give just a brief presentation of themselves.

22 So why don't we start at this end, and for
23 whomever is new, and introduce yourselves.

24 LEO BLACKSMITH: I don't know that I'm part of
25 the committee, but my name is Leo Bakersmith. I'm

1 with the Department of Health, State of Florida.
2 Inspector; I'm an environmental consultant with the
3 with the Department out of the Orlando office.

4 ADAM WEAVER: Well, I'm not new, but Adam
5 weaver, University of South Florida Radiation Safety
6 and Laser Safety Officer there. And I think I've
7 been on for about two years, something like that.

8 RANDY SCHENKMAN, CHAIRPERSON: why don't we
9 just go through with everybody. Get to know each
10 other.

11 ADAM WEAVER: Makes sense.

12 DR. ARMAND COGNETTA: Armand Cognetta,
13 Tallahassee, dermatologist, about four years.

14 MATTHEW WALSER: Matt walser, physician
15 assistant, Englewood, Florida, University of
16 Florida.

17 MARK WROBLEWSKI: Mark wroblewski, basic machine
18 operator and I'm employed by Florida.

19 CHRISTEN CRANE-ARMORES: I'm Christen
20 Crane-Amores. I'm a radiologist assistant in
21 Tallahassee.

22 KEVIN KUNDER: I'm Kevin Kunder. I'm the new
23 administrator for Department of Health, Radiation --
24 Department of Health, Radioactive Materials.

25 JORGE LAGUNA: Jorge Laguna. I am the

1 administrator in the inspection section in
2 Tallahassee.

3 NICHOLAS PLAXTON: I'm Nicholas Plaxton.
4 I'm a nuclear medicine physician at the Bay Pines VA
5 over here in Bay Pines.

6 MARK SEDDON: I'm Mark Seddon. I'm a medical
7 physicist for Advent Health, based in Orlando,
8 Florida. Been on the committee for -- the council
9 for ten years or so.

10 RANDY SCHENKMAN, CHAIRPERSON: Okay. You know
11 about me.

12 JAMES FUTCH: James Futch, Florida Department
13 of Health, Bureau of Radiation Control.

14 CYNTHIA BECKER: Cindy Becker, Bureau of
15 Radiation Control.

16 BRENDA ANDREWS: Brenda Andrews, Bureau of
17 Radiation Control.

18 GAIL CURRY: Gail Curry, program operations
19 administrator for the medical quality assurance.

20 CLARK ELDREDGE: Clark Eldredge, administrator
21 of the machine section, Bureau of Radiation Control.

22 DAVID O'HARA: David O'Hara, environmental
23 consultant, Bureau of Radiation Control.

24 KATHLEEN DROTAR: Kathy Drotar. I'm the
25 university department chair for radiologic

1 technology for, for Keiser University and FSRT
2 vice-president and I'm the radiation therapy council
3 member.

4 WILLIAM ATHERTON: Bill Atherton. I'm a
5 chiropractic radiologist in private practice in
6 Miami, Florida.

7 CHANTEL CORBETT: Chantel Corbett, fusion
8 physics and I'm a radiologist technologist.

9 REBECCA MCFADDEN: Rebecca McFadden. I'm from
10 Advent Health Ocala. I'm the radiologic
11 technologist for this committee and I think this is
12 my fourth year.

13 JOHN JORDAN: John Jordan, Bureau of Radiation
14 Control, Tampa area.

15 RANDY SCHENKMAN, CHAIRPERSON: Okay. Now we
16 need to approve the minutes of our May 15th, 2018
17 meeting. Does anybody move to approve?

18 KATHLEEN DROTAR: I make a motion to approve.

19 RANDY SCHENKMAN, CHAIRPERSON: Okay. Is there
20 a second?

21 MARK SEDDON: Second.

22 RANDY SCHENKMAN, CHAIRPERSON: Okay. All in
23 favor say aye.

24 ALL: Aye.

25 RANDY SCHENKMAN, CHAIRPERSON: Any opposed?

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(No Response)

RANDY SCHENKMAN, CHAIRPERSON: Okay. So the minutes are passed.

Cindy, do you have any updates?

CYNTHIA BECKER: Updates. Well, I wanted to introduce a few new staff that we have because they're going to be doing some presentations later.

So first I have Jorge Laguna. He introduced himself earlier. We were lucky enough to steal him from the radon section. Thank you, radon. He has a lot of experience with our preventive radiological nuclear detention exercises our power plants exercises; has some managerial experience. We're very glad that he has joined us. And he will do a presentation a little bit later.

And then next to him we have Kevin Kunder and he is our newest employee probably. Environmental administrator. Been here a couple months now. He is leading our radioactive materials section. He has come from FEMA and also from the private sector. Nuclear medicine is his specialty. So we're glad to have him join us too. And he'll be doing a presentation a little bit later.

Paul Pavlick, anybody of you know Paul, he's retiring. He's one week left. May 30th, I guess.

1 And he's our northern area field manager.

2 And Ken Barnhart, which there's Ken. I know I
3 saw you earlier behind me. He will be taking Paul's
4 place, if that's even possible, because we know it
5 might not be. And you will be in Gainesville.

6 PAUL BARNHART: Yes. For now.

7 CYNTHIA BECKER: For now. So he will be in the
8 northern area inspection leading that group.

9 And Tim Dunn. Tim Dunn works for John
10 Williamson. Twenty-eight years with us. He has
11 left us. I was going to say for greener pastures,
12 but that would only be money, I think. NASA, he's
13 at Cape Canaveral now. He's joined many of our
14 staff there. So he's in good company, but we will
15 miss him, seriously miss him. So I wanted to say
16 that about our updates for our staff.

17 The other update I had, Clark Eldredge and I,
18 there you are Clark, we were lucky enough to attend
19 the Conference of Radiation Control Program
20 Directors, CRCPD meeting and it was in Anchorage,
21 Alaska which was nice but cold. Clark gave a
22 presentation on fun with BMI and x-rays. So if you
23 remember from last year's meeting, talked a lot
24 about BMI and x-rays. It was definitely a
25 presentation that a lot of states were interested

1 in. We had a lot of comments afterwards.
2 Discussions. A lot of states are facing the same
3 issues we are, as you would expect, on what to do
4 with certain modalities that are out there now that,
5 and uses that haven't come up before. Like the BMI
6 and like security scanners.

7 So, and also, Jorge won first place in his
8 poster, had a blue ribbon and everything, and
9 unfortunately, he was not at the meeting. So Clark
10 got to accept that for him. And I attended the
11 board and luckily, I'm off the board now. It was a
12 lot of work. But I was treasurer for a while.

13 And I want to just kind of share with you some
14 topics over the three-and-a-half days that seem to
15 be themes throughout a lot of the talks. And I also
16 wanted to encourage all of you to try to attend next
17 year. It will be in Williamsburg, Virginia. And
18 that might be a doable drive for some of us. But
19 kind of the themes running through is how to safely
20 use and regulate all the new emerging medical
21 technologies that are out there. Both in new radio
22 pharmaceuticals and new uses of x-ray. A lot of
23 things happening out there. We're just kind of on
24 the verge of all that coming to us as state
25 regulators, so it's going to be something I think we

1 all will have to look at and address.

2 How we can work on better communicating
3 radiation risks to the public. That's always a
4 theme, I think. That's a, that's a very difficult
5 thing, I think, especially for the scientific
6 community to commute -- communicate to the public.

7 NORM and TNORM issues. The NORM 9
8 International Conference will be in Denver this
9 year. And it will be September, I think it's -- do
10 you know the dates, Clark? 19th or something like
11 that.

12 CLARK ELDREDGE: I don't know exactly.

13 CYNTHIA BECKER: But it's an international
14 conference. It very rarely comes to the states. So
15 if anyone's interested in attending that conference,
16 that should be out soon, the announcement of that.
17 The CRCPD is involved in trying to help host that.
18 There's already over 200 presentations or people
19 that want to present. There's no way they're going
20 to have that many.

21 The aging health physics work force, oh, boy,
22 we all know this one. So everybody's trying to keep
23 their existence, as far as the quality of the things
24 they do. And that's with NRC and with other federal
25 agencies and the state agencies, so we want to keep

1 a quality work force, but how do you bring younger
2 people into the health physics industry and keep
3 them interested in it. And they talked about trying
4 to be more active in our intern programs. NRC has
5 such an intern program and they do have some fairly
6 young folks that are starting out in the field. And
7 we have a few, too, in our Bureau. So I think
8 that's going to be a hard one over the coming years.

9 The last one I have on here is kind of the
10 safety, security and preparedness regarding licensee
11 activities and that kind of folds into with the new
12 emerging medical technologies, how we're going to
13 handle the safety and security issues and that's a
14 big issue for NRC and their Part 37 introduction.

15 So I wanted to encourage everybody to come to
16 the next meeting, May 2020 in Williamsburg,
17 Virginia. It's an excellent way to meet the
18 international and national partners of radiation and
19 to see a lot of good things happening there.

20 I also wanted to mention the Health Physics
21 Society, National Health Physics Society annual
22 meeting in Orlando. It's the 64th annual meeting.
23 It's going to be at the Hilton in Orlando July 7th
24 through 11th. World of information at that meeting
25 as well. I'm hoping some of our staff could attend

1 and wanted to promote that out there.

2 There was one other meeting coming up. Any
3 meetings?

4 Okay. Well, those are the things I wanted to
5 share and then later, I have a little discussion
6 about IMPEP and what that means, but that was the
7 updates I had.

8 RANDY SCHENKMAN, CHAIRPERSON: Okay. Anybody
9 have anything else to add?

10 JAMES FUTCH: I want to say on the Health
11 Physics Society meeting, there are a very diverse
12 array of topics being covered and some of the people
13 on the, one of the committees that I'm part of that
14 sets the national standards for radio frequency,
15 decided to put together a workshop on nonionizing
16 radiation, which I think is pretty unusual even for
17 this society. It's kind of a specialty in a
18 specialty. So there's going to be some, I think
19 some talks about studies and some talks about
20 measurement and types of emitters. And everybody
21 wants to talk about 5G and what's, what's coming and
22 what frequencies are going to be used and so that's
23 just one aspect of it. They also have many typical
24 health physics topics, gamma spectroscopy. Medical
25 side of things, emergency response. All of it.

1 CYNTHIA BECKER: And I have the agenda. So if
2 anybody wants to take a look at it, I can either
3 pass it around or leave it up here at break. And
4 see all the wonderful topics in there.

5 RANDY SCHENKMAN, CHAIRPERSON: Okay. Next we
6 have our introduction of new administrators.

7 CYNTHIA BECKER: Oh.

8 RANDY SCHENKMAN, CHAIRPERSON: Do you want to
9 do this first?

10 CYNTHIA BECKER: Do you want to do that one
11 first? Okay. I'm back on again.

12 RANDY SCHENKMAN, CHAIRPERSON: We are going to
13 leave this to Cindy.

14 CYNTHIA BECKER: Okay. Another update. We had
15 a show-and-tell. And what we had hoped to show and
16 tell is our capabilities regarding emergency
17 response activities. So John and his group from the
18 Orlando lab brought up a lot of their toys. And we
19 also got to do some refresher training of our staff.
20 And we got to try to entice people to come into the
21 radiation field and see how exciting it was. I
22 don't know if we had any takers there, but we had a
23 lot of people come by.

24 This was held at our Bureau of Radiation
25 Control office in Southwood. Okay. So this -- I

1 like the guy in yellow. That's actually, of course,
2 the dummy that we have propped up there. But we, of
3 course, had sources there. That's what we like do
4 and had people play with our detention equipment and
5 see if they could find the sources.

6 Let's see. This one is our MERL, which I think
7 a lot of you have probably seen. It's kept mainly
8 in the Orlando office. It's our Mobile Emergency
9 Radiological Laboratory and it analyzes the samples
10 on site. So we can move it around to a power plant
11 exercise or a natural incident.

12 Then we had tours of the lab. So we brought
13 people in; showed them our high purity germanium
14 detectors, or gas and alpha beta proportional
15 counters and I think we impressed some folks with
16 how much equipment and how much expertise we do have
17 in the Bureau.

18 JAMES FUTCH: We actually had a lot of folks
19 from the Public Service Commission. The complex in
20 Tallahassee has a wide array of governmental
21 offices. So there were people there from the
22 Division of Emergency Management, which when you see
23 the Governor standing in front of the big monitors
24 when the hurricane is approaching, that's in the
25 complex where DEM is in Tallahassee.

1 Public Service Commission, people from
2 corrections --

3 CYNTHIA BECKER: That is true.

4 JAMES FUTCH: Of course, our own department and
5 especially the people who do the purchasing of said
6 \$100,000 instruments and sometimes wonder what it is
7 you're spending all the money on. So we give them a
8 picture of what it is and what it does.

9 CYNTHIA BECKER: And this is a picture of our
10 sample prep vehicle. And it prepares prep samples
11 for the MERL. So we had that vehicle there.

12 And this is a look inside the actual emergency
13 response trailer with our supplies and the nice
14 cabinets that I guess Reno must have put those
15 together and his staff. Is this the one that they
16 helped put together?

17 JAMES FUTCH: I think so.

18 CYNTHIA BECKER: Okay. And some of our folks,
19 you can see James there and Tim, I'm going to say
20 Tim like that.

21 JAMES FUTCH: My good side.

22 CYNTHIA BECKER: Okay. And this is kind of a,
23 a big view of everything we brought there. So we
24 did tours of the vehicles and trailers. And we also
25 provided ride alongs. We had sources also out in

1 the field. And so we were able to show them our
2 radiation detection equipment and how sensitive it
3 is. We took the Intimidator and the EzGo golf cart
4 out to do those surveys.

5 And this is a picture of our two Radiation
6 Solutions Incorporated mobile detection systems.
7 The RSIs and we're very proud of these, they're very
8 expensive, very sensitive. And we have taken them up
9 in helicopters and planes and boats.

10 JAMES FUTCH: Whenever, in recent years, people
11 have had questions about radiation readings and
12 certain places, around houses, in a park; things
13 like this, this is the device that we can take out
14 and in a relatively short period of time, half a
15 day, map radiation background in the area and show
16 them. It's very loyal and well below regulatory
17 limits for the outside.

18 CYNTHIA BECKER: And the ride alongs. And
19 that's Miss Wanda, who's retiring from us maybe
20 soon. I hope not, but getting a ride along.

21 And this is Ginni, works in our x-ray section
22 with Clark. And she's playing with some of the
23 detection equipment.

24 And then this is part of our training. We did
25 a refresher training for our staff, where we got

1 into a little bit more detail of how the equipment
2 works.

3 And this is also showing the portal monitor,
4 which as many of you know, the Radiation Response
5 Volunteer Corp. when we do the training for the RVC,
6 then we have them use the portal monitor, put it
7 together, take it apart, show them how to use it.

8 And any questions? Okay. Nice.

9 JAMES FUTCH: We're near the ocean, so I
10 thought it would be appropriate to do that.

11 RANDY SCHENKMAN, CHAIRPERSON: If anybody has
12 their cell phones, which I'm sure everybody does,
13 can you just make sure you put them on silent? We
14 talked about that earlier. I was flying here on the
15 airplane last night, and all of a sudden, about
16 seven or eight minutes out of Tampa, somebody's
17 phone started ringing on the airplane. It was quite
18 interesting.

19 Okay. So we have our next speaker. Jorge
20 Laguna.

21 JORGE LAGUNA: Thank you. Madame Chair,
22 members of the council, and staff. I'm Jorge Laguna
23 and I'm the administrator of the inspection program.

24 This is a map of the division of our inspectors
25 in Florida. And we currently have 39 people in the

1 inspection section, including administrative
2 assistants and all that. I think there's 31
3 inspectors out in the field. And the Bureau has
4 about 92 individuals that work for the Bureau.

5 These are the technical sections, the
6 environmental radiation section, the technology
7 section, the x-ray section, the radiology section
8 and the inspection section. And there's also the
9 administrative section in Tallahassee that is not
10 included in this chart.

11 The inspection section is divided into four
12 regions and we have the northern region, the central
13 region, the western region and the southern region.
14 And each one has a manager and then they have a
15 staff in each section.

16 And this chart represents, the blue line
17 represents the number of staff that we have had in
18 the inspection section through the years. We have
19 had a slight decline in the number of inspectors out
20 there before my time. I guess due to budget cuts
21 and some positions that were not filled and were
22 lost. So right now, we're down to about 32
23 inspectors; and therefore, the time spent by our
24 staff has gradually increased, as you can see on the
25 red line. Time spent for staff in the field. I

1 guess it would be good to be at a happy medium to
2 grab a couple more inspectors for the area because
3 we need some coverage in some parts of the state
4 that we don't have coverage.

5 And what we do, we coordinate inspections with
6 the x-ray section, with the materials section, and
7 we also do mammography inspections in coordination
8 with FDA. We respond to emergencies all over the
9 state, which might involve possible or actual
10 release of radioactive materials.

11 And there's about 19,000 radiation facilities
12 in the state and we inspect about 6800 a year; 560
13 mammography inspections are conducted each year as
14 well. There's about 1700 RAM facilities in the
15 state of Florida and we inspect about 700 of them
16 each year. And basically, we are the front line out
17 there of the Bureau interacting with the public, the
18 general community, the medical community, and we
19 deal with any sort of radiologic issues that might
20 develop out there.

21 That's all I have. Thank you very much.

22 RANDY SCHENKMAN, CHAIRPERSON: Thank you.

23 Okay. Next, we have Kevin Kunder.

24 KEVIN KUNDER: I don't have any slides. Just a
25 quick overview. I replaced Charlie Hamilton over

1 the radioactive materials section. I come from -- I
2 started out in 1985 at Miami Heart Institute, which
3 I believe now is a Ritz Carlton. I worked for ADEC
4 Laboratories, built the medical system for about 13
5 years. Alberto Tineo, he couldn't be here today,
6 but he ended up hiring me. I worked for him at
7 Halifax Health in Daytona, Florida for a little over
8 13 years.

9 So over top of the materials section, we're
10 responsible for anybody who possess or uses
11 radioactive materials that they do so in a manner
12 that protects the workers, the public and the
13 environment. We do this through licensing,
14 inspection, enforcement. We're the second largest
15 state. California is the only larger state as far
16 as specific licenses go, and we regulate almost nine
17 percent of the radioactive materials used in the
18 United States.

19 Florida has more medical licenses than any
20 other state by almost 50 percent. Our staff is
21 responsible for the regulation, radioactive
22 materials including licensing of all facilities and
23 users, developing and revising radioactive materials
24 regulations and guidance documents and inspecting
25 licensee activity open to insure compliance with the

1 safety.

2 My group also serves on the State Emergency
3 Response Team and responds to any type of radiologic
4 incidents or accidents. Our core business is to
5 approve and deny radioactive material licenses;
6 identify needed inspections and enforce radioactive
7 material section requirements.

8 As Jorge had mentioned, we license about 1700
9 users across the state a year, including the
10 hospitals, university settings, doctors' offices,
11 facilities, our industrial facilities. Radiators,
12 medical product radiators. We have 11 FTEs in my
13 group and we do around 2000 licensing actions a
14 year, and that brings in about \$3.5 million in fees.

15 RANDY SCHENKMAN, CHAIRPERSON: All right. Not
16 bad.

17 KEVIN KUNDER: Yeah.

18 WILLIAM ATHERTON: Question. You said, was it
19 you have more licenses than, Florida has more
20 licenses than 50 percent more than other states?

21 KEVIN KUNDER: Yes.

22 WILLIAM ATHERTON: Is that the radioactive
23 licenses for materials or is that physician
24 licenses?

25 KEVIN KUNDER: No, radioactive material

1 licenses.

2 WILLIAM ATHERTON: Okay.

3 RANDY SCHENKMAN, CHAIRPERSON: Any other
4 questions?

5 NICHOLAS PLAXTON: why do you think we have
6 such a high amount of licenses here in the state?

7 KEVIN KUNDER: Probably the size and the warm
8 climate. we have more elderly population coming
9 here.

10 NICHOLAS PLAXTON: Lot of medical staff.

11 KEVIN KUNDER: Lot of medical stuff.
12 Specifically you know, down in Miami we have a lot
13 of people coming from all over down there.

14 CYNTHIA BECKER: I think when I was at the
15 CRCPD meeting, what I was hearing a lot when they
16 talked about new medical modalities, they were in
17 Florida. So we seem to get them first. That or
18 California.

19 MARK SEDDON: Do you guys see a lot of new
20 stuff coming through, across your desks?

21 KEVIN KUNDER: Yeah. I'm just -- I've only
22 been here about a month so --

23 CYNTHIA BECKER: Yes, but we do, in fact, well,
24 I'm thinking back to x-ray because Clark is going to
25 talk about some new things coming with x-ray, but

1 with materials, too. Or, well, you know, the gamma
2 knife was new years ago and that was, I think Miami
3 was one of the first facilities to get the gamma
4 knife and that was all new. So, yes.

5 KATHLEEN DROTAR: Question. Do you see a
6 hiring concentrations in licenses in any particular
7 areas or is it around the bigger cities or.

8 KEVIN KUNDER: I don't know.

9 JAMES FUTCH: I think it pretty much follows
10 the population.

11 KATHLEEN DROTAR: The population.

12 RANDY SCHENKMAN, CHAIRPERSON: Okay. We are
13 now going to the IMPEP update.

14 CYNTHIA BECKER: IMPEP, Integrated Materials
15 Performance Evaluation Program. I love NRC always
16 has so many acronyms. I think we all do, but boy,
17 they really do.

18 So what this is, you know, everybody has
19 somebody that evaluates them or audits them. In our
20 case, it's the Nuclear Regulatory Commission. They
21 do this every four years. It's a team approach that
22 they started probably about ten or fifteen years
23 ago. Based on performance.

24 So they're looking at, just like we do when we
25 audit our licensees. We look at performance. So

1 they're not coming in to look at every single
2 record, every single thing or report that we issue.
3 They're coming in to see are we performing
4 comparable to how they would in their regions.
5 There are, I think, now 38 or 39 agreement states,
6 which means those rest of the states are regulated
7 strictly by the NRC.

8 So every four years they come. It's now time.
9 So they're bringing in a team of, I think four NRC
10 staff and one or two state staff come with that
11 team. They've already started the audit process.
12 They went out with about 50 percent of our
13 inspectors, which was about 15, 16 of our staff.
14 And they want to go out with them on the increased
15 control or the high-risk licensees to see if they're
16 being safe and secure in following the new Part 37.
17 So they have gone out with about 15 of our staff.

18 Next they're going to come and spend the last
19 week of June and that last week, they're going to
20 spend in Tallahassee and they're going to be talking
21 to our staff, they're going to be pulling reports,
22 both inspection reports and also licensing actions.
23 They're going to make sure that we are being timely.
24 That we're being -- having quality inspections.

