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

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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

ADVISORY COUNCIL MEMBERS PRESENT:

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

FLORIDA DEPARTMENT OF HEALTH STAFF

Cynthia Becker, Bureau of Radiation Control
James Futch, Bureau of Radiation Control
Brenda Andrews, Bureau of Radiation Control
Douglass