25 So it's, it's kind of a big deal for us. And

1 they look at what they consider common performance
2 indicators. They have five of those. And they're
3 common because they're found across most state
4 programs and NRC regions as well and they rate those
5 five common indicators only three ways.
6 Satisfactory, satisfactory needs improvement or
7 unsatisfactory. And we usually come through with
8 flying colors, which is satisfactory. So I'm hoping
9 that's the case.

10 The five common indicators are technical
11 staffing and training, status of materials
12 inspection program and technical quality of
13 inspections, licensing actions, and incident and
14 allegation activities. So those are the five main
15 focus areas they will have when they come visit us.

16 And there's two, what they call non-common
17 indicators, compatibility requirements. The
18 compatibility requirements are going to be looking
19 to see that our rules are compatible or match
20 closely with their rules. We can be more
21 restrictive, of course, but we can't be less
22 restrictive in some areas that they have.

23 And they're also going to be looking at our
24 sealed source and device evaluation program and as
25 we're talking about new emerging medical modalities,

1 if these are new devices that are coming on to the
2 market that some facilities want to begin using and
3 we want to make sure that they're following protocol
4 and procedures to safely use that material.

5 And so the bottom line is, it's an effective
6 evaluation for us. And that's where our focus has
7 been and where Kevin and his staff's focus has been
8 for a while and will be until at least July 1. And
9 fun times. So it's kind of pay back on our end.
10 You know, we evaluate you guys and we get evaluated
11 as well.

12 Any questions on the IMPEP?

13 RANDY SCHENKMAN, CHAIRPERSON: Do they give you
14 feedback on what they're seeing?

15 CYNTHIA BECKER: Oh, yes. Oh, yes.

16 RANDY SCHENKMAN, CHAIRPERSON: Okay.

17 CYNTHIA BECKER: They already have. They
18 provide a lot of feedback and we have a chance, just
19 like I think we do when our inspection staff go out,
20 we have a chance to talk about it and talk about
21 what they find. And they also, when they get done
22 with their report, we will have an opportunity at
23 that time, to discuss their findings. And then they
24 have to send their report through a management
25 review board. So it's still not final until it's

1 final as they say, so --

2 MARK SEDDON: It's an improvement evaluation
3 more than anything else to make sure you're
4 complying with the targets of NRC.

5 CYNTHIA BECKER: Yes.

6 MARK SEDDON: Okay. They're not punitive in
7 any way, right?

8 CYNTHIA BECKER: Punitive to them would be hard
9 to do because they would have to take over our
10 program. That would be the most punitive thing they
11 could do. We don't see that they have the staff to
12 do that, but they can put us on heightened oversight
13 or stationary status which they've done to a few
14 state programs. So they have some punitive
15 measures. Not in the way of fining.

16 MARK SEDDON: Do they make recommendations on
17 staffing?

18 CYNTHIA BECKER: Yes.

19 MARK SEDDON: Would that be followed through,
20 like if Jorge is looking for more staff?

21 CYNTHIA BECKER: It can be. And they can
22 recommend things like that. That we need staff in
23 certain areas. Both maybe in licensing and
24 inspection. They can.

25 JAMES FUTCH: And a replacement can go in our

1 room, right.

2 CYNTHIA BECKER: Yeah.

3 JAMES FUTCH: That was a joke.

4 RANDY SCHENKMAN, CHAIRPERSON: Anyone have any
5 other questions? Okay. So moving right along. We
6 now have Medical Quality Assurance.

7 GAIL CURRY: Good morning. I'm Gail Curry.
8 Medical quality assurance, for those of you that
9 don't know, that's the licensing of the
10 technologists to run your machines and give the
11 dosages correctly and that sort of thing.

12 I do have some numbers for you today. We have
13 general radiographers, we have 22,215 licensed
14 active, clear active licenses.

15 Radiation therapy, we have 1,805.

16 Nuclear medicine technologists, we have 2,505.

17 And for radiologic assistants, we have 31.

18 So without the radiologic assistants, we have
19 27,897 total clear, active licenses.

20 And I can tell you that the CT modifiers that
21 we issue, we have 515 of those at this present time
22 that are clear and active.

23 We are actually licensing a complete
24 application that's ready to be licensed in 2.6 days.
25 And we are working applications in two days. So

1 from the time we actually receive it in the office,
2 our processors are getting those done in roughly two
3 days. We are in graduation right now, so those
4 numbers do go up a bit, as Kathy can tell you. And
5 right now, we're sitting on 25 open applications
6 that we have not worked yet. That are still in the
7 pipe ready to be reviewed.

8 And I did want to tell Cindy and James, thank
9 you for putting together a presentation for our
10 children. We had our our
11 take-your-sons-and-daughters-to-work day last month
12 and they were kind enough to put together a
13 presentation for our kids. And even the parents
14 just commented greatly about what a wonderful job
15 they did and how interesting it was. So I want to
16 tell you all thank you for doing that for us.

17 JAMES FUTCH: We enjoyed it.

18 CYNTHIA BECKER: It was fun.

19 GAIL CURRY: The kids are always excited about
20 it.

21 JAMES FUTCH: We had help from, Clark was there
22 and some other folks.

23 GAIL CURRY: Yeah. Unfortunately, I was at a
24 board meeting that day, so I didn't get to go.

25 JAMES FUTCH: That was pretty much it, right?

1 Does anybody remember the number? I think it was
2 over 50 wasn't it, kids?

3 GAIL CURRY: Yeah. I know we had over 50
4 children that were going to attend that day. So I'm
5 sure you did have over that.

6 JAMES FUTCH: And then everybody had a parent
7 with them. Any educational opportunity we can take,
8 we love it. It's also a lot of fun.

9 GAIL CURRY: well, I always enjoy it, myself.
10 So but -- so that's pretty much where we are. I
11 think we've gotten a lot of things straightened out,
12 hopefully since this whole department has come back
13 under me. We had some things that kind of got lost
14 in the shuffle, but I think we've gotten back on top
15 of those things. And if you ever need any
16 assistance, I have cards here. You're more than
17 welcome to take my card.

18 I do run that office, so you know, if there's
19 any issues that you have, or suggestions, you know,
20 anything, you can call me and, and we can discuss
21 it.

22  CHANTEL CORBETT: what's the status of getting
23 the CT application running smoothly online?

24 GAIL CURRY: Is it not running smoothly? I
25 don't know because nobody's given me that feedback.

1 CHANTEL CORBETT: Yeah. I've had multiple
2 texts in the last month saying it's still not
3 operational online. They had to print out the
4 applications and mail them in.

5 GAIL CURRY: If I give you my card, can you get
6 me more detail?

7 CHANTEL CORBETT: Yep.

8 GAIL CURRY: Then I'll check on it. I have to
9 go through my IT department, but I'm more than happy
10 to do that.

11 CHANTEL CORBETT: It's already on the project
12 list, so --

13 GAIL CURRY: Well, I don't know because I
14 didn't know there was an issue. So I would venture
15 to say no, depending on what the issue is. Now, I
16 will tell you we were having some problems with our
17 server. So we were down for several days.

18 CHANTEL CORBETT: Yeah, I don't think it was 19
that. I think it was something in the process.
20 They could get part way through and just not have it
21 complete.

22 GAIL CURRY: Okay.

23 CHANTEL CORBETT: I'll get those to you.

24 GAIL CURRY: That way I can look at it and get
25 back to you. Hopefully it's not a major issue

1 because it should be running pretty smoothly. So,
2 yeah. But things like that, I need to know so that
3 we can get them figured out. So everybody's back on
4 track. Thank you for bringing that to my attention.

5 CHANTEL CORBETT: Thank you.

6 KATHLEEN DROTAR: And I would like to thank
7 Gail for all the work that she's put in to getting
8 the, the licenses, the temporary licenses and then
9 issuing, getting the permanent issue, licenses
10 issued for our graduates. Because it was, it was
11 total chaos about a year ago. And Gail stepped in
12 and brought it back to where the last class I had at
13 graduated in April, had their temporary licenses
14 issued within about ten days of graduation, which
15 insured that they were going to be able to get a
16 job. And because one of the important things that
17 we see happening in some of the hospitals now
18 especially, is that they don't want to hire until
19 they have a permanent license. So she's been very
20 instrumental in helping us with that and carrying it
21 through for a number of our grads. So not just, not
22 just at our university, but it's affected everybody.
23 So thank you.

24 GAIL CURRY: Thank you, Kathy.

25 JAMES FUTCH: So if I can say a couple things.

1 Do you know if it was just the CT folks from the
2 OTCB side of the shop or was it --

3 CHANTEL CORBETT: I'll doublecheck. It was two
4 different techs. I know one was NMTCB. I'll check
5 with the other.

6 JAMES FUTCH: For my two cents from what Kathy
7 and Gail were saying, so in 2005, MQA sister
8 division took over the day-to-day licensure of the
9 rad techs. Some of you were around back when that
10 happened. Previously to that, from '78 on, the
11 Bureau of Radiation Control did all the licensure
12 directly, as well as materials facilities and x-ray
13 machines and all that. We handled the people, too.

14 It ran -- there was a couple bumps the first
15 year or two getting it straightened out. It ran
16 pretty smooth, Gail was part of that office back
17 then, underneath a completely different person and
18 we were together with the medical facilities
19 licensure and it worked beautifully for many, many,
20 many years. As time went on, leadership changed
21 over there and the person who was responsible for
22 the office retired. They separated medical
23 physicists into another area. And the technologists
24 kind of went to a couple different, as they called
25 them board offices. They got matched up eventually

1 with pharmacy. And when you hear of the references
2 to, you know, straightening things out, it required
3 a little bit.

4 So I wanted to thank Gail also for having us
5 back underneath her wing for the past, what is it
6 couple, couple --

7 GAIL CURRY: It's been just a little bit over a
8 year. We took you on back in April of last year.

9 JAMES FUTCH: And a lot of things had gotten
10 very straightened out.

11 GAIL CURRY: Just --

12 JAMES FUTCH: Thank you for that.

13 GAIL CURRY: Just to give you a little history
14 of what I do, in our, our office, we have
15 chiropractors, clinical lab personnel, optometrists,
16 nursing home administrators, medical physicists,,
17 EMTs, paramedics and Rad Techs. So those are all
18 the professions that I take care of. You all are
19 lucky because James hired me back in 2002 and until
20 2017, I worked strictly with Radiation Control and
21 then EMT and paramedic. So I have what I call a
22 wealth of knowledge as far as those professions go.
23 So when they came back under me, I was able to
24 continue to work to get those straight. So, you
25 know, I'm a little stretched thin sometimes but, I

1 think we're on the right path.

2 RANDY SCHENKMAN, CHAIRPERSON: That sounds like
3 you're doing a great job.

4 GAIL CURRY: Thank you, Randy.

5 RANDY SCHENKMAN, CHAIRPERSON: Anybody have any
6 other questions for her?

7 okay. So next we have Christen for supervising
8 radiologist assistant.

9 CHRISTEN CRANE-AMORES: So the role of the
10 radiologist assistant has evolved. And I think it's
11 going to still -- and there's still much more to it.
12 And I know in the past, a couple of you have asked
13 what does a radiologist assistant do? So I just
14 wanted to touch base on that.

15 So a radiologist assistant is an advanced
16 practice of a radiologic technologist that we
17 completed an advanced academic program that's been
18 nationally recognized for a radiologist assistant
19 based curriculum. And then it's a radiologist
20 directed clinical preceptorship. And then which
21 therefore, qualified us as a radiologist extender.

22 The primary role of the radiologist assistant
23 is to enhance the patient care, productivity,
24 efficiency of the diagnostic imaging environment.
25 And then assisting the radiologist with patient

1 assessment, the patient management and then
2 performing our own radiologic procedures.

3 So these are the academic programs that are
4 throughout the nation. There's not too many of
5 them. But you do have to be certified as a
6 radiographer through ARRT. And you do have to have
7 your Bachelor's degree. And all of those have now,
8 all of those universities have now gone over into a
9 Master's program. A degree in which, when you get
10 done, you have that Master's in radiologic science.
11 And then you sit for your RA certification
12 examination.

13 JAMES FUTCH: Christen, could I ask you a
14 question?

15 CHRISTEN CRANE-AMORES: Sure.

16 JAMES FUTCH: Is Weber State still around?
17 Are they doing RA? Are they --

18 CHRISTEN CRANE-AMORES: I actually looked all
19 of them up last night to see and make sure they were
20 all a Master's program and it looks like they are.

21 JAMES FUTCH: Because I think Weber because
22 they were kinds of the genesis of this back when it
23 was just the RPA thinking kind of coming from the
24 military need for someone in the field to do
25 radiologist type procedures.

1 CHRISTEN CRANE-AMORES: Right. Yeah, it looked
2 like they were all, they converted all over to the
3 Master's programs. They're curriculum somewhat
4 looks the same. I just kind of touched base on all
5 of them. I went through the University of North
6 Carolina at Chapel Hill. I wanted to put that one
7 at the top, but I put them in order.

8 WILLIAM ATHERTON: And those programs are how
9 long?

10 CHRISTEN CRANE-AMORES: It's a two-year
11 program. So you have to go through -- you have to
12 be a radiologic technologist. And then they require
13 you to work in the field for at least a year before
14 applying. And then you have to also have your
15 Bachelor's degree. It doesn't have to be specific
16 as to what your Bachelor's degree is into, but of
17 course, it has to be science related. And then that
18 way you have all your precepts going into that
19 program.

20 So a radiologist assistant's leading role is
21 for basically patient management, assessment before
22 procedures. Obtaining the consent for most of the
23 procedures, themselves, and that way it actually
24 also saves the radiologist a lot of time from
25 reading, dictating whatever they need to do at that

1 time. And it helps that flow of the whole
2 department if, if we consent all the patients.

3 We also get to spend a lot more time with the
4 patients, themselves. So I feel like we do provide
5 more like the quality care. The radiologist
6 assistant performs specific radiology procedures
7 under different supervision levels. And we have to
8 do everything under that radiologist. So we don't
9 practice, ourselves. We can't make our own
10 decisions. Everything goes through that
11 radiologist.

12 And we can't actually dictate studies, diagnose
13 someone; anything like that. We have to -- we were
14 only able to give initial observations for the
15 radiologist, themselves. Like if we're doing a lung
16 biopsy, that lung collapses, you can tell the
17 radiologist, same thing with the thoracentesis, just
18 those initial observations.

19 I wish these were a little bit bigger so you
20 can see them, but these are some of the procedures
21 that are -- not some. These are all the procedures
22 that we can perform. On the left-hand side is the
23 fluoroscopy aspect of everything. Whether or not
24 it's a tube placement, an upper GI. Over to the
25 right is more involved with a little bit more like a

1 minimally invasive procedure. A lumbar puncture,
2 thoracentesis, chest tube placements. I mean, it
3 kind of varies. All the way down to taking a biopsy
4 of the actual thyroid. A random liver biopsy.

5 So it's not -- everything has to be somewhat
6 superficial. It's not something specific. Like,
7 for instance, the random liver biopsies we can do,
8 but we can't do a targeted lesion in the liver,
9 itself. So we can't do a liver lesion because, just
10 those can be in different places and little bit
11 harder to get to. But we can do the thyroid lesion
12 biopsies and the lymph nodes.

13 MARK SEDDON: I have a question. So are those
14 -- is this list kind of a scope that is defined by
15 ASRT?

16 CHRISTEN CRANE-AMORES: The ASRT, ARRT and ACR.
17 They kind of come -- they are all pretty much the
18 same. They all come up with everything together as
19 a whole. They all pretty much created the position
20 together.

21 JAMES FUTCH: Christen, if I can add two
22 things. You folks do have this in your, in your
23 packet of information if you want to read it. The
24 full list. Also, when this was created in Florida,
25 some time around there, it was hard coded into the

1 statute that, that we, with this profession in
2 Florida, follow what scope of practice, the ACR,
3 ARRT and ASRT have agreed to with the level of
4 supervision required by them. So that's a little
5 background.

6 CHRISTEN CRANE-AMORES: Yeah. A little bit
7 more invasive procedures. We're able to place a
8 PICC line to port injections. Any type of tunnel,
9 non-tunnel catheter.

10 So the supervision levels recently have
11 changed, which is actually a big breakthrough within
12 this career as a whole. In 2003, the ACR, ART, SRT,
13 they came up with this statement that says what a
14 radiologist assistant actually is. 2005, the ARRT
15 kind of elaborated, expanded it a little bit on that
16 definition and came up with these supervision
17 levels. So it's general, direct and personal.

18 General is the radiologist assistant can
19 perform the procedure. The physician doesn't have
20 to be present. The direct, the physician has to be
21 within the building or within the office, itself.
22 But they have to be readily available in case
23 something, they need to intervene. They need to
24 change patient care.

25 I'm sorry. They need to be readily available

1 in case that the radiologist assistant needs
2 assistance from them. The direct, they are -- the
3 personal, they used to be able -- have to be in the
4 room. And that way, there would be a change in the
5 course of the procedure, itself. Like if they
6 needed to do a different direction or if something
7 needed to change or take over the procedure, itself.

8 So January as of this year, the personal
9 supervision has changed to where it can go now under
10 direct. So now we're only falling under general and
11 direct supervision and not personal. So the
12 radiologist does not have to be present in the
13 actual room anymore. So that was a huge supervision
14 change.

15 JAMES FUTCH: And that's at the national level.

16 CHRISTEN CRANE-AMORES: It is.

17 JAMES FUTCH: Actually, we haven't changed
18 anything here.

19 CHRISTEN CRANE-AMORES: Yes.

20 JAMES FUTCH: Tell me a little more, if you
21 don't mind. Did they change the definition to
22 personal to direct, did they remove personal or
23 replace it with the word direct? How did they --

24 CHRISTEN CRANE-AMORES: They're basically
25 saying your personal definition now can fall under

1 direct. So when a radiologist dictates that study,
2 they have to word or say that this procedure was
3 performed under my direct supervision. So the
4 personal aspect of it has gone.

5 JAMES FUTCH: So everything, if we look back at
6 the 2005 role delineation, which is what we've still
7 got adopted in regulation for this profession, all
8 of those many procedures where it had the word
9 personal, if we go and look at today, I guess it's
10 on the SRT site.

11 CHRISTEN CRANE-AMORES: It's on ACR, ARRT. I
12 haven't seen a document that actually says that the
13 personal aspect is taken away. It's just that the
14 definition of personal has changed to direct.

15 JAMES FUTCH: Okay.

16 MARK SEDDON: So they've aligned personal and
17 direct as basically being the same.

18 CHRISTEN CRANE-AMORES: Yes.

19 JAMES FUTCH: Interesting way of doing things.

20 CYNTHIA BECKER: Right.

21 JAMES FUTCH: Confusion.

22 CHRISTEN CRANE-AMORES: I think it's something
23 that's so new. And that's a huge, that's a huge
24 change.

25 JAMES FUTCH: Yeah, it would be because you had

1 to -- I was pulling up the old --

2 CHANTEL CORBETT: I was going to say maybe
3 they're trying to make it easier on the states that
4 already have personal everywhere in --

5 JAMES FUTCH: The old role delineation, and I
6 don't know how this exactly tracks with the list you
7 had there before, they had personal for things such
8 as -- hold on a second. I'll turn to the right
9 page. Lumbar punctures in the fluoroscopic
10 guidance, lumbar myelograms, thoracic, cervical
11 myelograms. This is -- I think there's a couple
12 more like that in different places.

13 CHRISTEN CRANE-AMORES: The liver. Anything --
14 I shouldn't say anything.

15 JAMES FUTCH: Breast localization.

16 CHRISTEN CRANE-AMORES: It was thyroid
17 biopsies, random liver biopsies. The paras and the
18 thoros, though, they didn't have to be involved in
19 the room. Even though that involved a needle. I
20 was going to say they had to be involved in the room
21 that involved a needle. But the paracentesis and
22 the thoracentesis, they didn't have to be a part of
23 it. They just had to be there in case something
24 were to happen and they have to intervene.

25 JAMES FUTCH: Okay.

1 CHRISTEN CRANE-AMORES: But I can -- I mean, I
2  can send over links because I don't know if any of
3 that needs to be uploaded into, into the system.

4 JAMES FUTCH: Let me go back and pull up the
5 statute, too, because when I saw the slide, I
6 figured this might be relevant.

7 So when we adopted this, two things happened.
8 We actually in the regulations, specified certain
9 things that were different from what the role
10 delineation said because they were contraindicated
11 by the statute, itself. And some -- I got three
12 different documents now, the fourth one we're trying
13 to figure out what's what. I can't do this on the
14 fly.

15 But in terms of the statute, language, this is
16 what it says: A person holding a certificate as a
17 radiologist assistant may perform specific duties
18 allowed for an RA as defined by the department by
19 rule, by the regulations 64E-3. The rule must be
20 consistent with the guidelines adopted by ACR, ASRT
21 and ARRT with the level of supervision required by
22 such guidelines.

23 So we're supposed to track with it pretty
24 closely. As I remember it when we adopted this
25 before, we had to modify it a little bit because of

1 the next paragraph, also from the statute: They may
2 not perform nuclear medicine radiation therapy
3 procedures unless they're currently certified as
4 radiation therapists in nuclear medicine. Not
5 interpret images, not make diagnoses, not prescribe
6 medications or therapies.

7 And the level of supervision thing the last
8 time around, I think it was in '06, when I went
9 through the department and the levels of legal
10 review and then outside of the department, something
11 in there with those levels of supervision, that's
12 where we got a little bit of, I don't want to say
13 blow back. We had to be careful in writing what was
14 there. It may be completely different now.

15 We haven't done anything with this in a number
16 of years, but I'm more than happy to take whatever
17 you've got, especially if it's from the combined
18 groups as they're adopted recommendation for the
19 practice standard, and go back to this and see what
20 needs to be changed.

21 CHRISTEN CRANE-AMORES: Okay.

22 KATHLEEN DROTAR: I think some of that was also
23 with CMS and unbundling the charges. And that
24 changed what the descriptions were for the, for the
25 levels of care also impacted on that. And that was

1 just within the last, I think, three months or
2 something.

3 JAMES FUTCH: Yeah. I think your next -- you
4 had a slide coming up.

5 CHRISTEN CRANE-AMORES: Yeah. So the next
6 thing is what they're still working on. It hasn't
7 gone through yet.

8 But back in March, they introduced a new bill
9 that -- because I think a lot of -- well, as I just
10 found out, there's only 31 of us licensed in the
11 state of Florida, but so there's not too many. And
12 it is a, you know, still a growing career. But I
13 think this is one of our hiccups is to where
14 Medicare doesn't reimburse for all of the procedures
15 that are being performed. So if this goes through,
16 this is going to be a huge step in, in what I think
17 is the right direction.

18 But it's going to propose that Medicare does
19 reimburse for these Medicare, Medicaid patients that
20 are being -- I mean whatever, whatever procedures
21 being performed at that time.

22 Now, it allows the radiologist to submit any
23 claims to the Medicare for imaging services or
24 non-imaging services. They're calling it MARCA. So
25 it would recognize radiologist assistants as a

1 mid-level provider and that way they could bill,
2 regardless of whether or not the setting is in the
3 hospital, or private practice, in an office,
4 whatever the case may be. So I'm waiting for that
5 to go through.

6 RANDY SCHENKMAN, CHAIRPERSON: And would the
7 reimbursement be the same as if the radiologist did
8 it or is there a difference?

9 JAMES FUTCH: They said they would recognize
10 them as a mid-level provider.

11 RANDY SCHENKMAN, CHAIRPERSON: What does that
12 mean?

13 JAMES FUTCH: Medical community.

14 MATTHEW WALSER: I understand it's 85 percent.
15 That's what for PAs and MPs, any service provided,
16 we get reimbursed 85 percent the physician fee.

17 ARMAND COGNETTA: Incident to.

18 MATTHEW WALSER: Well, incident to is totally
19 different than the, I can do the work. The
20 physician's around, then we can bill under the
21 physician's MPI number.

22 ARMAND COGNETTA: That's another way of
23 billing. It's another way of billing.

24 MATTHEW WALSER: So you guys as a dominant
25 profession, there's going to be a lot of adoption

1 for a fee reimbursement, which is the life blood of
2 your profession.

3 NICHOLAS PLAXTON: How is it done right
4 now?

5 MATTHEW WALSER: Right now if I do a Medicare,
6 Medicare procedure, I do not bill at all for it.

7 NICHOLAS PLAXTON: Whatever is done, it's
8 done for free.

9 CHRISTEN CRANE-AMORES: You'll be surprised.
10 So I've been in my position for six years now. And
11 I -- the main procedures that I'm in charge of are
12 paracentesis, thoracentesis and lumbar punctures.
13 And --

14 NICHOLAS PLAXTON: Difficult procedures.

15 CHRISTEN CRANE-AMORES: They are, but that way
16 if I'm doing those, they are be doing their CT
17 procedures, special procedures. It just keeps that
18 workflow going and to them, it just helps with the
19 day.

20 You know, I know a lot of practices probably
21 don't feel that way. I think you had said in the
22 very beginning when I started, you all had let go a
23 radiologist assistant.

24 MARK SEDDON: Yeah, we stopped using -- it
25 wasn't -- the reimbursement was an issue.

1 CHRISTEN CRANE-AMORES: Right. Maybe this is
2 going to change.

3 MARK SEDDON: Exactly.

4 CHRISTEN CRANE-AMORES: Maybe this 31 number
5 will go up.

6 KATHLEEN DROTAR: Florida I think has the
7 largest number of RAs in the U.S.

8 CHRISTEN CRANE-AMORES: Okay.

9 KATHLEEN DROTAR: That we are one of the
10 biggest. But one of the driving forces behind MARCA
11 instituting that and ARRT got behind it big time by
12 providing lobbyists and pushing this through, was
13 because CMS, Medicare, Medicaid services, had
14 bundled the services so that a physician had to be
15 in the room with the RRA. And ARRT's stand was that
16 these were people who had been educated, had the
17 ability and the knowledge to perform these. And
18 hospitals and other facilities said, well, if the
19 radiologist has to be there, why do I need an RA?
20 And so, it blocked the ability of RAs to get
21 positions.

22 And I know Sarasota Memorial, which is one of
23 the big ones, they said, I'm not going to hire them
24 because a PA can do more, so I'm going to spend the
25 salary on them.

1 So it was actually a way to educate the
2 Legislature that the RA was the person at this mid
3 level to be able to perform those procedures
4 independently and to be reimbursed for the services.
5 So it's all a part of it. And it, too, I think it
6 was one of the representatives from Pennsylvania,
7 maybe one from New York, that would introduce the
8 bill. So hopefully it's gaining a little bit of
9 momentum.

10 CHRISTEN CRANE-AMORES: I hope so.

11 MARK SEDDON: Are any of the education programs
12 looking at creating a program here in Florida?

13 KATHLEEN DROTAR: We looked at it but weren't
14 able to sustain anything because of the whole
15 backer, the feedback from the communities of
16 interest, that there might not be jobs for them.
17 Because -- and it all depends on the radiologist.
18 If the radiologist wants to have that person there
19 to, to give that, what -- to allow them to do those
20 procedures. So not every radiologist is willing to
21 do it. Or in an area that has sufficient number of
22 procedures to be able to do it.

23 So it's not that we didn't want to do it, but
24 in looking at it, and the funding that it will take
25 for us to graduate a person, that if they're not

1 going to be able to get the job, we can't support a
2 program like that. So it's, you know, it's
3 building. And it's the educating the communities,
4 themselves, and having the RRA recognized as that
5 person with that ability.

6 MARK SEDDON: Is there anything coming from the
7 associations for education -- educating hospitals on
8 how to privilege RAs versus like allied health
9 folks? That's a confusion in the past what can you
10 perform, PA versus RA.

11 CHRISTEN CRANE-AMORES: Right. I think it's --
12 I mean, because I guess it's just depends on where
13 you would do your preceptorship. And, for instance,
14 it took the hospital that I -- I worked for a
15 private practice but I have privileges to go into
16 the hospital. So it took a very long time for that
17 hospital to allow me to come in with those
18 privileges in order to perform procedures.

19 So now, if someone were to come behind me in
20 the radiologist assistant, that path is already
21 paved. So I feel like that it wouldn't happen
22 unless around the state, that that same something
23 would happen. And that way, it's someone
24 introducing it and then coming behind it. And that
25 way, it's not -- I mean, I know a lot of people know

1 what a PA can do. But this, the radiologist
2 assistant aspect of it is still so new to a lot of
3 people. And again, like I've been in my position
4 for six years and some people are like, what do you
5 do, you know. I still get asked that all the time.
6 Even in the hospital that I'm at, you know.

7 So, it's different. It's, like I said -- I
8 mean it's a growing career. It's still trying to
9 evolve. It's just taking a long time. And I'm
10 hoping. I mean, it looks like there's things that
11 are moving. And once that starts moving, maybe we
12 can get a program in the State of Florida.

13 JAMES FUTCH: I've got a question. Matt, how
14 many PAs are there licensed in Florida or Gail,
15 anybody have a rough idea?

16 MATTHEW WALSER: I don't know the answer to
17 that. A lot.

18 JAMES FUTCH: More than 10,000.

19 MATTHEW WALSER: I would say. I would say we
20 have so many programs in the state now, it's
21 unbelievable.

22 JAMES FUTCH: What percentage or when you go to
23 work, what are PAs doing with some of these same
24 procedures for radiologists?

25 MATTHEW WALSER: What are they doing?

1 JAMES FUTCH: Anything? Are they essentially
2 doing what the RA is doing?

3 MATTHEW WALSER: I think so.

4 CHRISTEN CRANE-AMORES: We would do, we would
5 do the same procedures because that what they're
6 credentialed for as well. It's just that they can
7 bill for the procedures that the PA is being.

8 KATHLEEN DROTAR: They can also do the patient
9 evaluation more in depth and prescribe medications
10 and so, there's those other ancillary services that
11 aren't really related to radiography that I think
12 drives that PA versus the RRA.

13 MATTHEW WALSER: In 2006 is when it first came
14 out. 2003 --

15 CHRISTEN CRANE-AMORES: 2003, 5.

16 MATTHEW WALSER: So it's a really new
17 profession.

18 CHRISTEN CRANE-AMORES: It is.

19 MATTHEW WALSER: There's going to be a lot of
20 growing pains. I've been a PA for almost 13 years
21 now. I think our profession started in the 60s. It
22 was right after Vietnam. So a physician at Duke
23 said, we got all these medics coming back from
24 Vietnam and they're super well trained and they're
25 got people and they've got a lot to offer but

1 they're not going to be doctors. We should create
2 some kind of mid-level type medical provider. And
3 that's how the PA profession came to be. And it
4 hasn't been without its struggle and its cost. I
5 think a, a bazillion dollars in lobbying fees.
6 That's the way, that's how it happens. And so it's
7 just a real slow process. I still get asked like
8 what can I do. And I mean, at my place, you know.
9 And we've been around a long time.

10 JAMES FUTCH: In the course of me being in this
11 position, and in our bureau, we have several
12 inspectors here that can attest to this, where's
13 Leo? In the corner.

14 We're familiar with the PA association. And
15 some, some citations and things that were clarified
16 to us up the food chain, so to speak. And our
17 statute exempts licensed practitioners from being
18 required to be licensed as Rad Techs or anything
19 like that. So every MD.

20 And then it also says, under the definition of
21 licensed practitioner, in addition to allopathic
22 physician, osteopathic physician or someone who is
23 otherwise authorized by law to practice medicine.
24 It doesn't specifically say physician assistants but
25 it also covers that, at least in the opinion of

1 lawyers.

2 MATTHEW WALSER: I think the one thing that,
3 that the legalese of PAs, at least in the State of
4 Florida, it is so generic. I mean, there's very few
5 things in the State of Florida that it says in the
6 law that we cannot do. It basically says, what
7 you're trained to do and what you're supervised,
8 under the some of your supervising physician, that
9 then you are you are allowed to practice. And if my
10 doctor doesn't want me to prescribe 800 milligram
11 Motrin, then legally I can't do that. So it's very
12 supervisory specific in my area medicine, which I
13 think is good.

14 JAMES FUTCH: Yeah.

15 MATTHEW WALSER: Because I'm not a doctor.

16 CHRISTEN CRANE-AMORES: You're not practicing
17 on your own.

18 JAMES FUTCH: The reason I asked about Weber
19 State was because they had the RPA "Radiology
20 Practitioner Assistant". Kathy, help me with the
21 regulation on this.

22 KATHLEEN DROTAR: Yeah.

23 JAMES FUTCH: Before all this started with
24 ARRT. If I remember right, they came, their
25 historical genesis was, people coming back from the

1 war, and going in to do the same things in the
2 radiology community and I seem to recall that scope
3 of practice being broader.

4 KATHLEEN DROTAR: I think originally, with
5 Weber State, because they were the first, and it
6 was not generally accepted. And then there were
7 some political issues between weaver. They weren't
8 an accredited institution at that time. And it
9 became harder for them to get the curriculum. And
10 then it got taken over by ARRT was setting those
11 standards, I believe is where it went. ASRT
12 providing a curriculum for what was needed, plus a
13 scope of practice. And then getting it approved by,
14 by, by ACR and the radiologist association, so that
15 we were covered because everything we do comes under
16 ACR. And our ability, our scope of practice is
17 mainly defined by them through ASRT.

18 So there were a number of things that happened
19 and then the other, Loma Linda I think was then the
20 next one to pick it up and carry it through and get
21 everything in place so that it was more
22 recognizable.

23 GAIL CURRY: James?

24 JAMES FUTCH: Yes, ma'am.

25 GAIL CURRY: Just to throw it out there to you,

1 there's 9,641 physician assistants. Clear active.

2 JAMES FUTCH: That's a good number.

3 RANDY SCHENKMAN, CHAIRPERSON: Is that in the
4 State of Florida?

5 GAIL CURRY: State of Florida.

6 MATTHEW WALSER: And it gets bigger every year.

7 GAIL CURRY: Yeah, I'm sure.

8 JAMES FUTCH: Christen, I think you had
9 another.

10 CHRISTEN CRANE-AMORES: Yes. So we have to --
11 we go through the same renewal processes as
12 radiologist technologist in which we apply for. We
13 have the -- we have to hold that license as well and
14 pay that fee. And then we have our own radiologist
15 assistant license and then we pay that fee as well.
16 And then continuing education credits that you have
17 to provide are just a little bit more than a
18 radiologic technologist, but it counts as both.

19 My concern for a radiologist assistant and
20 years ago, when I called to say what do I need to
21 do, what do I need to provide, they -- I was advised
22 to come up with the statement that says who I am; my
23 license number. For the State of Florida, we have
24 to have a list of supervising radiologists. And if
25 you go online right now, you can look up anybody's

1 license to make sure that -- to verify it, is there
2 anything deemed underneath them. So you would click
3 on that left-hand side. You can verify the license.
4 You can type in their name, their profession, their
5 license number. whatever the case may be.

6 To the right, this is when you look underneath
7 my license and supervising practitioners -- I
8 blocked out all their names just because -- but it
9 will tell you all their names, their supervisor,
10 their medical doctor and then to the right it will
11 say, like, their actual license numbers. But I've
12 never had all of them listed and I don't know if
13 there's a better way of assuring that all the
14 physicians are there or a way to have us -- because
15 right now, it's advised that we fill out, or not
16 fill out. You just write a piece of paper and you
17 fax it in. And still, I mean for six years, I still
18 don't have all of my physicians underneath me.

19 I even asked. I called and they say, oh,
20 they're there. You just can't see them. But for
21 instance, the facility that I work under, if they
22 were to ever look this up and try to match it with
23 the list of physicians that I fall under for them,
24 it's not going to match. So that's my concern is
25 maybe we can try and help.

1 Also, the next one is coming up with this
2 supervisory relationship statement. So this is my
3 generic, something that I came up with. I just -- I
4 have the date. I am asking for this relationship
5 between the radiologists and I just make these lines
6 and they sign it. Add it to the agreement that we
7 made back in 2013. And then I had to provide a
8 termination statement as well that if I were to ever
9 leave the practice, I have to submit something that
10 that termination agreement has now gone away.

11 So if we can possibly come up with a statement
12 for all radiologist assistants, since this is, you
13 know, I mean there's only 31 of us, I'm sure they
14 come up with something on their own, but if we can
15 maybe come up with a statement that is already
16 provided for someone who is coming into this and
17 then how to upload this maybe more into the system,
18 instead of faxing it in.

19 JAMES FUTCH: Okay. So we're from the
20 Government. We're here to help.

21 CHRISTEN CRANE-AMORES: Yeah.

22 (Laughter)

23 REBECCA MCFADDEN: Canned statement.

24 JAMES FUTCH: Gail has little bells going off
25 in her head over here.

1 I'm going to pass this to you. I just went
2 out, I saw this slide yesterday or the day before.
3 So I looked into the licensing database that Gail
4 and I have access to and you do have, like, two or
5 three or four more radiologists listed on that
6 screen, which is when the staff told you, oh, yeah,
7 there's more people. You just can't see them
8 online.

9 CHRISTEN CRANE-AMORES: Yeah.

10 JAMES FUTCH: Than are listed online. I'm
11 wondering that kind of sounds like a Leads issue.

12 GAIL CURRY: Sounds like an IT issue. There's
13 only so many fields that you can actually see.

14 JAMES FUTCH: Yeah. I'm not sure what's
15 typical for the PAs. Since you stuck your hand up
16 I'll ask you.

17 MATTHEW WALSER: So that has been an issue for
18 us for a million years.

19 JAMES FUTCH: Ah-ha.

20 CHRISTEN CRANE-AMORES: Okay.

21 MATTHEW WALSER: And about two years ago, Gail,
22 you probably can give me a better idea, but it seems
23 like two years ago, we went to the ability to do it
24 all online. It was before the same thing. There's
25 a standardized form. Fax it to Tallahassee. Give

1 it a few days. Nothing changes on the website.
2 Give them a call. Leave a message. Call back.
3 Leave another message.

4 I mean, you can think about all the 9600 PAs
5 are constantly changing and there's three people
6 working in an office in Tallahassee. That's an
7 incredible amount of work. Well, they went to an
8 online system, I think it was about two years ago,
9 year and a half, two years ago, and it's great. And
10 all of my people are listed. And I can go, I can
11 change them, I can add, I can delete. Because in,
12 in PA world, I have 30 days to end a relationship.
13 If I don't end a relationship with the physician
14 after moving practices, then I think the fine is
15 like \$600. To me, per person, and I have, I have
16 like 25 doctors on my list. And so that's a big
17 amount of money. And so, I make sure that it's up
18 to date all the time.

19 And once I had that ability online, it was,
20 it's so much better. So I think the technology is
21 there.

22 GAIL CURRY: It is. It is. You can actually
23 upload any document into your profile to match up.

24 CHRISTEN CRANE-AMORES: Is that on here?

25 JAMES FUTCH: So Matt knows because he does

1 this for his profession. So this is a view into the
2 licensure screen for someone who's currently
3 licensed. I'm guessing it's probably Christen's.
4 So things appear, if they're possible for that
5 profession, in that additional activities down
6 below. At least this is where I would suspect it
7 is. But I have a big question. So when you submit
8 this using this new mechanism, where do you put it?

9 MATTHEW WALSER: That looks different.

10 CHANTEL CORBETT: That's not it?

11 JAMES FUTCH: I strongly suspected that would
12 not look the same.

13 MATTHEW WALSER: That's not what I use.

14 GAIL CURRY: And it is different by profession.

15 MATTHEW WALSER: Okay.

16 GAIL CURRY: Because the actual board office or
17 the certification office gets with IT and sets it up
18 specific to the needs of the technologists. So I'm
19 sure it does look different.

20 JAMES FUTCH: Where does it appear, what do you
21 see that's missing that you would use?

22 MATTHEW WALSER: It's --

23 JAMES FUTCH: Does it say supervising? I see
24 the title says supervising radiologist system
25 upload.

1 CHRISTEN CRANE-AMORES: I'm sorry. I wrote
2 that just so that we can maybe put it into this
3 screen. So the screen, I did a screen shot. And
4 above where it says my application, is my two
5 drop-down boxes for radiologist technologist and
6 then I have to do, do them separate. So I have to
7 pay that fee, upload, and then I have another
8 drop-down box, right below that that's radiologist
9 assistant.

10 JAMES FUTCH: If you pick radiologist assistant
11 and then look at this, is there anything on there,
12 and is that what you're talking about that's
13 missing, what does the line say? Is it a
14 supervising practitioner, something like that?

15 MATTHEW WALSER: Yeah. I think it says
16 add/delete supervising physician or something like
17 that. You click on it, you have to go through a
18 waiver that says I understand that I'm changing a
19 supervisory relationship. And then it takes me to
20 another window and there's a list of all of my
21 people. And then there's a blank box where I can
22 add the name, their license number.

23  JAMES FUTCH: You're doing data entry into the
24 system.

25 MATTHEW WALSER: Yes.

1 JAMES FUTCH: Do you also submit a piece of
2 paper with a signature?

3 MATTHEW WALSER: I don't do that anymore.

4 GAIL CURRY: And you shouldn't have to do that
5 if you're doing that online.

6 JAMES FUTCH: Gail, if you're in agreement with
7 this, we'll take this under advisement and go back
8 and talk to the IT people and figure out what needs
9 to happen so we can get the same kind of thing.

10 And also, let me just mention when we set this
11 profession up, in '06 I think it was, we used PAs as
12 a model. So when you hear talking about had to
13 submit the, you know, a statement -- did you have an
14 actual form that you had to use before -- adopted
15 form?

16 MATTHEW WALSER: Yeah, there was a form and
17 it's still online, actually, that I think when you
18 apply for your initial license, I believe that you
19 have to submit a new, like a paper copy. Like
20 Shands UF Health, they've adopted that copy. So I
21 recently changed departments and so I had to fill
22 that thing all the way out by hand and send it to
23 the hospital people for credentialing privileges in
24 a different department.

25 JAMES FUTCH: Would you mind sending whoever is

1 e-mail you have, mine, Brenda, Gail's --

2 MATTHEW WALSER: Sure.

3 JAMES FUTCH: Some of that information, this is
4 the form. This would help us -- you would think we
5 work in the same organization, we should be able to
6 just go and ask some of this. But they have
7 contractors and subcontractors who do different
8 parts of what you see online up there.

9 MATTHEW WALSER: It sounds like you guys got
10 the travel people.

11 (Laughter)

12 JAMES FUTCH: Could somebody remove the knife
13 from my back, please?

14 MATTHEW WALSER: It was open. I had to take
15 it.

16 BRENDA ANDREWS: That's your one for the day.

17 JAMES FUTCH: Gator. I'm sorry. We would
18 appreciate it. Thank you.

19 when we set the profession up, if you go back
20 and look at the regulation, we never wanted to adopt
21 a form because adopting forms is a whole another
22 level of years of waiting for things to happen with
23 the state government. That's completely, Clark is
24 shaking his head. It's completely out of our
25 control. Just because you have a piece of paper,

1 you said, hey, you must use this to submit the
2 information.

3 So what we did instead was in the regulation,
4 we came up with the description of the information
5 that you must submit. And you can put it on
6 whatever kind of document, a piece of paper that you
7 want to. So it's supposed to be easier. And then,
8 of course, nobody envisioned this 10 years later, 14
9 years later, whatever it is. I think it's fixable
10 and hopefully without too much pain and suffering on
11 our part. I'm not going to say it's a hundred
12 percent possible, because I've run under, every once
13 in a while something in the computer system will say
14 your profession is not set up like that, you can't
15 do that.

16 And with only 31 people in it, I don't have,
17 you know, 10,000 folks beating down the doors
18 helping to make the point with the rest of the cogs
19 and the spokes in the wheel. But thank you for
20 letting us know.

21 CHRISTEN CRANE-AMORES: Yeah, absolutely. Just
22 so we can figure out something. And I do like the
23 fact, though, that the radiologists sign something.
24 And that I -- what I do like the other aspect of
25 being able to put it into the system, myself. But I

1 do feel like some kind of document should be there
2 that they possibly sign that that way -- I'm not
3 saying that, you know, Doctor so-and-so, I'm adding
4 him, but what he -- I -- there are certain
5 radiologists that I don't do procedures with or for
6 at all. They may not come over to the hospital at
7 all. They keep me just at the hospital. I don't go
8 over to the, to the office. Just because they're so
9 busy at the hospital. So I don't -- the group, I
10 think, is 18 or 20 of them. So I fall under, like,
11 14 or 15 of them.

12 CHANTEL CORBETT: I still think that is a great
13 CYA on your part for your personal records going
14 forward. Especially in that kind of field when
15 you're doing that kind of procedures.

16 CHRISTEN CRANE-AMORES: Right.

17 GAIL CURRY: We do actually have with our
18 chiropractic, certified chiropractic assistant,
19 physician assistant, they do have a form that the,
20 that the chiropractor has to fill out as their
21 supervisor.

22 CHRISTEN CRANE-AMORES: Okay.

23 GAIL CURRY: So that wouldn't be a hard --

24 JAMES FUTCH: No.

25 GAIL CURRY: -- thing to implement.

1 JAMES FUTCH: Yeah. We've got, whatever the
2 PAs are using, whatever the other professions are
3 using, take a look at it, throw something together,
4 bring it back to the council after talking to you.

5 RANDY SCHENKMAN, CHAIRPERSON: And what do they
6 have to do?

7 JAMES FUTCH: Two years later, we'll have
8 adopted it.

9 GAIL CURRY: They can either upload it from
10 their profile online. They can upload it into their
11 file. Or they can e-mail it us or fax it to us.
12 Whatever is convenient for them. We would like them
13 to upload it using the online access, just because
14 it goes straight to our processors for them to look
15 at. But it also puts it straight into our, like,
16 microfiche. So it goes straight to their profiles.

17 JAMES FUTCH: Less chance of it getting
18 diverted.

19 CHRISTEN CRANE-AMORES: Yes.

20 JAMES FUTCH: It ends up in your actual
21 electronic file.

22 GAIL CURRY: So any of our processors could see
23 it. Not just the one that's basically working your
24 application. So if you were to call, they can look
25 there. Anybody can look there and see it.

1 CHRISTEN CRANE-AMORES: Okay.

2 GAIL CURRY: That's a good point. Thank you.

3 MARK SEDDON: Just a question. So say you
4 stopped working as a PA or RA under supervision.
5 Then would you lose your license? You just, how
6 does that impact your license?

7 CHRISTEN CRANE-AMORES: Um, I know some -- I
8 know one radiologist that he, I mean, radiologist
9 assistant that he keeps up with his license, but he
10 doesn't practice. So he can still pay, do his
11 continuing education credits, pay for the fees, and
12 then he is now like a medical device sales rep. So
13 he's still holds that. Now as far as the --

14 MARK SEDDON: You have 30 days to, say you're
15 no longer under supervision. So what happens if
16 you're -- no one is supervising you anymore?

17 MATTHEW WALSER: Then you can't practice.

18 JAMES FUTCH: You still have a license. You
19 still have to maintain it.

20 MARK SEDDON: You still have a license. You
21 can't practice.

22 MATTHEW WALSER: You can't practice. You don't
23 have a supervisory relationship. It would be
24 against the law. Like, I could probably go do it
25 and the chance of somebody finding out about it

1 probably would be next to nothing. But if somebody
2 did, I'd be in big trouble.

3 CHANTEL CORBETT: Any of the medical techs can
4 do that. Maintain your license and not touch a
5 patient. But you're technically under the
6 supervision of radiologists for nuclear medicine or
7 individual.

8 MARK SEDDON: Right, but for other professions,
9 we don't have to have them submit who's our
10 supervising physician. Unlike the RAs.

11 CHANTEL CORBETT: I mean, for nuclear medicine,
12 you're supposed to submit your place of practice. 13
14 If you're not practicing, that shows up on your
15 actual state license. So then that tech goes back
16 to work. Their state license for a long time will
17 still say not practicing. So, you know, there's
18 still that little gap in there. But, you know, as
19 long as you're -- I think that's part of the
20 inspection process possibly, too. I mean, if you
21 have to have supervising, are the inspectors even
22 having to check that you have supervising, you know,
23 when they come on site? So that may be a question
24 too.

25 MARK SEDDON: There's a lot of moving parts. A
lot of practices have a lot of physicians coming and

1 going and as you say, you would be constantly
2 updating and deleting people.

3 MATTHEW WALSER: Yeah. So in my former job,
4 four weeks ago, I was a supervisor of 19 PAs and
5 nurse practitioners. And in a physician group of
6 almost 30 physicians, that was happening. We would
7 have fellows that would moonlight in our after hours
8 and would work under their, they were our
9 supervising physicians and so, there was a lot. And
10 so, I would constantly be sending out e-mails to the
11 group, hey, delete this guy. He's gone. Hey, this
12 person will be here in two weeks.

13 MARK SEDDON: So you're doing it for the
14 privileging folks, as well as the State.

15 MATTHEW WALSER: For me, the most important
16 people are the State. The hospital, I let our HR
17 people handle all that.

18 CHRISTEN CRANE-AMORES: I submit my documents
19 to the hospital as well and then, of course, their
20 private practice. But just, I mean, but my first go
21 to is I send it to the State of Florida.

22 MATTHEW WALSER: Yeah. That's how you lose
23 your license is the State. The hospital is not
24 going to take your license away. They may say, hey,
25 slap you on the wrist and say, you need to update

1 your form, but they're got going to take your
2 license away. The state, they may call you over to
3 Tallahassee to have a little meeting.

4 CHRISTEN CRANE-AMORES: Now, as far as I know,
5 we don't have a timeline, like the 30 days.

6 JAMES FUTCH: You do.

7 CHRISTEN CRANE-AMORES: We do?

8 JAMES FUTCH: You do. Well, that's what it
9 says. Within 30 days of beginning work on the front
10 end. And then at the end of it, within 30 days of
11 terminating supervisory relationship, you're
12 supposed to let them know.

13 CHRISTEN CRANE-ARMORES: What about when
14 someone gets --

15 JAMES FUTCH: But you have multiple -- so when
16 we put this together, one thinks of a supervisory
17 relationship between a radiologist and a person.
18 And then, of course, you're working for an
19 association, and so you have multiple folks. So
20 that kind of came along later. Now you've got 25
21 supervisory relationships. Because you never know
22 who's going to be there, I guess, that you're going
23 to work for that day.

24 But, yeah, it does say within 30 days of
25 beginning work.

1 CHRISTEN CRANE-AMORES: Okay.

2 RANDY SCHENKMAN, CHAIRPERSON: Or it says both.

3 CHRISTEN CRANE-AMORES: It does say change.

4 KATHLEEN DROTAR: But if they're not listed,
5 you can't do -- you're not under their supervision.

6 CHRISTEN CRANE-AMORES: That's always been my
7 concern because there's, even with this list, for
8 instance, there's still are some radiologists that
9 are not on here. And then others, there's actually
10 one gentleman who is not a physician at all where I
11 work. And then when someone retires, I'll submit
12 that termination relationship agreement to get rid
13 of that particular person. But --

14 CHANTEL CORBETT: In a hospital setting, you're
15 going to also have problems coming up with joint
16 commission. They're always looking for primary
17 source of verification. They will go specifically
18 online to look. And if that list isn't complete,
19 they can't see it, the hospitals can get hit pretty
20 hard for that kind of thing. So that's definitely
21 that's something that should fall down.

22 JAMES FUTCH: I think right now, perhaps
23 there's not a hard answer to -- you have to be
24 supervised when you're performing the procedures.
25 And hopefully, if something bad happens and there's

1 an issue or complaint and the rest of it and they go
2 looking for the supervising radiologist who was
3 supposed to be supervising you to do this, that
4 person will say, yes, I was.

5 CHRISTEN CRANE-AMORES: Yes.

6 JAMES FUTCH: If not, you and I have a problem.
7 No, I wasn't doing that. I wasn't supposed to be
8 supervising today. I was supposed to be doctor so
9 and so. The other part of the building whose wife
10 had a baby this morning, himself, today or whatever.

11 RANDY SCHENKMAN, CHAIRPERSON: Yeah, but if the
12 list she submits is not the same list that's in her
13 profile, for the state --

14 JAMES FUTCH: Yeah.

15 RANDY SCHENKMAN, CHAIRPERSON: That's not her
16 fault, either.

17 JAMES FUTCH: Let me give an example.
18 Insurance companies and x-ray machines, Clark. I
19 think a long time ago, the companies who were paying
20 for procedures for machines, realized that they
21 probably can go and check and see if those machines
22 that are being used are actually registered and
23 inspected.

24 CLARK ELDREDGE: We would get calls, you know,
25 during the month after renewal season. They would

1 be looking to -- they would be contacting the
2 program regulators and say hey, is XYZ therapy
3 facility, is their registration up to date because
4 then they would go and say, we don't have to
5 reimburse you because you didn't pay, your
6 registration wasn't up to date.

7 JAMES FUTCH: So maybe this one will be looked
8 at more critically by maybe the non-governmental
9 side of the shop when you get MARCA and you're
10 actually, you know, able to, be able to be
11 reimbursed for procedures performed by an RA. There
12 may be a greater scrutiny of who is that person
13 being supervised by or maybe not. I don't know.
14 who can predict?

15 CHRISTEN CRANE-AMORES: Well, thank you,
16 everybody, for your feedback. In addition to --

17 NICHOLAS PLAXTON: I'd like to back up a
18 little bit. If you update this program so it has
19 the names of the physicians, which makes sense like
20 the PAS do, then that same program should have some
21 kind of a little button, or some kind of thing that
22 will reach out to the physician and they can just
23 say, yes, I am supervising. So that way, you're
24 covered. You shouldn't have to go faxing forms and
25 all that and waiting for all that. That just causes

1 more problems. I think the program should have an
2 interaction between physicians as well as the
3 person, the PAs or their RAs.

4 JAMES FUTCH: Matthew, do you have that
5 currently?

6 MATTHEW WALSER: I'm pulling it up right now.

7 JAMES FUTCH: Answer this afternoon after
8 lunch.

9 MATTHEW WALSER: So that's interesting because
10 when I've added physicians and taken physicians
11 away, I don't think they're ever contacted.

12 NICHOLAS PLAXTON: I'm saying they should.

13 MATTHEW WALSER: I agree.

14 RANDY SCHENKMAN, CHAIRPERSON: Then you have to
15 put in their contact information as well.

16 MATTHEW WALSER: The State has it.

17 NICHOLAS PLAXTON: You're having the person
18 as an employee under you should have that.

19 RANDY SCHENKMAN, CHAIRPERSON: Yeah, I guess if
20 you have to put the medical.

21 MATTHEW WALSER: License number.

22 RANDY SCHENKMAN, CHAIRPERSON: License number.

23 MATTHEW WALSER: It should send them an e-mail,
24 hey, by the way somebody just added themselves to
25 your license or, hey, can you confirm this.

1 NICHOLAS PLAXTON: Exactly. It's good for
2 all parties involved.

3 MATTHEW WALSER: It is. It is.

4 NICHOLAS PLAXTON: If they type in the
5 wrong person or something, the physician will say,
6 send an e-mail back and say no.

7 MATTHEW WALSER: Back in the fax days, I had
8 somebody that practiced in New York on my license.
9 And they only way I knew that was if I went online
10 and I did Florida license lookup.gov or whatever it
11 is. And somebody from New York was on my license.

12 NICHOLAS PLAXTON: Yeah.

13 MATTHEW WALSER: A physician I never heard of.
14 I think that was just an error from the old fax them
15 days. And I have to refill it all out, fax it back,
16 delete this person and I was freaking out that I was
17 going to get a fine because this guy is on my
18 license or I'm on his license.

19 NICHOLAS PLAXTON: Yeah.

20 JAMES FUTCH: It sounds like a very desirable
21 capability to have. I would, I would think that if
22 it were to happen, the driving force would probably
23 be the 10,000 PAs and the PA association or I have
24 no idea how many nurse practitioners there are.

25 MATTHEW WALSER: Probably almost an equal

1 amount, I imagine or more.

2 JAMES FUTCH: A large number. It certainly
3 makes sense. I'm pretty sure it's not going to be
4 driven by 31 --

5 CHRISTEN CRANE-AMORES: Right.

6 JAMES FUTCH: -- profession, even though it is
7 an excellent idea. Requires resources. Requires
8 time. And again, sounds like a good idea. What I
9 would take solace in is that when you go to the
10 radiologist and you get the signature, you both have
11 a copy of it.

12 CHRISTEN CRANE-AMORES: Yes.

13 JAMES FUTCH: Because I wouldn't want to rely
14 upon any governmental database actually being the
15 one to be able to tell you that this is happening.
16 Although it is a great idea.

17 KATHLEEN DROTAR: I would think you also have a
18 contract with the, with the facility, itself,
19 because that's where your liability would be
20 covered.

21 CHRISTEN CRANE-AMORES: Right.

22 KATHLEEN DROTAR: And that that should, at some
23 point, include everybody. All the physicians that
24 practice in that, in that, in that facility.

25 CHRISTEN CRANE-AMORES: Yeah. I do -- I mean,

1 I keep a copy for myself. I send it to the -- their
2 own practice so that they have it. I mean, if
3 anything were to ever happen, or I also send it to
4 the hospital. I mean, that's basically for when The
5 Joint Commission comes around, they want to see,
6 like, hey, let me see or who and what she does and
7 what she falls under. You don't have an issue.

8 REBECCA MCFADDEN: Your medical staff also has
9 the exact credentialing process you have gone
10 through.

11 KATHLEEN DROTAR: You're covered.

12 REBECCA MCFADDEN: You have a physician that
13 signs off on your --

14 CHRISTEN CRANE-AMORES: And that has to be
15 renewed every two years by the medical staff.

16 REBECCA MCFADDEN: The medical staff, right.

17 CHRISTEN CRANE-AMORES: Making sure that list
18 is up to date and then a supervising radiologist
19 does have to sign off on that. They have to
20 doublecheck it.

21 REBECCA MCFADDEN: Yeah.

22 RANDY SCHENKMAN, CHAIRPERSON: Okay. we've
23 given you a little bit more work to do here.

24 Anybody have any other comments? Thank you.

25 Okay. Now we're going on to Nicholas.

1 JAMES FUTCH: Let me ask a question. We're at,
2 what time is it? It's 11:40. Do we want to break a
3 little early for lunch and come back after?

4 MATTHEW WALSER: I second.

5 KATHLEEN DROTAR: Third, fourth.

6 CHANTEL CORBETT: We've asked to keep going.

7 NICHOLAS PLAXTON: So we're going to --

8 RANDY SCHENKMAN, CHAIRPERSON: Okay. Onward.

9 NICHOLAS PLAXTON: I'll push forward, only
10 because it sounds like that's what you want to do.
11 I know there are -- this lecture stands between you
12 and lunch, so I'm not going to -- I'll try to breeze
13 through it. There's a lot of topics, but I'll try
14 to touch on --

15 JAMES FUTCH: You take -- you're fine.

16 NICHOLAS PLAXTON: Yeah, I'll hit the important
17 points on it. There's a lot of new --

18 JAMES FUTCH: We're not in a hurry or anything.

19 NICHOLAS PLAXTON: -- advances coming out
20 in nuclear medicine some of the medical community is
21 aware of. But I'll try to touch on the salient ones
22 that are currently being practiced and to give you
23 guys some information.

24 This is kind of the traditional nuclear
25 medicine, for somebody that doesn't work in the

1 medical field, this is kind of like our bread and
2 butter stuff we deal with on a daily basis. The
3 main studies that we deal with is myocardial
4 perfusion imaging, which basically looking for
5 cardiac ischemia or infarction, with radio tracers
6 through a stress test. So it's kind of combined
7 together.

8 And then FDG PET, which is a radioactive
9 glucose, which is another main thrust in our field
10 because we image a lot of cancer. A lot of the
11 aggressive cancers will burn glucose ten times more
12 than regular background tissues, so it lights up on
13 tumors. You'll see these fancy images a lot.
14 Hospitals will display them because they look cool
15 where you have a CT with all these little hot spots
16 where the tumor is. It works really well.

17 The ones I've listed up here, lung, colon,
18 breast, melanoma, lymphoma, SPN, head, neck,
19 squamous cell and then the solitary pulmonary
20 nodules kind of help figure out, you know, stage
21 these cancers and to follow-up treatment with these
22 cancers. So, again, this is another, like, major
23 portion of our field.

24 Then there's like, other general studies that
25 we do. Like, actually nuclear medicine started back

1 in the 50's with thyroid imaging and thyroid
2 treatments for hyperthyroid and thyroid cancer. So
3 we still do that today because it works really well
4 because there's -- the only thing that takes up
5 iodine in your body is your thyroid gland. That
6 really works well.

7 And then the other general studies that kind
8 of, like, main ones we do are like bone scans to see
9 if there's any turnover from either metastases,
10 fractures or infections. And we also do white blood
11 cell scans. Again, looking for either soft tissue
12 infections or bone infections. HIDA scans, which
13 you guys are probably familiar with are looking at
14 the gallbladder and GI bleeds and VQ scans for
15 emergent situations. That's kind of what we do on a
16 daily basis for people that are familiar with what
17 we do in nuclear medicine.

18 Now I'm going to, like I said, this talk I'm
19 going to focus on the newer things that we're now
20 unveiling or taking into practice, which is
21 basically a little bit more specialized. And these
22 are the ones I'll touch on today. The top one is
23 sodium fluoride, which is a bone scan using PET/CT.
24 And I can't go into all the details between --
25 there's the gamma cameras and then there's the

1 PET/CTs, but basically, the PET/CTs are kind of like
2 the high-definition imaging versus the old non
3 low-depth CTs, so that's kind of the idea of it.
4 But the, that bone scan agent has been around. But
5 that's got a -- I'll talk about that. But then
6 there's a neuroendocrine imaging. There's Liver
7 Y-90. Again, I'll talk about this in detail. Then
8 there's prostate cancer imaging and therapies that
9 we're doing. And then the other thing I'll touch
10 upon is congestive heart failure.

11 So these are kind of like new aspects that,
12 except for this, actually. The bone scan, actually
13 has been around a long time.

14 This bone scan, like I said, is like, it's
15 using Flourine 18, and that actually was approved
16 back in 1972. So this agent has been around a long
17 time. Actually, the cameras weren't that good to
18 image back then. Now we have PET/CTs from our
19 glucose FCG PET/CT. And a lot of the agents are
20 switching over to PET/CT now. This is coming back
21 into favor because it gives greater sensitivity and
22 specificity than the Technesium 99 MDP that we use.
23 The thing is it does give higher radiation dose to
24 patient. And right now, CMS is always kind of back
25 and forth on it, to get them approved or not,

1 because they're more expensive. And they're not
2 crazy more expensive, but when you add up the, you
3 know, thousands of bone scans that are done today,
4 that makes a difference.

5 so this is kind of just an image. I think, I
6 guess I should have put an old traditional bone
7 scan. But this is the PET/CT fluoride. The nice
8 thing, there's several good things about this is
9 one, you get to see, whenever you're doing the PET
10 on this one, you're actually getting CT images that
11 fuses with it. So you can directly correlate the
12 anatomy with whatever activity you're seeing and
13 actually evaluate it. And you can also look for
14 things that aren't lighting up. So some, some, like
15 metastatic disease and other things, won't light up,
16 but you can see them on the CT.

17 The other great thing about this is it's a lot
18 faster to do for the patient. So the traditional
19 bone scans we do now, you inject them, you have to
20 wait four hours for the radio tracer to distribute.
21 Then we image. When we image, we only get the gamma
22 portion of it. So it's kind of plowed up
23 information. If we want to pinpoint something, we
24 have to do a SPECT-CT, which is additional imaging to
25 image it. Whereas this one, we inject them; an hour

1 later, they're getting imaged and they're done
2 because you have the whole thing and you don't need
3 to get anymore imaging. So it's a lot more
4 convenient. It's like, again, like a
5 high-definition T.V. versus a low def. And I think
6 in the VA system, we're doing these and it's kind of
7 interesting because the high end of the VA is
8 pushing to have these done. Even though CMS is kind
9 of keeps kicking back on approving, so the private
10 practice would like to do these and they do
11 sometimes, but usually they have to have a person
12 pay out of pocket, which is not crazy expensive, but
13 in the VA, they don't have that same kind of
14 requirement, so we -- they're pushing to have more
15 of these done.

16 Kind of switching gears, this is the NetSpot
17 agent, which is a neuroendocrine tumor. It's not as
18 common as other cancers, but this is kind of a lower
19 grade type cancer. But there's 12,000 cases per
20 year. The thing is is that these can become very
21 metastatic and cause either -- or be very
22 symptomatic, one of the two. And this can be lethal
23 for people. If you're in that group, there's not
24 really any good imaging or therapies for it at this
25 current time. With this new agent coming out with

1 Gallium Ga-68, which again is a PET scan, so it's on
2 that high-resolution camera, they just came out with
3 it in 2016. And, you know, imaging time is about
4 the same as our FDG PET.

5 So the nice thing about this one is that you
6 can, the images light up with a neuroendocrine
7 tumor, you can follow it with a different
8 radioisotope. In this case, Lutetium-177 or
9 Yttrium-90. You can go back and radiate those,
10 whatever was lit, had the image update.

11 And again, just kind of comparison to other
12 imaging because the problem with these tumors is
13 that looking for, on CT, you have -- unless it's
14 really large, three centimeters is really large, you
15 can see that from across the room. By that time,
16 you know, the disease is already taking place.
17 Where, you know, if it's lower, when you're looking
18 for it early on, it has CT has 45 percent
19 sensitivity.

20 We used to have Octreotide, which was an agent
21 that we used on our gamma cameras. But again, that
22 was like a 40 percent sensitivity. We used to do
23 quite a bit of them for these patients that there's
24 no really good imaging for. But as soon as the
25 NetSpot came out, actually, I think it was a month

1 later we try to reorder Octreotide for a follow-up
2 on a patient and they did stop -- they don't even
3 have the trace anymore. So but the NetSpot is
4 available and has a great sensitivity, as you can
5 see, 95 percent.

6 And this is kind of the images you get. It has
7 a different distribution. This one has attached to
8 the neuroendocrine tumors. That's how the agent
9 works. And the pancreas, in this case, has a large
10 tumor in it, so you can see it on the -- well, the
11 image you have the liver on the left there. And
12 this is the -- I think it's a laser. This is the
13 liver here. This is your kidney, your back, your
14 spine, kind of a cross section. And this is the
15 whole body kind of image, and this is the radio
16 tracer being cleared in the bladder.

17 So you can see, this right here is in the
18 center is where the pancreas is and there's a large
19 mass. This one is pretty obvious because you can
20 see that on the CT, but just for demonstration, it
21 lights up.

22 But this is another example. So this is a
23 patient that is later stage. And so, you know, on
24 this one, you can see there's all these, like,
25 little lesions so that you may not see on CT. Like

1 here down in the bottom, that's actually the primary
2 down there and that's in the ileum. If you're
3 looking at a CT, there's probably no way you can see
4 that. So now with this agent, it lights up. You
5 see it. Now you know that's the primary there.

6 They have these other little lesions that are
7 probably sub centimeter, but you can see on this
8 image they stand out really well. You can see all
9 the hot spots and then same thing up here in the
10 lung. He has a lung nodule. Again they couldn't,
11 they're probably sub centimeter on a CT, you're not
12 sure what that is, what's going on with this imaging
13 agent, that's a neuroendocrine tumor, they can
14 biopsy it and treat them.

15 Another agent, or another aspect of, just kind
16 of shifting gears again, is Y-90. There's two
17 different types. We're doing the Sirtex over here
18 at the VA. This is kind of -- the idea is when
19 people get liver mets, one of the ways to treat it
20 is by immobilizing them so they would send in, the
21 IR would go in there and they would just deliver a
22 bunch of material that basically chokes off the
23 tumors. You can send it down the vascular system
24 and they've done that for many years.

25 But the idea here is, okay, well, not just send

1 in just the -- these particles, but send them in
2 with radioactivity attached to them so they're
3 basically radioactive spheres. They're lodging
4 where the tumor is and they'll going to radiate the
5 tumor from the inside.

6 So this was approved in 2002. And it was
7 approved for unresectable liver cancer. But it's
8 also being used now for liver mets. Like if you
9 have colon cancer or breast cancer and you treated
10 the primary and now there's only liver mets that
11 have reappeared and nothing else, you can treat it
12 with this.

13 So it works well. It costs a lot of money and
14 there's a lot of people involved. There's IR,
15 surgeons, nuclear medicine department. There's a
16 lot people that do it. And the treatment you can
17 see there, 30,000 per treatment. Sometimes they'll
18 do like a right lobe or left lobe and sometimes come
19 back to get retreated, but it does extend the life
20 of these patients.

21 There's a lot of planning that goes in with
22 these -- that's involved. You have to map out where
23 the liver, where the lesions are and IR has to do --
24 they do a test run with our Technesium agents. I
25 don't know if I have that on here. And basically,

1 they have to address all the different vascular
2 approaches that they're going to do. And I think I
3 have one here. This is like a test run.

4 So instead of -- so basically, once they figure
5 out where the mapping is, the IR will go in and
6 inject these, the Technesium agent, which is an
7 imaging agent only. And that way we can map and
8 see, okay, yeah, we're going to hit the tumor and
9 not other organs that aren't -- won't be damaged.
10 Because the vascular had some kind of -- it feeds
11 into the, either the lungs or something else, then
12 you can't do it.

13 And here's an example of a patient, they have
14 the liver patients, like they will have open other
15 vessel, vessels and in this case, it's an umbilical
16 vein that's been reopened because the liver failure
17 probably, so if you treat them instead of getting
18 into that area, so they have to go in and coil off
19 that before they do treatment.

20 And this is kind of an example of what they're
21 doing. So they go in there, IR does, and they, they
22 release these radioactive leads.

23 This is kind of what the set up looks like.
24 You don't need a lot of radiation protection. Just
25 that plastic will keep these beta emitters. So just

1 the plastic will protect most people there in the
2 area, so --

3 And then the post treatment, just follow up to
4 make sure that you can see that radioactivity
5 actually has gone where the tumor is. It's kind of
6 basically matching up all the images. And again,
7 just extends the life of the patient.

8 Then this is another aspect that we're going
9 into, which is prostate cancer. And again, there's,
10 there's not been really good imaging available for
11 this. A lot of people are -- this is the number one
12 cancer involved with men. So the old adage -- I
13 remember when I was going through med school, they
14 always said was, if you get prostate cancer, don't
15 worry too much about it, you don't even really have
16 to treat it. You're going to end up dying from
17 something else. And that's true of a lot of the
18 prostate cancers, but you don't want to be in at
19 that group of people that -- I mean probably
20 everybody in this room probably knows somebody that
21 has had horrible prostate cancer and ended up, so
22 it, yeah, so that's not the way we attack it
23 anymore.

24 So they came with this new agent that's called
25 Axumin. There's a couple other ones coming out.

1 This is, actually this guy here, Dr. Schuster, he
2 was the guy that trained me when I was at Emery. So
3 he's my nuclear medicine chief.

4 So anyhow, they approved this in 2016. It was
5 originally designed as a brain tumor agent. Then
6 they realized ed it works for the prostate. And so,
7 this is kind of the images you get.

8 The nice thing about this, you can find these
9 little -- this is the problem. It's been approved
10 for patients that have been treated for prostate
11 cancer, but there's recurrence now. And the problem
12 with that is when you have recurrence, it's very
13 hard to find where the recurrence is. And what
14 we've been kind of finding is that you see, this is
15 a little lymph node that's here in the pelvic side
16 wall. If you see that on CT, you would just think
17 it's a regular lymph node. This agent is a surface
18 antigen for prostate, so any lymph node that has
19 activity is going to be metastatic disease.

20 So you can find these little lymph nodes and
21 either radiate them or surgical remove them. So
22 it's definitely a new agent to help find.

23 And you can see here's another agent. I mean,
24 this is another patient here where, you know, they
25 couldn't find, its PSA is going pretty high. Again,

1 he has a regular-size lymph node and this is in the
2 center of his chest right here. And it lights up.
3 So on this agent, you'll note, they can go in and
4 biopsy it and they'll remove it.

5 And this is a bone metastasis that also shows
6 up in the sternum.

7 There's another agent coming out, very similar,
8 should be out within this year, it's called Gallium
9 68. It's PSMA. And you know, it works similar to
10 the, the other agent which actually uses Flourine.
11 But the nice thing about this one, I mean, it has
12 the same kind of qualities and imaging. You can see
13 these are a bunch of lymph nodes in the pelvis that
14 are lighting up.

15 I mean, if you're reading the CT, these lymph
16 nodes are very tiny. So normally you would a CT,
17 the radiologist will read this and say it's
18 negative. But on ours, it's obviously positive.
19 But the nice thing about this agent, as soon as this
20 comes out, right behind it is this other
21 Lutetium-177 which is a beta emitter. Again, once
22 you see the images that are positive instead of
23 going after these, you can give them that agent and
24 it will radiate them, it will absorb it and radiate
25 the tissue.

1 Another aspect in prostate cancer which has
2 been out for a couple years, I think this got
3 approved in 2013, called Xofigo. This is more for
4 late-stage prostate cancer. And the idea here is
5 Radium 223. This one is one of the only alpha
6 emitters that we deal with. And, you know, an alpha
7 emitter doesn't penetrate well, but works well with
8 this because you can inject it into the patient and
9 it goes to the bone metastases and it will sit there
10 and does high rate, extremely high damage, but it
11 doesn't damage anything outside that area where it's
12 absorbed.

13 So the thing is, it's very expensive. I think
14 it's \$70,000 to treat a patient. But if they
15 have -- it's usually used in patients that are
16 end-stage prostate cancer that are having severe
17 problem with pain from a lot of bone meds, so this
18 will go in and go -- it does extend life but it
19 helps with the bone meds. It is kind of a, it could
20 be a springboard for something else coming down the
21 pike.

22 And then just real quick, I'll touch on
23 congestive heart failure. I guess I didn't put on
24 the images of the -- again, what we've done in
25 nuclear medicine for many years is they're looking

1 for ischemia so we can determine if their coronary
2 arteries are blocked or not, or if there's
3 infarction or scar in the heart. Basically
4 indirectly with our imaging, so taking that same
5 software and the same agents that we already have,
6 you can actually just apply some mathematics to it
7 and then you can, and determine congestive heart
8 failure patients how to help them.

9 The thing is we've been improving the life of
10 coronary artery disease in the United States. So
11 now people are living longer with heart disease, but
12 now they're getting heart failure because
13 eventually, they get heart failure.

14 So congestive heart failure is actually now a
15 very huge problem. Six million people in the United
16 States. There's a half a million cases new each
17 year. After diagnosis, they have about five years
18 to live. And treatment is very expensive. And in
19 the end, we're paying \$35 billion a year on
20 congestive heart failure a year alone. It's
21 something to address and again, there has been a
22 lot, but now they're starting to shift gears to go
23 towards that.

24 And one of the things they have here is this
25 device they came up with which is the -- you have

1 pacemakers and then you have the defibrillators that
2 people get implanted with. And this one is the
3 cardiac resynchronization therapy, which is
4 basically, it senses the heart rate and then it
5 creates -- it actually is like a pacemaker that will
6 do all the above. So it will defibrilate; it will
7 actually create a better rhythm for the heart, so
8 that it actually improves the patient with
9 congestive heart failure.

10 So the thing is with our imaging, they can do,
11 like I said, they can -- you can watch the video of
12 the heart beating. And with these, with this
13 imaging, you're actually able to figure out where
14 the contractility in the left ventricle is. If
15 everything goes right, it all contracts at the same
16 time. You can imagine kind of squeezing that
17 chambers. It all squeezes synchronously. It will
18 squeeze out all the blood. This is what a normal
19 one is you can see on the histogram here, there's a
20 nice spike.

21 This is how the heart is supposed to look. And
22 then, you know, these patients that have a lot of --
23 problems with their heart, they end up having this,
24 you can see the dyssynchrony over the whole cycles.
25 You can different areas of the wall contracting all

1 different times. You can imagine that's not going
2 to pump out blood well because you have turbulence
3 and not really squeezing right. So the idea is to
4 figure out this dyssynchrony.

5 The reason -- the idea of doing this, when you
6 put in those devices, because before, they would
7 just get a congestive heart failure patient and say,
8 well, okay. Let's try you with this CRT to see if
9 it improves you or not. And so, they realized that,
10 okay, if you have this pattern, this dyssynchrony
11 pattern, that CRT is going to help you much better
12 because it's going to resynchronize this and force
13 the chamber to squeeze all at the same time.

14 And so, by figuring out this map here, then you
15 can then predict who should get the CRT and who
16 shouldn't. Because if you put it in a patient that
17 has congestive heart failure but has a nice, sharp
18 tight peak like that, it really doesn't do anything
19 for them. And sometimes, you can actually make them
20 worse.

21 The other thing you can do with it, you can
22 determine where the last point of contraction is on
23 the cycle. Looking at the map of the heart. And
24 normally when they put in the CRT, they would just,
25 as they're putting them in, they would just kind of

1 put the leads into the left ventricle. Where ever
2 it fell, it fell. Now you can say, actually if you
3 put it at the last point of contraction instead of
4 randomly putting it in there, it will actually
5 improved the outcome of your CRT placement.

6 So those two things, like again, they didn't
7 really have that information and it really hasn't
8 caught on yet, so this is all new stuff that's
9 coming out now. And again, there's not really a
10 change because we already do, all of these patients
11 are already getting MPIs, because they're looking
12 for underlying ischemia that's causing congestive
13 heart failure, but we're not able to say anything
14 about it, but now by looking at another page in our
15 software, we're reading -- we can actually give them
16 information.

17 And this is another thing. It's been around a
18 little while, but they're changing it from a, again
19 that low res. This is SPECT I-123. They usually do
20 like planar images. Now they realize if they do a
21 3D image -- sorry. This is like totally different
22 radiotracer altogether. I-123. What it does is it
23 innovates, it shows the innervation of the heart.
24 And so in a normal heart, I guess you guys, probably
25 the images probably look weird to you. This is the

1 heart right here. You can see that little half
2 circle there. And on a patient that doesn't -- has
3 de innervation of the heart, they're no activity.
4 That's just activity in the lungs. And so, they're
5 able to figure out if your nerve innervation of your
6 heart has, is still intact or if it has basically
7 gone bad, it doesn't work anymore. And that can
8 basically determine the outcome of these patients
9 with congestive heart failure. Because if you have
10 no innervation, then the outcome is not well.

11 The take home message in general is like, you
12 know, I just went through like, multiple different
13 things that are now currently available. We're
14 doing the Y-90, the micro spheres, we're doing that
15 at the VA, as well as the bone imaging, and as well
16 as the NetSpot imaging.

17 We haven't done the therapies yet in the
18 NetSpot because we don't have that. And we're doing
19 the Axumin prostate imaging, which in our
20 population, the VA we have a lot of older men with
21 prostate cancer, so it's a big impact in our, our
22 veterans. But the whole idea here is a lot of these
23 newer tracers are becoming much more specific and
24 sensitive for very particular, either tumors or
25 cancers or, or disease. And we're coming out with a

1 lot more therapies that didn't even exist anymore.
2 Because before, with neuroendocrine tumors, the only
3 thing they did was give you some Metastatin, which
4 kind of basically floods the tumor, so that it kind
5 of stays static. It doesn't get rid of it. But the
6 therapies they have here is trying to get rid of it.

7 So, in general, in general, probably the next
8 ten years, maybe even a little longer because
9 cameras cost so much, but they're going to go from
10 all the gamma spec, all the gamma spec CT imaging,
11 which is the low res kind of imaging. They're going
12 to switch over to PET/CT because basically, all the
13 general studies that we do today, even the cardiac
14 stuff, are all going to switch over to PET/CT
15 scanners.

16 So it's going to be a big change because all
17 these hospitals have multiple gamma cameras. Like
18 usually one, if that, or two PET cameras and they
19 have usually five or six, you know, ten gamma
20 cameras. But in the next ten, fifteen years,
21 they're going to be switching over to PET/CTs. So
22 it's going to be a big kind of change, but the
23 imaging is also developing as well at the same time.

24 So any questions? I know it's a lot of
25 information in short amount of time, but -- yeah?

1 DAVID O'HARA: The Gallium and the, is it
2 Yttrium?

3 NICHOLAS PLAXTON: Yttrium-90.

4 DAVID O'HARA: Yeah, the Gallium and the
5 Yttrium radioisotopes, are those attached to glucose
6 or to something else? How do you get them into the
7 tumor?

8 NICHOLAS PLAXTON: So the Yttrium-90, in
9 general, yes, it depends on what you're using it
10 for. So the Y-90 liver, we actually just, it's just
11 attached to a glass bead or a plastic sphere. And
12 so it's like the chemo embolization that they're
13 using. So it's inside that, like, resin or glass
14 bead, which is small enough to kind of go into the
15 arteries. So they just inject it directly into,
16 because these tumors in the liver, in particular,
17 are very vascular compared to the rest of it. So
18 when you inject into that artery, it goes right to
19 that tumor and then just sits there.

20 DAVID O'HARA: That's the next question. How
21 do you get the beads to the tumor.

22 NICHOLAS PLAXTON: They get to the tumor,
23 because the tumor has created its own vascular event
24 and it's hypervascular. So that's how the chemo
25 embolization worked. We're just adding the extra

1 radiation on top of that.

2 So some of the other tracers, so like the, like
3 the, like the Gallium 68 is an imaging agent. And
4 for instance, like the PSMA, which is a prostate
5 surface antigen, and they can switch it out with
6 either Lutetium or Y-90. So the actual thing
7 they're attaching the Y-90 to in that case is
8 actually a molecule and that molecule is a receptor
9 that attaches to the prostate cell's membrane. So
10 it's an actual molecule.

11 And so that's what I'm saying. So some of
12 these are -- it depends on what you're specifically
13 looking for or what your task is at hand.

14 The only one that's really not that case,
15 there's two agents that we just directly inject,
16 which is iodine, because the only thing, again, that
17 takes up the iodine is your thyroid. So that's why
18 it was easy to do when they first came out in the
19 1950's because you don't have to attach to anything.
20 You just inject them or you have them take a pill.

21 The other one is the Gallium agent, not the PET
22 scan one. I think it's Gallium 67. And that was
23 used for, like it has -- it just goes to tumor or it
24 was a general inflammation. But we don't -- we do
25 that less often now these days. We have a lot more

1 specific agents that are available, like the bone
2 scan agents. Like the one that we currently use is,
3 is the same molecule that they use for like Fosamax
4 for osteoporosis. It's the same, same molecule.
5 They just attach the radioactivity to it.

6 So any other questions?

7 JOHN JORDAN: Yeah, the alpha, the radium
8 therapy.

9 NICHOLAS PLAXTON: Yes.

10 JOHN JORDAN: You see that causing new
11 requirements, say something that check wipes as far
12 as contamination? I haven't seen, you know, a
13 license written for an alpha emitter for medical. 14

15 CHANTEL CORBETT: Oh, yeah, there's tons.
16 They're usually 5B or 5C's. No, they're injections.
17 Xofigo is injection.

18 JOHN JORDAN: So we do have. I just haven't
19 inspected them.

20 CHANTEL CORBETT: You still have the same
21 requirements for wipes and surveys.

22 JOHN JORDAN: You just take your wipes and --

23 CHANTEL CORBETT: Yeah, I mean --

24 JOHN JORDAN: -- CTYs and everything?

25 CHANTEL CORBETT: Yeah, you're still getting a
reading on those.

1 JOHN JORDAN: The contamination limit might be
2 different for alpha as it might be for --

3 CHANTEL CORBETT: There's nothing in the regs
4 that says there is.

5 JOHN JORDAN: I haven't seen anything in the
6 statutes.

7 ADAM WEAVER: It's just licensed under the
8 regular treatment. It's a state approved treatment.
9 530, 532.

10 NICHOLAS PLAXTON: And you set up an IV and
11 inject it straight into the patient. So it's
12 handled similar to our other therapy agents. I know
13 we applied for it at the VA. Here at Bay Pines VA.
14 And I think there are a couple VAs that actually are
15 doing it. And it is very expensive. Especially on
16 these ones that are very expensive.

17 Usually, in the VA, we're always a little
18 hesitant to do it. The problem is the patient --
19 the oncologist will just send them out then and then
20 we pay like the double the amount of this insane,
21 expensive thing. It only makes sense for us to take
22 it on board in-house. That way it will be cheaper
23 for them to get it done. It just looks, for the
24 people that are in the administrative looking at the
25 numbers, when you start adding these crazy budgets,

1 they look at, what is this crazy number?

2 MARK SEDDON: You have to budget.

3 NICHOLAS PLAXTON: Exactly.

4 CHANTEL CORBETT: There are a couple. I mean
5 like Xofigo is one and Lutathera is the other.

6 NICHOLAS PLAXTON: Lutathera, yeah.

7 CHANTEL CORBETT: -- and if your patient has an
8 issue where they're hospitalized or whatever that
9 they can't come in, they actually don't charge the
10 facility for those doses. So that is a big selling
11 point, obviously, for the facilities, because
12 they're like, what happens if we get this \$30,000
13 dose and the patient is obviously end stage. They
14 may not make it. You know, we're going to be stuck
15 with this \$30,000 dose. So those -- we do have a
16 couple of the newer ones that the manufacturers are
17 not charging the facilities if they can prove that
18 those things happen.

19 MARK SEDDON: One, just the heads up for the
20 Y-90s, just of all the new procedures you're talking
21 about, probably the one of the most, from protection
22 concerns, would be the HMI administrations, I think
23 last year, they're the number one medical events
24 reported nationwide. As far as --

25 CHANTEL CORBETT: The what?

1 MARK SEDDON: Y-90s, the spheres. Combination
2 of both. Administration issues.

3 So you have issues with contamination of suite.
4 One of the problems is it's tiny glass or resin
5 spheres. So if you have a spill, it is not
6 impossible -- it is not impossible. It is very
7 challenging to clean up.

8 NICHOLAS PLAXTON: Yeah.

9 MARK SEDDON: I don't know if you dealt with
10 that before. But you have to wait for them to dry
11 out and then vacuum them up. They don't just pick
12 up easily.

13 CHANTEL CORBETT: So are you finding the
14 problem is the doctors are not respecting the stasis
15 and they're pushing still?

16 MARK SEDDON: It's a combination. They've had
17 some issues with inability to continue pushing
18 because the stasis and/or just because of mechanism
19 failure. There's a procedure you follow to make
20 sure you actually push everything out of the set up
21 into the patient and you track that dose and make
22 sure you have everything out and if that is not
23 functioning properly, then you see some failures
24 with that.

25 The bigger thing is more how are you

1 administering and where you want to go. I think
2 that's really, the reports have been a lot of, are
3 you dosing what you think you're dosing. Because
4 as, as Dr. Plaxton was saying, it's a collaborative
5 effort with the innervation radiologist and
6 radiation oncology to place your catheter upstream
7 and try to kind of paint spray your target area, the
8 lesions. So based upon how you're planning and how
9 you actually end up where you want to go. I think
10 that's where we're seeing a lot of problems with
11 this.

12 NICHOLAS PLAXTON: Yeah. That was
13 probably -- to go along with that, so remember, we
14 do all this planning and then we do like a pre-run
15 with this Technetium agent, which is an imaging
16 agent only. The only thing is that, you know, the
17 IR is going all the way down into the vessels, into
18 the liver. And they have to basically get to the
19 same point during the, you know, a week later. So
20 it's like --

21 MARK SEDDON: Things change.

22 NICHOLAS PLAXTON: Yeah. They may or may
23 not be in the exact place. The other thing is
24 they're some literature that says that Technetium
25 99M that we use, which is on the MMA, may not be

1 exactly the same in its flow dynamics as the spheres
2 or -- so that, that may play a little bit into it.
3 But I think it's more of a technique in trying to
4 get it. And, yeah, if you get a, you know, one
5 vessel off or something, yeah, you could get, you
6 know, a blood vessel that's now feeding the stomach
7 or the spleen or something else and now, that would
8 be a misadministration.

9 MARK SEDDON: So there's a lot of -- so the
10 requirement for the written directive has to be an
11 on-the-fly written directive as you're treating to
12 know exactly what you're doing so that there's, as
13 you're doing the procedure in the room, the
14 authorized user, radiologist has to work together to
15 say, what do you actually do? This is what I want
16 to do, but what was the actual end result?

17 CHANTEL CORBETT: Yeah, that's always been the
18 case with anything. You can have stasis. Your dose
19 can alter, obviously, quite a bit.

20 NICHOLAS PLAXTON: Yeah. You're supposed
21 to go until you get to -- it stops pushing in. So
22 that's what your supposed goal is.

23 CHANTEL CORBETT: Yeah. Sooner or later,
24 basically.

25 NICHOLAS PLAXTON: Afterwards, what we do

1 basically, after they're done with the procedure and
2 everything, we clean up, then you have to take the
3 patient over to the nuclear med department and
4 reimage them and verify. That's kind of what those
5 images I was showing which is showing the MRI images
6 and CT images and where it actually landed. So that
7 we confirm s it was in the same spot.

8 CHANTEL CORBETT: And the nuclear techs do the
9 vital pre-procedure and post-procedure. All the
10 calculations. Exactly.

11 MARK SEDDON: Make sure they actually end up in
12 the patient. They got FDA approval this year for
13 the post dissymmetry software. So that's now MIMS
14 and a couple other vendors have got some approval
15 for that, so that they are starting to look at what
16 actual dose did you see. Because right now,
17 everything is based upon a the written directive.
18 You administer this much to the patient, and that's
19 in nuclear medicine. In reality, therapy is looking
20 at how much dose do you deliver to a target volume.
21 And so, so that's now maybe changing how we're
22 approaching this.

23 So once that post dissymmetry software is the
24 standard of care of the vendors, they want to see a
25 whole new approach to how -- because you look at the

1 different lesions, you may be approaching it by
2 multiple doses, approaching it differently, you're
3 breaking up one larger lesion into multiple lesions.

4 CHANTEL CORBETT: And some of the Y-90 patients
5 have multiple events because they come back for
6 scans afterwards and --

7 NICHOLAS PLAXTON: Yeah.

8 RANDY SCHENKMAN, CHAIRPERSON: Okay. Well,
9 it's lunchtime. We're having lunch at World of
10 Beer, which is right next door.

11 JAMES FUTCH: Not a lot of restaurants right
12 next door.

13 ADAM WEAVER: Good planning, James.

14 RANDY SCHENKMAN, CHAIRPERSON: And we'll --

15 JAMES FUTCH: We're coming back at 1:30.

16 RANDY SCHENKMAN, CHAIRPERSON: -- be back at
17 1:30. Right.

18 (Proceedings recessed at 12:18 p.m.)

19 (Proceedings resumed at 1:44 p.m.)

20 (Gail Curry is not present)

21 RANDY SCHENKMAN, CHAIRPERSON: We're going to
22 change the order a little bit. We'll have Brenda go
23 next and then Clark.

24 BRENDA ANDREWS: Okay. The first thing I want
25 to go over is the travel. Some of you have travel

1 packets at your stations that look like this
2 (indicating). The main thing is do not write on the
3 authorization, itself, other than your signature and
4 the date. If it looks like something is not
5 correct, for instance, your time or your mileage,
6 just indicate the changes on those instructions --
7 on the instruction sheet that I gave you and then I
8 will fix it on your reimbursement. Okay?

9 The other thing I wanted to mention about
10 the travel -- and also, those need to be turned in
11 to me before you leave and put them back in the
12 envelopes that I've given you so that I can keep
13 track of them. And then if you have receipts that
14 you don't have here today, you can scan those
15 receipts in and e-mail them to me and that will be
16 fine. You don't have to worry about mailing them.

17 Any questions on what you've got in front of
18 you?

19 CHANTEL CORBETT: Do we keep everything except
20 the ones we signed?

21 BRENDA ANDREWS: You give me everything back.
22 You don't keep any of that.

23 CHANTEL CORBETT: Okay. Yes, ma'am.

24 BRENDA ANDREWS: Yes, I get all of it back. I
25 just kept it all together so it would be organized

1 for me.

2 ADAM WEAVER: It would be different the next
3 time.

4 DOUGLASS COOKE: Hey, hey, hey, I resemble that
5 remark.

6 BRENDA ANDREWS: So the other thing I want to
7 mention is because you all have paper travel today,
8 you know, that's not the way we've been doing it.
9 We've been trying to go through the automated
10 system, the electronic system, and it's been an
11 utter failure.

12 CHANTEL CORBETT: Amen.

13 BRENDA ANDREWS: I have to put it out there.
14 It's been a nightmare more for some of us than
15 others. He's not looking. However, we have a new
16 system. Now that we've tried that one out and it
17 didn't work, the State has gone to a new system.
18 They call it STEMS. It's the Statewide Travel
19 Management System. We acronymed it STEMS.

20 So because they have not figured out for our
21 department yet how to handle travel for people who
22 are not State employees, we were allowed to do paper
23 travel, which used to be a nightmare, in my mind,
24 but was a pleasure because Douglass did it
25 (laughter). It was a pleasure for me to do it this

1 way this time because we guaranteed everybody had a
2 travel authorization on time. So we have no
3 guarantee that we're going to continue to do it this
4 way. The department is working on their own
5 internal policies and procedures and is adding
6 different parts to the system to make it work for
7 people who are not State employees, the next time
8 around, it may be that we're doing the travel in the
9 system.

10 In the meantime, keep your fingers crossed and
11 maybe say a prayer that we can do paper again the
12 next time because I really don't like that headache.

13 That system, though, is the reason they came up
14 with the system, and I feel like it's important to
15 tell you this part, the Legislature came up with
16 this idea and House Bill 5009 is the one that
17 enacted this bill so the State system would interact
18 and interface with the personnel system as well as
19 the statewide accounting system so everything can be
20 reported and is all public record. And they can do
21 all their little reports that need to be done and
22 keeping up with -- keeping track of where people are
23 going and how much is spent in all kinds of
24 categories.

25 So this system standardizes the system, travel

1 system for all of State government. Now we are all
2 on the same page doing the same thing. We don't
3 know if they're some quirks. There are a few pros
4 and a few cons, but the first thing I need for you
5 to know is that if we do go to this system and
6 you're involved in it, you have to have Chrome.
7 Explorer does not work. Okay? So when we get to
8 that point, I will send out e-mails to everybody to
9 let you all know that we're integrating to that
10 system and give you all the details and the
11 instructions and all of that. What I have found, it
12 is easier to get into it. We haven't had as much
13 glitches with our passwords.

14 Once you set your name up and your user account
15 and your password, it seems to hold it much better
16 than the Go Travel system did. So hopefully that
17 will hold for people who are not State employees as
18 well.

19 With that said, if you have any questions on
20 your travel, like I said, make sure I get those
21 packages before you all leave today.

22 CHANTEL CORBETT: Got them.

23 BRENDA ANDREWS: Okay. All right. The other
24 thing I wanted to bring up today is, the by-laws, we
25 voted on the by-laws. In 2016, we revised them. We

1 did two revisions. One was for the fiscal year.
2 The fiscal year in the original by-laws said October
3 1 through September 30th. So we revised it and made
4 it the same as the State fiscal year, which is July
5 1 through June 30th. That change was made.

6 The other thing that was in there was the chair
7 and the vice-chair only served a one-year term
8 before it was time to vote again. And so, we
9 changed that to a three-year term to coincide with
10 the terms, basically that you all serve anyway.

11 So in 2016, we voted and Dr. Schenkman and Mark
12 Seddon were elected as the chair and vice-chair.
13 Today it's time to do that voting again. It's been
14 three years. So that's going to be opened up for a
15 nomination and a vote and you second and all that.
16 And if you all want to do that at this time, we can.
17 Or I can just talk to you one more minute about the
18 vacancies and the updated terms that are coming up
19 for their -- the terms that are ending up pretty
20 soon. So which would you rather do?

21 ADAM WEAVER: Are they willing to serve again?

22 RANDY SCHENKMAN, CHAIRPERSON: I am.

23 MARK SEDDON: I am.

24 WILLIAM ATHERTON: I move to repeat.

25 BRENDA ANDREWS: Okay.

1 MATTHEW WALSER: I second.

2 CHANTEL CORBETT: All in favor?

3 ALL: Aye.

4 CHANTEL CORBETT: Opposed?

5 (No Response)

6 (Applause)

7 BRENDA ANDREWS: All right. So we have -- so
8 we will continue for the next three years.

9 RANDY SCHENKMAN, CHAIRPERSON: You can vote us
10 out. Now's your chance.

11 CHANTEL CORBETT: You have to wait three more
12 years.

13 BRENDA ANDREWS: It's too late.

14 ADAM WEAVER: It's been voted on.

15 KATHLEEN DROTAR: The council has spoken.

16 BRENDA ANDREWS: The council has spoken and we
17 like that.

18 okay. And the last thing that I have on my
19 list to talk about, there are four members whose
20 terms end this year. And I wanted to bring that out
21 today so we can, you can start thinking about
22 whether you want to run again or apply again for the
23 position or whether you'd, you know, rather move on
24 in life. Some people do that. But the four people
25 are Mark Wroblewski, Adam Weaver, Mark Seddon and

1 Christen Crane-Amores. Well, you just decided you
2 want to be here for three more years.

3 MARK SEDDON: Yeah.

4 BRENDA ANDREWS: So 10-27-19, those terms are
5 up. And I usually send out an e-mail saying your
6 terms are coming up to an end; do you wish to be
7 reappointed, you know. You can reapply, blah, blah,
8 blah, blah. And you let me know whether you want to
9 or not. We're trying to do this a little bit sooner
10 than we have in the past because we get bogged down
11 with everything else going on and these don't get
12 done quite on time. So we want to make sure we
13 don't have any gaps.

14 Right now we do have the one vacancy with Dr.
15 Lagoutaris' position was -- his term ended in
16 October of last year. We've had our ups and downs
17 with -- because we don't have a Surgeon General
18 right now, so we're trying to get all our ducks in a
19 row so we can appoint people at the right time and
20 make sure we have the Surgeon General in place. Or
21 if not, somebody else that's going to do it. But
22 we'll have our paperwork in line when we find out
23 who that person's going to be.

24 So that's it for me. Any questions?

25 CHANTEL CORBETT: Thank you.

1 ADAM WEAVER: You'll send us an e-mail?

2 BRENDA ANDREWS: I will. I always send out an
3 e-mail ahead of time so you're aware that your term
4 ends. I give you the date that it's ending and I
5 give you the opportunity, ask if you want to
6 reapply. It is a reapplication. It's not an
7 automatic reappointment. You have to go online and
8 fill out the online Department of Health
9 questionnaire; update it and submit a new CV or
10 resume' to me. You can -- if that -- if the resume'
11 or CV doesn't attach in that DOH questionnaire,
12 don't fret. Just send it to me via e-mail, because
13 sometimes they've had problems in the past with it
14 attaching. Don't let that stop you, okay? Just
15 attach it to an e-mail and send it to me.

16 And I automatically get those questionnaires.
17 Once you fill them out, I get an e-mail and James
18 does, too, saying that you've applied, because we're
19 in the system. So if you -- if that's what you want
20 to do, feel free to, you know, send me an e-mail
21 back and say you wish to serve another term and then
22 we go from there.

23 Anything I forgot? I believe when you were
24 appointed the first time, we sent a letter out to
25 your founding societies and they nominated you. And

1 so, we do that same practice each time a position is
2 open. Whether or not the person wants to reapply or
3 re -- be reappointed or not, we still send that
4 letter out to the societies. We do let them know if
5 you're interested in being reappointed. But that
6 letter still has to go out and they are the ones
7 that send us their nominees. And sometimes it may
8 be a reappointment and sometimes they may have
9 somebody else in mind. So it's not a guarantee, but
10 at least your name is in the pot.

11 Any questions? Okay. Well, you'll be hearing
12 from me within the next few months in time for you
13 to make your decisions whether you want to, you
14 know, reapply or not.

15 Any questions on the travel? Okay.

16 RANDY SCHENKMAN, CHAIRPERSON: Okay.

17 BRENDA ANDREWS: That's it.

18 RANDY SCHENKMAN, CHAIRPERSON: Now we're
19 turning it over to Clark.

20 CLARK ELDREDGE: Okay. I want to start out
21 with a little, just update you on current medical
22 events. We currently are responding, I guess say
23 responding to five -- two of them happened at the
24 very end of last year. These were actually both
25 superficial dermatological events. One is fairly

1 cut and dry. The physician was actually changing
2 from one system to a new system. The new system
3 required that he hire a -- he hired a therapist to
4 operate for him. The marking wasn't clear for where
5 the location was. The therapist called him in; he
6 said right here. Treat that spot.

7 After a couple treatments, the patient's going,
8 I'm not sure that's right. That's when the
9 physician decided to actually, let me doublecheck my
10 photographs. It was off by a couple centimeters.

11 So the other -- the next one is a case where
12 this is a mobile therapy facility. A dermatologist
13 runs a mobile therapy. Taking his van around to
14 nursing homes; that type situation. During the --
15 their annual service physics check, in the morning,
16 the technician from the company saw no problem with
17 the machine, so there was nothing physically
18 identified at that time. When the physicist
19 performed his calibration, he noticed it was 30
20 percent below what was anticipated or expected to be
21 the output.

22 They further investigated, pulling the, the
23 engineer back out, determined that the tube was
24 misaligned; had shifted inside the -- its housing.
25 It was kind of shooting into the, into the shielding

1 on the side rather than straight down the bore hole.
2 There was a history of the therapist said, well,
3 whenever it drifted three percent, we would put --
4 we were told that one way to stabilize it was to put
5 it in service mode and let it warm up in service
6 mode. Something they shouldn't have been doing.
7 They were also missing a good three months, four
8 months of the QA documents up until that event.

9 So at one point, the therapist, their primary
10 therapist said, well, I don't think it should be a
11 problem because the day before you all came to
12 service it, I was in the back of the vehicle and I
13 bumped the thing into the side. Maybe that's what
14 misaligned it. The issue is, if that was when it
15 would happen, when they powered up the system, it
16 could've set up warning bells that the system was
17 off, the output was off from that from the previous
18 time it was fired up. None of the warning bells
19 were seen by either the engineer or the physicist.

20 This year with all within a week, we received,
21 or week and a half, we received three medical events
22 related to breast treatments. Two wrong sites where
23 a physician had ordered a boost treatment and they
24 lined up on the wrong scar on the boost treatment in
25 two cases.

1 The other one was where it's the wrong side.
2 After reviewing -- yeah, the treatment was all
3 ordered for the left side. That when the physician
4 in charge of the case left the practice and the new
5 physician came in, he reviewed everything. They
6 noticed that actually the biopsy said it was on the
7 right side and not left side. So the person, 19
8 fractions to the wrong side of the body. Wrong
9 breast.

10 So these -- all these are currently, the visits
11 for these three were just last week. And so, we're
12 preliminary information on those.

13 Any questions about the medical events?

14 RANDY SCHENKMAN, CHAIRPERSON: Are we allowed
15 to ask were they all the same place?

16 CLARK ELDREDGE: They were all the same chain.
17 All under the same regional direction of the same
18 chain. So two Fort Myers facilities and one
19 Sarasota facility.

20 MARK SEDDON: Do you think it has do with an
21 interpretation of the report or is it just that they
22 happened to have all the -- they all happened at the
23 same time?

24 CLARK ELDREDGE: Well, they all pretty much
25 happened within a week or two of each other. They

1 were all reported within a week or two. We actually
2 did have -- now that you mention it, we did have a
3 little bit of that discussion when they called up
4 about how to interpret whether or not it was a
5 medical event.

6 MARK SEDDON: Right. You know, I've been at
7 the Florida chapter meetings, I've been doing the
8 last couple years in discussion with them as far as
9 better defining for them what a medical event is;
10 when to report them.

11 CLARK ELDREDGE: Right.

12 MARK SEDDON: I think that's been kind of a big
13 push to do a better job. Traditionally, there was a
14 lot of anecdotally, one faction, you know, it
15 doesn't meet the 20 percent, you know. Wrong site,
16 it's not really wrong site.

17 CLARK ELDREDGE: Yeah, because what happens
18 when the treatment volume and target volume overlap.

19 MARK SEDDON: Exactly.

20 CLARK ELDREDGE: So I guess we'll go ahead to
21 that, which I actually have some draft language in
22 here for an information notice to tighten up our
23 interpretation of wrong site and wrong dose.

24 So in the beginning of this information notice,
25 this draft that we have, the section out of our

1 rules that defines what the -- what constitutes a
2 medical event. I did look at Massachusetts and
3 whatever, it's been a while since I read the other,
4 a couple other different definitions on how they
5 tried to approach this and I thought a simpler thing
6 would be wrong site is if the iso center of the
7 treatment is outside the target volume. You know,
8 that's -- if you miss it, so that your point you're
9 aiming at is outside your planned, that that's
10 pretty much.

11 Also, the -- then there's the question of how
12 much of the target volume is covered. And that, I
13 hate to say I just picked a 50 percent as a, let's
14 just start somewhere for discussion. Whether or not
15 that that's -- or whether that is even necessarily
16 to discuss. Because if you consider the difference
17 in dose, that may actually cover about the -- how
18 the, how the shift occurs. How much of that
19 physical overlap because how often, how it actually
20 does adjust the dose to the tissue. And so that may
21 take care of itself, but I don't know the math close
22 enough to be sure.

23 The other, the other clarification here is in
24 part because of the -- this was the two medical
25 events or the three medical events involving the

1 breast, is that each modality should be treated --
2 in any given series of treatments, each modality
3 should be treated separately because, obviously, if
4 you're doing an electron beam boost treatment over
5 external beam treatment, that the electron beam was
6 inside a much larger target volume from the overall
7 treatment. You had the course of electron beam,
8 your area of your treatment can be much more
9 precise. So the wrong site should be considered for
10 each modality separately.

11 MARK SEDDON: That makes sense.

12 CLARK ELDREDGE: Because the argument was made
13 by the physicist involved, well, you've got to
14 understand -- well, we discussed this. I should say
15 the argument was made, we did discuss this is a
16 thing about the fact that the total dose. Of
17 course, when we discussed this, I did not understand
18 there were two different modalities involved. That
19 the total dose could be adjusted for the whole
20 tissue just, you know, by -- when you do the
21 calculations, that the actual doses may not be
22 outside the 10, 20 and 50 percent.

23 MARK SEDDON: Yes, 10, 20, 50.

24 CLARK ELDREDGE: Yeah. Just because the boost
25 treatment is a small fraction of the total treatment

1 to the breast. And so -- now, within any treatment,
2 you would, I would hope or assume that when you do
3 find out there's been a shift in the, a shift in the
4 treatment over the actual target volume, that the
5 physicist and folks would actually be redoing their
6 dose curves, looking at the plots, making to see
7 where the treatment was, what the doses were. And
8 that you could actually, at that point, evaluate
9 whether or not any of the tissue involved was
10 actually what the difference in the framing of the
11 tissue involved and that's where applying that
12 standard to the -- not the total treatment dosage,
13 which is what I've had physicists talk to me about,
14 but actual treatment dosage to specific sub
15 centimeter, sub cubic, you know, centimeters of
16 volume, millimeters of volume.

17 MARK SEDDON: They should be doing both. They
18 should be looking at that fraction where your dose
19 is in the fraction and back to the overall treatment
20 volume.

21 CLARK ELDREDGE: volume is, right. When you
22 look at the nice little curves, you'll see when done
23 right, how, what percentage dose to this volume of
24 tissue and how much dose this volume of tissue; that
25 type of thing. By taking simple math differences of

1 those curves, you out to be able to find out when
2 the treatment volume and target value are shifted,
3 whether or not you're actually violating any of
4 these.

5 MARK SEDDON: Right, because you would have a
6 weekly 50 percent rule and the overall 20 percent
7 rule.

8 CLARK ELDREDGE: Right.

9 MARK SEDDON: That kind of helps capture the
10 two different, fraction versus overall treatment.

11 CLARK ELDREDGE: Because the problem with the
12 volume, the dose before, it was unclear, unspecified
13 in the rule whether or not you're talking about the
14 total treatment dosage to all tissue --

15 MARK SEDDON: Right.

16 CLARK ELDREDGE: -- without subdividing it into
17 any of the specific tissue you're trying to treat,
18 as well as the potential of giving too much dose to
19 the surrounding tissue.

20 MARK SEDDON: Yeah. I think from the medical
21 physics side of the fence, you know, you want to
22 encourage that, you know, they do that step of
23 redoing the calculation, confirming whether there's
24 an adjustment required, conferring with the
25 physicians; make sure it's not underreported because

1 you don't want -- if they get in trouble for
2 reporting things and they just have the therapist
3 level, they refuse to -- don't want to report it
4 just because, you know, they might cause issues.
5 You want to try to encourage them as a form of
6 improvement, patient safety approach. So they
7 actually are going ahead and doing those steps to
8 make that determination whether it is reportable to
9 you guys.

10 CLARK ELDREDGE: Right.

11 KATHLEEN DROTAR: And I would add to that as
12 the therapist, that you need to be able to go to the
13 physicist or the physician and say, hey, look at
14 this. It may not be right. It looks like there's a
15 shift. Patient could have lost weight and there's a
16 whole shift involved.

17 MARK SEDDON: Right.

18 KATHLEEN DROTAR: Or if there's a shift that's
19 ordered and somebody hasn't seen the verification
20 films or just goes ahead and treats with
21 verification films, like we've had happened last
22 year, that there's somebody that's going to be able
23 to say, well, this was -- this part was treated, but
24 it doesn't impact on the overall. And that it gives
25 the therapist a lot more ability to bring things

1 forward to question, which is where the physicist
2 and the oncologist should be coming into the
3 conversation.

4 MARK SEDDON: Right. So they would be making
5 that decision on their part. You put here where
6 they're doing the recalculation determine, you know,
7 the actual dose difference. That's key. So I like
8 that.

9 CLARK ELDREDGE: Okay. Any other comments,
10 suggestions, observations?

11 MARK SEDDON: Dr. Williams is not here. I'm
12 sure he'd have comments. Isn't the weekly 50
13 percent, though, or is it 30? I thought it was 50
14 percent.

15 CLARK ELDREDGE: Weekly is 30, I think. Is it?
16 Come on. Sorry, 30. Calculated weekly is 30.
17 Total is 20 when it's -- and 10 percent when it's
18 fewer than three fractions. Three or fewer
19 fractions.

20 JOHN JORDAN: Larry, is there a caveat in case
21 the patient dies before he gets the full treatment
22 and ends up with 20 percent less? Is that an event?

23 CLARK ELDREDGE: So if the -- so basically, if
24 the patient doesn't survive treatment just for other
25 medical reasons, it's palliative care or something.

1 JOHN JORDAN: Right. Takes off, decides he
2 doesn't want the full treatment, but it's 20 percent
3 less because he quit taking the treatment.

4 CLARK ELDREDGE: That wouldn't be -- no. That
5 wouldn't -- and this is under control. There is
6 some concept if it's stuff within the control of the
7 facility.

8 KATHLEEN DROTAR: It's always the patient's
9 right to decline.

10 ADAM WEAVER: Read the definition of tube.
11 There's nothing wrong.

12 JOHN JORDAN: So these are ands instead of ors.

13 ADAM WEAVER: Yeah.

14 CLARK ELDREDGE: Yeah, there is, as I say,
15 somewhere we've got it where there's a clear
16 statement about it being --

17 ADAM WEAVER: Yeah, it's either two or three
18 apply here. If they cancel the treatment, they say
19 they don't want to do it anymore or they pass away
20 or they --

21 CHANTEL CORBETT: Refuse the rest of the
22 treatment.

23 ADAM WEAVER: Yeah.

24 JOHN JORDAN: The machine breaks down.

25 ADAM WEAVER: That's not a misadministration.

1 CLARK ELDREDGE: Yeah. Okay. You all were
2 sent out an e-mail. This is where I want some
3 feedback to see if you all have any items that we
4 need to be aware of.

5 Again, going to the CRCPD meeting, they -- this
6 actually is something that Kevin, for Kevin,
7 although the presentation earlier today kind of went
8 in a bunch of that already. You've got it up there.

9 But just so that we are -- just so that we're
10 aware of changes, if, you know, whenever we get, you
11 get the opportunity, if you would let us know what
12 you're hearing type thing of any new -- of any new
13 and evolving practices, you know, whether or not
14 they are going to impact regulatory or to make sure
15 that we understand that they have no impact on
16 regulatory. These are just a few of the things that
17 they mentioned in passing at the CRCPD meeting about
18 evolving practices.

19 They showed -- they had a slide of an
20 interesting tunnel-looking device and mentioned
21 heating up the patient before performing either
22 radiation or chemotherapy. Saying that hot tissues
23 don't respond as well to healing, et cetera, as -- I
24 thought the later, accelerators for ventricle
25 tachycardia, so working, using accelerators for --

1 now really, none of these particularly would
2 necessarily have any change in how -- none of these
3 I really see upfront they can have an impact on how
4 we're going to regulate anything.

5 Now, the handout in your thing about the Zap-X,
6 here is one where ourselves and our procedures,
7 itself, may be impacted. It is a self-shielded
8 therapy machine. A pod the person slides into.
9 It's fully, you know, it's primary and secondary
10 beam block, you know, primary beam block, secondary
11 scatter shielding or primary scatter shielding is
12 fully contained in here. It's a 2.7 MV photon
13 accelerator. It's for lesions, brain lesions
14 treatment. And part of the safety procedure on this
15 is it has sensors built around it, sets up a
16 electronic fence around it. So when somebody
17 crosses the threshold, the machine will shut down.
18 But other than that, there is no physical
19 interlocks, not like a normal therapy vault type
20 thing. It's intended to be put in a large room
21 with, you know, microwave sensors and lasers around
22 it to check where people are standing. Make sure
23 they're away from it. The person slides in, get
24 treated and slides out.

25 So in our case, currently with therapy, of

1 course, we have to have shielding designs submitted.
2 we look at surveys and things like that. And so,
3 this kind of changes all that when the device is
4 intended to be self-shielded and self-contained.

5 ADAM WEAVER: What kind of dose rates are they
6 seeing?

7 CLARK ELDREDGE: Okay. The first one was
8 installed in Arizona, I hadn't heard the numbers on
9 it. The second one is going to be being put in in
10 Miami some time later this year. We'll find out at
11 that point. And I don't --

12 LEO BAKERSMITH: When you go to their website,
13 it basically shows an animation of a person in the
14 room while the treatment is going on.

15 CLARK ELDREDGE: So I do not know the exact
16 numbers that they published. Lisa has been, Lisa
17 Gavathas has been talking to them for us.

18 MARK SEDDON: How does this compare to the
19 Mobetron? How do you handle those?

20 CLARK ELDREDGE: I'm sorry?

21 MARK SEDDON: The Mobetron, the intraoperative
22 system. I think Mayo has one. Like the -- like an
23 intraoperative accelerator used in the OR.

24 DAVID O'HARA: The Mobetron still requires
25 normal shielding.

1 CLARK ELDREDGE: I mean, you have to worry
2 about with those, you do have to set parameters and
3 all that, and there is shielding, you know, mobile
4 barriers that are used and things like that. The
5 fact that you actually have to have the surrounding
6 rooms have to be evaluated for those. You have to
7 have surveys around for intraoperative systems.

8 MARK SEDDON: Right.

9 ADAM WEAVER: So they're not self-shielded like
10 this.

11 CLARK ELDREDGE: No, they're not self-shielded.

12 MARK SEDDON: Right.

13 CLARK ELDREDGE: You have to -- right.

14 DAVID O'HARA: Do we simply consider that the
15 machine, itself, is the room?

16 CLARK ELDREDGE: That's -- yeah. I mean,
17 that -- but it's more like it's a cabinet system
18 than a room.

19 ADAM WEAVER: Well, you still have a body part
20 for a potential scatter to exit.

21 MARK SEDDON: Yeah.

22 ADAM WEAVER: It's not totally enclosed.

23 CLARK ELDREDGE: Enclosed. I mean, although --

24 ADAM WEAVER: At least from the picture anyway.

25 CLARK ELDREDGE: From the diagram. But it does

1 have shielding at the end of it. I mean, it is
2 designed to cap off. Now, I do not know that the --
3 what am I trying to mumble? It's supposed to have,
4 again, primary scatter shielding all the way, and
5 so, it's just secondary that's -- secondary scatter
6 around the --

7 ADAM WEAVER: So the picture is better than
8 the --

9 CLARK ELDREDGE: Yeah, this picture here. So
10 this is supposed to -- I've not seen that the sides
11 here are shielded, but the end is. It was described
12 to me that as this comes in, it blocks the scatter
13 coming down here.

14 LEO BAKERSMITH: If you go to their site, it's
15 all, it shows --

16 ADAM WEAVER: They have like an iso --

17 LEO BAKERSMITH: Yeah, they've got a --

18 ADAM WEAVER: Isodose.

19 LEO BAKERSMITH: It doesn't have an isodose in
20 the pictures that I've seen.

21 CLARK ELDREDGE: I'm drawing a picture, if you
22 can follow my laser pointer. It's supposed to be
23 somewhat of a doughnut shape or little of an, excuse
24 me, or a figure 8 shape around, key hole shape
25 that's the perimeter that they measure for folks to

1 stay away from it.

2 But so, this again, this is new and emerging
3 tech that we're going to have to follow and adjust
4 some inspection criteria or evaluation and
5 registration criteria for. We have yet to see -- we
6 should shortly be seeing how they actually play out
7 when it's installed in Miami.

8 CHANTEL CORBETT: So you're saying like this
9 virtual vault of a system. So you have housekeeping
10 that walks by, oh, what a cool thing in the middle
11 of a treatment and it's going to shut down the
12 machine?

13 CLARK ELDREDGE: Something to that effect,
14 yeah.

15 CHANTEL CORBETT: Yeah, I don't think that's 16
going to be good. I think I'd rather just build a 17
room around it be able to shut it off.

18 LEO BAKERSMITH: I'm thinking where it's going
19 in Miami, it's going to end up going in a room
20 anyway, isn't it?

21 CLARK ELDREDGE: Yeah.

22 CHANTEL CORBETT: From a facility standpoint, I
23 think it would be easier in the long run.

24 CLARK ELDREDGE: Now, the facility in Miami
25 currently has a gamma knife.

1 LEO BAKERSMITH: They're supposed to put it in
2 the same room?

3 CLARK ELDREDGE: Anyhow. I had -- is that all
4 mine? Is it now yours? Did I cover my three
5 things?

6 DAVID O'HARA: All right. Well, at BRC, we
7 often got phone calls from machine users who do not
8 want to pay for the yearly fee for their machine.
9 And this is because their machine is in storage and
10 they think that my machine is in storage, why should
11 I have to pay for this?

12 Now, remember, we're not talking about much
13 money at all. I mean, you spend more on coffee in a
14 week than these people are talking about, but they
15 are adamant about this. They don't want to pay for
16 their machine that's in storage. Okay.

17 So what we -- the machine owners need to know
18 that they are not just paying for the registration.
19 We're required by law to inspect these machines.
20 They are also paying for the inspection whether the
21 machine is in storage or not. The inspector is
22 going to have to go over there and find this machine
23 at the bottom of somebody's closet and pull it out
24 from under all this stuff and inspect it. And so,
25 that's what this, this fee is covering. It's not

1 just the fact that the machine has been registered.

2 So -- and the typical machine that is in
3 storage, I went through our database, and by far,
4 the typical machine that is -- has been put in
5 storage, is an older non-digital Intra-Oral dental
6 machine. So these machines have been put in storage
7 just in case the primary machine doesn't work.
8 These guys should simply get rid of them.

9 So this raises the question of when do we not
10 assess fees for machines. And possession of a
11 radiation machine requires a registration fee. And
12 the standard for assessing the fee or for not
13 assessing the fee is whether the machine is truly
14 defunct. If it has a power supply, if it has the
15 controller and it has the tube and all of those
16 three things are there and all three things work,
17 then that is a radiation machine and we will charge
18 the fee for it. They can't get away with simply
19 chopping one of the leads off of it and saying it
20 doesn't work. That's because they could very easily
21 put that back together. So as long as they have
22 those three things, it is considered a radiation
23 machine and we'll charge a fee for it.

24 Now, that raises the question of what -- when
25 should we not be assessing the fee? And if they get

1 a vendor out there and the vendor says this machine
2 is dead, it's going to require -- you have to
3 replace the tube or replace this or that, then
4 that's fine. we'll take the vendor's word for that.

5 If it's in a condition where the vendor says,
6 well, we're going to essentially have to rebuild
7 this machine, so it's going to be a different
8 machine, so you're going to have to resubmit this
9 2579 form, then we'll simply re-register it as a
10 different machine.

11 There are some machines that people will simply
12 keep for God-only-knows what reason. But they are
13 very -- they are antiquated. They are obviously not
14 intended for use and they are just to look at.
15 They're boat anchors.

16 Okay. So the other issues that -- another
17 issue that we often see is vendors -- first of all,
18 are there any questions about that? About when we
19 do or don't assess the fee? Okay.

20 We often hear about vendors -- about people
21 obtaining machines from outside the normal vendor
22 distribution channels. And this is specifically
23 through EBay. There's been a problem with people
24 obtaining a specific dental, hand-held dental
25 Intra-Oral device through EBay. And this device is

1 okay in Europe, but it is not FDA approved. So
2 they'll buy this thing and when they go to register
3 it, they find, oh, I can't register this thing. We
4 require that they prove that they have gotten rid of
5 this machine because we obviously cannot register
6 it. The FDA won't allow us to register this
7 machine.

8 So if you were to, to see how -- what the issue
9 is, you should probably go on to EBay and look under
10 x-ray tubes or x-ray equipment and you would be
11 shocked at what's available out there. I mean, I
12 could buy a complete x-ray system for very little.
13 I know from personal experience, I can buy a
14 complete electron microscope that works for less
15 than \$2000 on EBay.

16 But here's a few things I found on EBay. These
17 hand-held XRF systems that people use in scrapyards,
18 3 to \$6000. I think you buy them for somewhere
19 around the order of 25,000. A hand-held dental
20 Intra-Oral machine from China for \$500. I can't
21 tell whether these are toys or whether they're real.
22 And it doesn't say they're FDA approved, either.
23 But they're ones -- there is FDA approved is the
24 Aribex Nomad. There's one on EBay for \$2000. What
25 a deal.

1 You can get a chiro system for 4500 to \$6500.
2 You can buy a Sensus SRT-100. This is the
3 dermatology system, the therapeutic system. The
4 original price on one of these is a quarter of a
5 million dollars. You can buy it on EBay in
6 supposedly very good shape for 69K.

7 So the problem that I'm -- that we're seeing is
8 that people are going on EBay and they're buying
9 outside of the normal distribution channels and a
10 lot of people don't know they should be licensing
11 these things or they simply forget to do so. They
12 run into problems when they do try to license them.

13 All right. There are some exemptions to what
14 is required to be licensed. And that is typically
15 if it can produce radiation, but if the radiation is
16 incidental to the operation of the machine, or it
17 produces less than 5 mR per hour at five
18 centimeters, then it doesn't need to be registered.

19 And let's see. Some of the machines that, that
20 we're currently -- that we don't register, that
21 actually do produce radiation, is obviously electron
22 microscopes. Electron microscopes, they can produce
23 up to 50 kilovolt electrons. They can produce
24 x-rays. But the power that an electron microscope
25 puts out, if a typical medical x-ray tube is

1 hundreds of watts, an electron microscope is
2 hundredths of watts. And they also operate in a
3 vacuum. And if you happen to break the vacuum, then
4 the machine is not going to work. There's
5 essentially zero chance of radiation getting out of
6 the electron microscope, so that's why we don't
7 register electron microscopes.

8 There are these gadgets called OJ electron
9 spectrometers. You typically find them at
10 universities. They are research instruments. They
11 are just like an electron microscope, but they even
12 require a better vacuum than the electron microscope
13 does. So we would probably not register them as
14 well.

15 There are these things called Extreme
16 Ultra-Violet Systems. They're starting to be used
17 for printing microchips. When they put the photo
18 resist down, they put this to polymerize the photo
19 resist and that also requires a vacuum system and
20 the radiation there is on the order of about ten
21 electron volts up to about a hundred electron volts.
22 These are -- if you break the vacuum, you're not
23 going -- they're not going to work anymore, so they
24 would not be registered.

25 Another device that you would find in a -- in

1 research labs like universities, X-ray
2 Photo-Electron Spectroscopy. This uses about a 15
3 kilovolt tube. But it is an ultra-high vacuum. If
4 you break vacuum, this thing is not going to work.
5 And so, they probably should not be registered.

6 There's one that currently is registered and I
7 think we need to clarify this.

8 Let's see, some machines that are open for
9 discussion about whether or not they should be
10 registered. There are electron beam welding
11 machines and what -- this is what it sounds like,
12 you have two pieces of metal and you put it in this
13 vacuum chamber and the electron beam comes down and
14 melts both of them together. The diagrams for these
15 things look exactly like an electron microscope
16 except they are operating at up to 200 KVP and tens
17 of amps. So these things can actually produce huge
18 flux of x-rays inside the system. They typically
19 operate in a vacuum. And the electron beam won't
20 operate if the vacuum is broken. So right now, we
21 do not register these machines.

22 This was a report of where an operator had the
23 leaded glass in the viewpoint had broken and he had
24 replaced it with normal low density glass and
25 supposedly he got a pretty good dose from this. And

1 as long as they keep the thing, the glass -- as long
2 as they keep the ports in place, they're in good
3 shape.

4 Electron Beam Evaporation Systems.

5 CLARK ELDREDGE: So any -- so the question here
6 is, do you all have any consideration on the
7 specifics for the electron welders of us going to
8 pursue these folks for registration? We aren't
9 really sure where they are. This is second-hand
10 verbal.

11 DAVID O'HARA: There are only two electron beam
12 welders in Florida.

13 CLARK ELDREDGE: But the fact that they
14 actually did mishandle these devices and cause an
15 exposure to the operators. Even though under normal
16 operation, they shouldn't be a problem.

17 CHANTEL CORBETT: How was it determined that 18
they exposed the operators?

19 CLARK ELDREDGE: Well, they had a health
20 physicist come and check it and he reported it to
21 us.

22 REBECCA MCFADDEN: So there's only two of these
23 things in the whole state?

24 DAVID O'HARA: Yes.

25 ADAM WEAVER: It's kind of older technology.

1 We used to have some when I was with Department of
2 Energy and we did have a lead window failure.

3 DAVID O'HARA: There's a new iteration coming
4 along. There's a new iteration on this coming along
5 that may make the situation worse.

6 WILLIAM ATHERTON: That may be significant. If
7 I may ask, so I would recommend that it should be.
8 At least there's only two.

9 ADAM WEAVER: It's not a direct purpose of the
10 machine to generate an x-ray. It's a by-product.

11 WILLIAM ATHERTON: Oh, okay.

12 CLARK ELDREDGE: Although it's still generating
13 radiation, it's an electron beam. So it falls under
14 our regs.

15 DAVID O'HARA: It's significant radiation.
16 They're producing x-rays.

17 ADAM WEAVER: You can't produce it without a
18 vacuum.

19 DAVID O'HARA: Right. It turns out that one of
20 the things they're doing now is they are building
21 machines like this where they bring the beam out
22 into the open air. I don't know what kind of window
23 they're using, but they're bringing this many amp
24 beam out into the open air and, of course, they've
25 got to have shielding around this, but when -- if

1 anything like that is ever put in Florida, it would
2 obviously have to be registered. I mean, that is
3 certainly producing radiation.

4 ADAM WEAVER: Using that at like a shipyard or
5 an industrial?

6 DAVID O'HARA: The drawings I saw did not look
7 big enough to put them in a shipyard, but they are
8 putting large objects in there. Things that cannot
9 go into a vacuum system. So they will require --
10 something like that is -- should obviously be
11 registered. It's producing x-rays.

12 ADAM WEAVER: Do you have, like, a manufacturer
13 so you can search?

14 DAVID O'HARA: Yes. I talked to the
15 manufacturer about this and he said that that is
16 going to be their next big product.

17 CLARK ELDREDGE: Their opinion is they should
18 be registered.

19 DAVID O'HARA: The manufacturer thought so.

20 ADAM WEAVER: Are other states registering
21 these devices?

22 DAVID O'HARA: I simply don't know.

23 ADAM WEAVER: That is a question you could ask
24 the CRCPD folks.

25 RANDY SCHENKMAN, CHAIRPERSON: why is the

1 manufacturer recommending that they be registered?

2 CLARK ELDREDGE: This is for the open beam one,
3 because they do recognize it's an open beam.

4 DAVID O'HARA: This thing, it's open so that
5 they can put a large object in there. And if they
6 have some very large object, and you've got -- even
7 if the space between the beam window and the object
8 is a few inches, you're still getting x-rays going
9 laterally.

10 ADAM WEAVER: Scatter all over the place.

11 KATHLEEN DROTAR: Just from radiation safety
12 for the employee, that there needs to be some kind
13 of structure and guideline and registration if we're
14 talking about that.

15 ADAM WEAVER: I'm sure if they're going to use
16 it, they're going to have shadow shielding around
17 it.

18 KATHLEEN DROTAR: Not necessarily.

19 ADAM WEAVER: Well, just on how I've seen them.

20 KATHLEEN DROTAR: The manufacturer, yes. But
21 then the user, somebody took a -- a window fractured
22 and they just put a regular glass, they don't know
23 the equipment that they're using, because typically,
24 if somebody comes in and shows you how to use it,
25 and not why or what the, what the safety concerns

1 might necessarily be.

2 DAVID O'HARA: You can assume that the
3 quantities are always going to be very low on this.
4 But the manufacturer of this new device was very
5 clear that it should be registered.

6 LEO BAKERSMITH: Is the manufacturer going to
7 inform you guys when they sell one in the state?

8 DAVID O'HARA: We didn't discuss that.

9 ADAM WEAVER: Otherwise, how --

10 LEO BAKERSMITH: How would we know what's
11 happening?

12 DAVID O'HARA: Okay. And let's see.
13 Industrial devices that -- certain devices that do
14 not require a vacuum that are -- that we do require
15 registrations, are hand-held XRFs. These -- we just
16 discussed these atmospheric electron welders that we
17 will require registration. We require various
18 industrial process gauges. Gauges measuring the
19 thickness of paper and various things like that.
20 They obviously require registration.

21 A machine that we may start seeing some of is
22 an electron beam exposure system for curing
23 polymers. And this is a machine -- there are some
24 of them are actually accelerators for curing
25 polymers and those are already -- we all know those

1 are radiation machines. The ones I'm talking about
2 are much smaller where they have a beam about this
3 big around, this big (indicating), and they are
4 typically used for curing the photo resist on a, on
5 silicon wafers. So they would be in silicon wafer
6 fab places. And there's probably very, probably
7 little chance of getting exposure -- however, if
8 somebody came up to the thing, they could, they
9 could be exposed to it.

10 It's not clear -- well, the pictures that I
11 saw, they were definitely not in vacuum. But my
12 guess is that they would be, would all be robots
13 around this thing. But if somebody was to open the
14 system and go in, they could be exposed to it. But,
15 so, we need to, at some point, may need to look into
16 licensing of these, of these machines.

17 LEO BAKERSMITH: Do we not currently with -- I
18 mean, device makers that I can think of that are
19 using the wafers, most of them have kind of gone out
20 of business. But a lot of them were licensed for
21 krypton. When we were, like InterCell and Harris at
22 a time when they were doing chip making and using
23 the wafers. AT&T, at a time, was doing that, too.
24 They were licensed by us. So I don't think they
25 would be abhorrent to probably registering these

1 machines.

2 DAVID O'HARA: Well, the reason I bring this up
3 is that we registered a machine in, in Orlando that
4 was an experimental Extreme Ultra-Violet machine.
5 And I wasn't really sure that this machine should be
6 registered. It was a -- I'm familiar with the
7 machine, itself, and I know that it can't operate if
8 it's been opened. And I know that it doesn't
9 produce any radiation outside the system. And like
10 I say, the radiation is between 10ev and 100ev. It
11 will not even pass through air. I'm not sure the
12 machine should have been registered. So that's the
13 Extreme Ultra-Violet systems and then there are
14 these electron beam curing systems.

15 So does anybody have anything to say about
16 these?

17 ADAM WEAVER: I haven't seen one of those yet.
18 Maybe I should check on a solar panel or solar
19 people, see if they have something like that. I've
20 never seen one of those in the state.

21 DAVID O'HARA: But if you -- if any of you
22 happen to see unusual machines, let me know, because
23 I'm the person who is supposed to be dealing with
24 these things. So give me a call.

25 MARK SEDDON: Do you have a criteria?

1 ADAM WEAVER: Wouldn't that be covered under
2 your current one?

3 DAVID O'HARA: Pardon?

4 ADAM WEAVER: Atmospheric electron welders.
5 You have that one covered.

6 MARK SEDDON: Do you have some type of standard
7 you follow? Is this -- is every time it's subject
8 to review?

9 DAVID O'HARA: No. We typically go by the,
10 the, the exemption guidelines.

11 ADAM WEAVER: The definition.

12 CLARK ELDREDGE: The statute does say if the
13 purpose -- if the working function of the machine is
14 to, is to -- it uses radiation to do its job, it's
15 got to be registered. So what we then are looking
16 for reasons not to register it that we cannot issue
17 an exemption.

18 MARK SEDDON: Gotcha.

19 CLARK ELDREDGE: Or not issue an exemption,
20 just not ignore it. Our version of issuing an
21 exemption is, yeah, now you don't need to do it. We
22 don't actually issue a formal exemption.

23 So that's -- and the curing systems, I mean,
24 those are -- I see them being, you know, almost
25 being like our gauge systems. Any industrial work

1 line, you know, gauge system, so that, you know,
2 unless they're actually in some sort of -- when they
3 finally get, you know, somebody actually brings it
4 to us and says this is how it's been set up. Unless
5 it is some other controlled environment, then I
6 suspect they'll have to register it just because
7 it's like any, as I say, bottle line or any other
8 process line that we do where the soda, the fill
9 measuring device is on the soda lines and all the
10 bottlers. Even though they've got certain -- Leo,
11 when is the last time you inspected one of those?
12 They have a certain --

13 LEO BAKERSMITH: Pepsi Cola. Lays has them. 14

CLARK ELDREDGE: You have a certain distance. 15
They have a certain safety area where you can't get 16
that close to where that spot is and that's

17 basically how -- they will have some beam block on
18 the other side and the main way to control the
19 scatter is you have an industrial distance you have
20 to be away from it. And if somebody crosses the
21 boundary, it usually shuts down the production line.

22 DAVID O'HARA: I also think we're going to
23 continue to see or the problem of people obtaining
24 machines from outside of the normal chain of vendors
25 is going to get worse because the machines have

1 become extremely expensive. And you go online and
2 start looking for surplus machines. And it would be
3 really tempting to go that way instead of buying one
4 from the vendor.

5 ADAM WEAVER: You can even buy x-ray machines
6 from a lot of facilities that close down and they
7 have a -- they have a vendor come in and sell
8 everything.

9 MARK SEDDON: Like an estate sale.

10 ADAM WEAVER: Yeah, like that. They have a lot
11 of those offered.

12 CLARK ELDREDGE: I had the opportunity to buy
13 one at an FSU surplus auction one time. It was an
14 old one and would've took up this room for all the
15 equipment. But, you know, now the current, I want
16 to clarify the current tact we're talking and this,
17 of course, is only for human exposure. Medical use.
18 So it's the FDA devices is that if someone purchases
19 one, we give them first the opportunity to say, can
20 you -- can you demonstrate to us that this is FDA.
21 So they have the option of going to the manufacturer
22 and see if they can get some certificate from them
23 or you hire their own engineer to have that
24 approved. And if they can't, then we tell them, you
25 know, you can't hold it. You can dispose of it.

1 Or actually, I've come up -- the other thing is
2 they can convert it to industrial use. Because, of
3 course, we're not worried about what's in the beam
4 for an industrial-use device. And then you have to
5 come up with the radiation safety plan and how it's
6 going to be used, et cetera.

7 So any questions, any on that, that our current
8 policy for those?

9 ADAM WEAVER: As long as you define human use.
10 That's the important thing. There are other uses.

11 MARK SEDDON: I think long-time hospitals have
12 the question, you have the cabinet top unit that's
13 just user specimens, is that really human use or is
14 it just use?

15 CLARK ELDREDGE: For that RSU, what's easier
16 for you to handle in your inspection and inventory.
17 We've had some that would prefer to have them on
18 their --

19 MARK SEDDON: I see them both.

20 CLARK ELDREDGE: I mean, specimen cabinets is
21 really industrial.

22 MARK SEDDON: Yeah.

23 RANDY SCHENKMAN, CHAIRPERSON: All right.

24 JOHN JORDAN: The hand-held dental unit that's
25 not approved by the FDA could be used on animals by

1 a veterinarian?

2 CLARK ELDREDGE: It's non-human.

3 RANDY SCHENKMAN, CHAIRPERSON: I think we're
4 going to have to move on, unless anybody has
5 anything else specifically related to this.

6 JAMES FUTCH: So last little bit before we work
7 on dates for next meeting.

8 Two things. I want to bring you up to date on
9 the rule making since the last meeting in May of
10 2018. And you -- I don't think you have this in
11 your packet, but this is the adopted regulation.
12 I've highlighted it for you and you've seen it all
13 before.

14 So basically, what's changed is we have adopted
15 some, some practice standards. So we have now
16 adopted the practice standards -- this was in
17 October of last year -- for radiographers, nuclear
18 medicine techs and radiation therapy technologists.
19 This is in yellow up here in regulation legal speak.

20 We already had a practice standard. It was
21 essentially the definition of the practice of
22 radiologic technology since 1984 on, I think. It
23 was very general. The performance of activities
24 requiring special knowledge and skills, including
25 physician technique, safe operation of equipment and

1 radiation protection. Each of those terms,
2 physician technique was defined in the regulation
3 going way back.

4 So what we've done here is basically added to
5 that and say for radiographer, the practice is
6 further specified in the ASRT practice standards for
7 radiography dated June 2017. So you're now attached
8 to the national practice standards for those same
9 professions in Florida.

10 And if somebody figures out a way for me to do
11 that for basic machine operators, I'll be happy to
12 do that, but I'm not sure. Maybe ASRT will come up
13 with one.

14 Let's see. What's happening here? That was
15 October last year.

16 We also updated the basic machine operator
17 study guide, which is the commonly available
18 textbook by Bruce Long, et al, Radiography
19 Essentials. We've updated it, at this point, to the
20 Fifth Edition. I think they may be out with the
21 next one or coming out with the next one soon. That
22 was in August.

23 And then going down to the thing that Chantel
24 alluded to, that's just, that harken back to
25 Christen's language on what she has to submit for

1 her -- that did not change. I highlighted that in
2 blue to remind myself to talk about it.

3 So specialty technologists, we adopted, after
4 many years of work with the NMTCB and the Society
5 for Nuclear Medicine and Molecular Imaging, the CT
6 pathway from NMTCB as a qualifier to get a CT
7 license in Florida. And that's what this language
8 is doing in the middle of the page.

9 So you can come in for a Florida CT license by
10 endorsement with ARRT, which has been for many, many
11 years -- now you can do it with a current CT license
12 issued by NMTCB. You can come in through either of
13 those two pathways to get a CT license in Florida.
14 We've modified the proof requirement a little bit up
15 above what proof means and what the wallet card has
16 on it.

17 And then the practice standard that goes with
18 that. And this was the big, the big sticking point
19 from our perspective is we have the same practice
20 standard for both of those folks, because the
21 societies worked it out. And the ASRT has
22 referenced NMTCB folks in this practice standard.
23 So it covers both. So we don't have two different
24 practice standards for the same CT license in
25 Florida. And that's what happened rule wise with

1 64E-3.

2 Since then, that's pretty much everything
3 that's changed in the past year. And the page makes
4 reference to 64E-4 updates and there are essentially
5 none, but I will probably be working to update the
6 reference to the American National Standard that's
7 used in the laser regulation to the current AN2036,
8 voluntary national standard that's used in the rest
9 of the country, and which they're training ocean
10 inspectors all over the country to use when they go
11 into laser facilities to see if there are any
12 violations of OSHA regulations. Okay. So that's it
13 for the rule update.

14 One more thing which is not explicitly on here.
15 If you will pass that to the council members down
16 there. I apologize, I only have one of these sheets
17 of paper. Each council member just take one. I
18 wanted to give you a snapshot of radiologic
19 technology enforcement standards because you spend
20 an awful lot of time and effort in this area.

21 So Gail's group and MqA handles the day-to-day
22 licensure and the Bureau of Radiation Control --
23 it's the same thing on the screen for the rest of
24 the audience. The bureau of Radiation Control
25 remains responsible for updating regulations,

1 representing the department in -- when the
2 Legislature asks or proposes any legislative changes
3 for which, by the way, there were also none this
4 year that we're aware of. And the lawyers say there
5 were none, so I believe them.

6 But we also still as part of the rule making,
7 determine based upon the statute, what the penalties
8 are for violating the different disciplinary
9 statutes that exist, and there are statutes for
10 committing crimes, there's statutes for being
11 disciplined by a national organization. Whether or
12 not you currently still have the license or not.
13 There are statutes for being impaired. The general
14 ones under professional conduct; all those kinds of
15 things. That's comes back to the Bureau. Our
16 inspectors that some of them you see here, if they
17 find somebody, for example, working on an expired
18 license, that will come to us. We will actually
19 convey that into the disciplinary process, and then
20 at the end of it, the prosecutors will come back to
21 us to make a determination whether there's probable
22 cause to go forward with the prosecution. And what
23 they don't come back and ask us is what the penalty
24 should be. That's in the regulation. They figured
25 that out.

1 So we have, we have staff, Lynne Andresen, who's
2 very involved in this process; of course, the
3 inspectors in the field who are looking for these
4 kinds of violations and others when they're in the
5 facilities. We are working with the department's
6 investigators, one or two operations where someone
7 made a complaint. Hey, there's this person who's
8 doing this in this facility. We'll bring along an
9 MqA investigator from the other part of the
10 department with one of the State inspectors from our
11 part of the department and they'll go in and see
12 what's going on.

13 All of that is managed and it's constantly, new
14 complaints coming in; old complaints being processed
15 through the prosecutors; determinations being made
16 of probable cause. And then actual prosecutions and
17 what we call final orders. The end result of all
18 this, where the hearing officer, the administrative
19 law judge say, yes, this penalty has been imposed.
20 You've been reprimanded. Your license has been
21 revoked.

22 So this is a snapshot where things have been
23 the last year with Rad Tech enforcement cases. I'll
24 start out at the top. As of May last year, roughly
25 the time of the last meeting, there were about 80

1 open enforcement cases against Rad Techs of all
2 different types and varieties. Since then, they've
3 opened -- a few more complaints have been filed.
4 Nine new complaints since May of 2018 have been
5 brought to our attention and filed because of
6 unlicensed activity found during BRC inspections.
7 One AHCA exemption request that turned into an
8 unreported crime that turned into a complaint
9 against someone, AHCA exemption requested. Does
10 everybody know what that is? So a different agency,
11 the Agency for Health Care Administration has a
12 different statute under Chapter 435. They license
13 hospitals and certain other facilities.

14 So the Legislature, several years back, told
15 them, look, you need to be reviewing staff in
16 certain levels of administration, doing background
17 checks to see if there are unreported crimes. And
18 AHCA has been doing that for, I think like ten years
19 now. Maybe a little bit less. And when they find
20 someone who is in a facility -- and there's a
21 certain list of higher level crimes, felony stuff;
22 things of this nature, crimes against people
23 especially, they find someone who's an employee in
24 this facility, that person is essentially, as of the
25 date that AHCA notifies the facility, they can't

1 work. They can still work for the facility, but
2 they can't work doing that job dealing with patients
3 as of that point. At that stage, AHCA can grant
4 exemptions. They can actually go and look at the
5 facts and say, okay, well, you know, this is, yes,
6 we know this is a qualifying crime, but it's been 20
7 years and, you know, all of -- you're not a threat
8 anymore.

9 For any licensed professions in which AHCA is
10 not the licensing agency which, of course, is all
11 the health care professions, that has to come back
12 to the licensing agency, which is the Department of
13 Health. And then we have to go and evaluate whether
14 or not to actually grant that person an exemption
15 underneath this part of the statute.

16 In nine times out of ten, we do because usually
17 the person has reported a crime to us when they
18 initially became licensed. We made a determination
19 it wasn't a patient safety issue. So we let them
20 into the practice and they get caught in this at the
21 back end.

22 By the way, they do this every five years.
23 We've now had people that are caught in this the
24 first time and then five years later, they come back
25 to this again, no crime, no nothing has changed. We

1 have to give them an exception or we have to look at
2 that time it again anyway. In the meanwhile, they
3 can't work in the capacity of patient caregiver.

4 Sometimes, in this case, with this one person,
5 they didn't tell us about the crime when they first
6 were licensed with the department. So what we do,
7 we still look and see whether or not it's something
8 that's related to patient safety now and it's not
9 one of the flat out, you cannot work in this
10 profession. Like there's certain levels of sex
11 offender crimes. It doesn't matter how long it's
12 been, you're not going to work in this.

13 In this case, this person didn't tell us about
14 it, so that becomes a disciplinary complaint.
15 That's obtaining a license by fraud. And then that
16 goes into this whole process and it will eventually
17 come out the back end. So that's just new activity.

18 And the non-payment of student loans.
19 Somewhere in the middle of 2017, I think it was,
20 there was some statutory changes and the Department
21 of Education, I think, went to the Legislature and
22 said we have an awful lot of student loans and we
23 can't get these folks to pay them back and you've
24 got licenses issued by various licensing issues in
25 Florida that is allowing them to earn a living. We

1 need to come together some place and figure this
2 out. So now there's statutory authority to charge
3 not just Rad Techs, but any licensed health care
4 professional.

5 And so in May of 2018, 16 new cases of student
6 loans were entered as complaints into this system.
7 And I'll show you the outcome down here, some of
8 this. So that's a snapshot of May 2018, 80 cases,
9 new activity, another 26 cases or something like
10 that.

11 Fast forward, since that same time period, 25
12 of those cases you saw above, have turned in to
13 final orders. So they have now become -- they've
14 gone through all the legal process, appeal and all
15 the rest of that kind of stuff, and this is the
16 outcome of that. And we've kind of broken it down
17 for you by type of offense and number of incidences
18 of those offenses.

19 So the first one, ARRT acted against somebody,
20 revoked them, reprimanded or fined them. That
21 person was acted against in Florida for the same
22 person. We usually do what ARRT does in the
23 process.

24 The whole next section is conviction-related
25 stuff. Convictions not reported on the original

1 license application. Convictions for batteries,
2 conviction either against people or things somehow
3 related to radiologic technology.

4 Impairment, that's a huge one. Usually these
5 result in someone going into a treatment monitoring
6 program, which is for Florida, Physicians Recovery
7 Network, which is PRN. I forget what it is.
8 They're both in Fernandina Beach. And you try and
9 give the person, you know, the proper treatment to
10 get their problem fixed while restricting them from
11 practice as need be by the doctors.

12 Non-compliance, this is what happens, for
13 example, one of those six people stopped complying
14 with the PRN folks, they come back to us to act
15 against them.

16 The rest of this in the middle is
17 unprofessional conduct. Some of those it -- I think
18 Lynn has listed a couple of the things that
19 happened. Somehow they violated the scope of
20 practice in the process of administering various
21 things that usually they didn't have or they didn't
22 do it in the proper way.

23 Sexual misconduct, that's not convicted for it.
24 That's on a patient in the course of their duties
25 somehow.

1 unlicensed activity cases from the BRC
2 inspections. So the ones you saw above resulted in
3 these kind of penalties in five cases. And then
4 another ULA case from somebody who just filed and
5 went straight with the department.

6 So here's the current population. Same kind of
7 breakdowns you saw before, but this is fast forward
8 to now. There's 51 cases remaining. I'm not going
9 to go through each of these. It's the same topics.
10 These are just different case numbers. Different
11 numbers in each of those and in the bottom, we just
12 had a meeting not too long ago with the prosecutors,
13 and of these 51, 11 more of them are going into the
14 prosecution phase now.

15 Anyway, I think that's it. Yep, that's it. So
16 just an enforcement snapshot. So we haven't had
17 much interaction at this level of detail. We can do
18 it now. And I wanted you to be aware of it, just
19 from the standpoint of, hey, this is part of the,
20 you know, the Advisory Council. But also, so maybe
21 you can take back to your facility that there are a
22 lot of things happening. And I would highly advise
23 anybody who's a member of this or any other
24 profession, to go to your licensing website page and
25 pull down those disciplinary guidelines and look at

1 them. They're changing. The statutes change over
2 the years.

3 The student loan stuff is just, you know, that
4 wasn't there ten years ago, seven years ago. So
5 people have been practicing for a while, you know,
6 everybody is going to try to stay out of trouble, of
7 course. But people who have been practicing for a
8 while may not be aware of things that are changed
9 that are out there. And more importantly, you may
10 know somebody in your facility has done this and
11 doesn't want to have it reported and we'll find out
12 about it that way. So that's it.

13 WILLIAM ATHERTON: Is that based on the 22
14 files or so licensures?

15 JAMES FUTCH: Yes.

16 WILLIAM ATHERTON: That's the 22 percent.
17 That's not too bad.

18 JAMES FUTCH: Yeah. It's very small.

19 RANDY SCHENKMAN, CHAIRPERSON: Okay. Any other
20 questions for James? Okay.

21 NICHOLAS PLAXTON: I had a question,
22 backing up a little bit. You were talking about
23 the, the nuclear medicine techs versus the radiology
24 techs getting CT certification.

25 JAMES FUTCH: Right.

1 NICHOLAS PLAXTON: So with the nuclear
2 medicine techs, were they able to get certified
3 before or now are they able to get certified?

4 CHANTEL CORBETT: Only if they went through the
5 ARRT CT exam.

6 NICHOLAS PLAXTON: But now there's a
7 different exam.

8 CHANTEL CORBETT: Now there's an NMTCB exam as
9 well. So they can get either and apply for both.

10 JAMES FUTCH: And slightly different
11 philosophies apply for different organizations and
12 qualifying.

13 CHANTEL CORBETT: They're getting more closer
14 together.

15 NICHOLAS PLAXTON: Are they getting closer
16 together? Okay.

17 JAMES FUTCH: Chantel, so at the end of this,
18 all this, is it going to be exactly the same?

19 CHANTEL CORBETT: I'm afraid it's going to be
20 almost exactly the same.

21 JAMES FUTCH: All right. Well, it was fun
22 doing it.

23 CHANTEL CORBETT: I was not a happy camper. Me
24 and Katy O'Neill had a long talk.

25 JAMES FUTCH: When the first -- my recollection

1 is one the first fusion devices was a GE system with
2 a hawkeye option.

3 CHANTEL CORBETT: SPECT-CT.

4 JAMES FUTCH: Yeah, that was like when I recall
5 it was in 2000, the societies all kind of all came
6 together and said, look, what's happening with the
7 manufacturers of these devices. And we had, you
8 know, silliness like, you have to have two people to
9 operate this machine. One is a radiographer and
10 one is a nuclear med tech. I attended a couple
11 meetings, my staff attended some of the meetings in
12 '01 or 02 I think, with the societies and they
13 decided, ARRT decided to retool their CT exam from
14 an educational perspective to nuclear medicine
15 background who have to do some qualifying stuff.

16 CHANTEL CORBETT: Right.

17 JAMES FUTCH: NMTCB did a similar thing with
18 the PET exam.

19 NICHOLAS PLAXTON: PET/CT.

20 JAMES FUTCH: So the people from radiography
21 backgrounds could qualify for --

22 CHANTEL CORBETT: In certain states.

23 JAMES FUTCH: -- yeah, the PET certification.
24 And so there was this kind of like, oh, well. We'll
25 change and your folks can come over here and take

1 our tests and we'll change and you can come over
2 here and I guess maybe the end result of that was a
3 much taller hill to climb if you're a radiographer
4 trying to get into the nuclear medicine side of
5 being certified than the other way around. So we
6 modified the scope of practice of the nuclear
7 medicine techs in the Legislature to be able to do a
8 limited version of this and it took five years to do
9 that. And by the time we did it, there was this
10 huge population of nuclear techs who wanted to do
11 full CT, not the limited version the scope allowed
12 them in the statute.

13 So they started marching over to the ARRT and
14 taking the CT. I think every nuclear medicine tech
15 in the State of Florida called me at one point or 16
another saying, how do I get into the CT thing.

17 Then what they wanted to know when were done with it
18 is how do I become licensed.

19 So anyway, there's a lot of history to this.
20 And for a long time, there was just the one
21 certification. Now there's two. They will be back
22 to two, but they are exactly the same. I don't
23 know.

24 CHANTEL CORBETT: The only reason -- the main
25 benefit to Florida techs, to the NMTCB, was the

1 problem with ARRT required clinical competencies and
2 in Florida, as a nuclear tech, you can't push the CT
3 button. And to technically be comped for ARRT, you
4 had to push that button. So you couldn't do that
5 without going back to school. And so most of these
6 text were already full time in the clinic, working,
7 and they don't have time or whatever to go back to
8 school as an x-ray tech just to be able to push the
9 x-ray button. They were hoping that it would do
10 that. It was that when we pushed this through for
11 the last three years. And now they're changing it
12 to pretty much read what the ARRT does. So we're
13 probably going to be in the same original position.

14 JAMES FUTCH: I would be interested to know 15
 what the existing population of nuclear med techs 16
 who wants to get CT certified haven't yet by this 17
point in time.

18 CHANTEL CORBETT: There's a lot.

19 RANDY SCHENKMAN, CHAIRPERSON: Is it going in
20 the direction that they can't push the button?

21 CHANTEL CORBETT: We're going backwards.

22 JAMES FUTCH: When does the, when did the
23 population of new people coming out of our programs
24 who hopefully being trained to do this from --

25 CHANTEL CORBETT: Most will have the

1 competencies during the school. But that doesn't
2 put them in a good light with the old techs that are
3 already out there doing jobs. Because then they are
4 like, that's not fair because they can walk out and
5 do it and I've been out here trying; had all the
6 experience.

7 RANDY SCHENKMAN, CHAIRPERSON: Okay. We have
8 one more thing. We have to figure out when we're
9 going to have our next meeting.

10 BRENDA ANDREWS: You have a calendar, September
11 and October calendars in the very back, the last
12 page of the packages.

13 RANDY SCHENKMAN, CHAIRPERSON: I know I'm not
14 going to be here from the 2nd through the 24th of
15 September.

16 BRENDA ANDREWS: So what does September look
17 like for everyone?

18 RANDY SCHENKMAN, CHAIRPERSON: I won't be here
19 from the 2nd through the 24th.

20 BRENDA ANDREWS: That's the entire month.

21 MATTHEW WALSER: That takes care of September.

22 MARK SEDDON: I'll be around -- is there some
23 stuff going around in Orlando the second week?

24 JAMES FUTCH: I don't know.

25 MARK SEDDON: I think there is. I'm supposed

1 to be working with you guys on some stuff.

2 CYNTHIA BECKER: Yes, please.

3 MARK SEDDON: So the third week is fine. Or we
4 can wait until the fourth week.

5 JAMES FUTCH: If you wait until the crossover
6 week, I won't be available, which is fine with me.
7 You can do the whole thing, yourselves.

8 BRENDA ANDREWS: Okay. So the first two weeks
9 are out in September, right? So far.

10 CHANTEL CORBETT: The first three.

11 BRENDA ANDREWS: The first three?

12 CHANTEL CORBETT: Randy won't be back until the
13 24th.

14 RANDY SCHENKMAN, CHAIRPERSON: I'll be back on
15 the 24th.

16 CLARK ELDREDGE: Which is Wednesday, Thursday.

17 CHANTEL CORBETT: The 8th of October.

18 BRENDA ANDREWS: Do you want to try and go back
19 to Tuesdays, because some people were having
20 difficulties with Thursday. I know Alberto has a
21 problem with that. Tuesdays, go back to Tuesdays?

22 KATHLEEN DROTAR: That's fine. That's okay.

23 BRENDA ANDREWS: Are we down into October?

24 CHANTEL CORBETT: Yeah, pretty much.

25 LEO BAKERSMITH: If you would like Tuesdays,

1 sure. October 8th, that looks good.

2 RANDY SCHENKMAN, CHAIRPERSON: That looks good
3 for everybody. October 8th?

4 KATHLEEN DROTAR: Looks good.

5 BRENDA ANDREWS: Okay. October 8th it is and
6 location?

7 RANDY SCHENKMAN, CHAIRPERSON: Here is -- seems
8 to be convenient. Is it convenient for everybody or
9 is some place else better?

10 KATHLEEN DROTAR: Lunch was good.

11 MATTHEW WALSER: I think you said Key west.

12 RANDY SCHENKMAN, CHAIRPERSON: That would be
13 bad.

14 JAMES FUTCH: Are you going to fly us down in a
15 helicopter?

16 CHANTEL CORBETT: In October?

17 BRENDA ANDREWS: So we'll be here in Tampa?
18 Tampa it is.

19 RANDY SCHENKMAN, CHAIRPERSON: That's okay for
20 everybody?

21 KATHLEEN DROTAR: Yes.

22 RANDY SCHENKMAN, CHAIRPERSON: Okay. So we'll
23 all see each other again October 8th, same place.

24 (Proceedings concluded at 3:03 p.m.)

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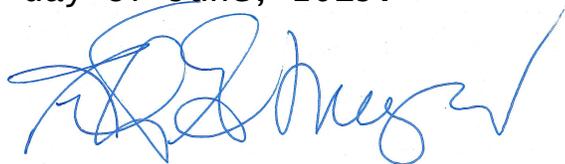
CERTIFICATE OF REPORTER

STATE OF FLORIDA:
COUNTY OF HILLSBOROUGH:

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

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

DATED this 11th day of June, 2019.



RITA G. MEYER, RDR, CRR, CRC

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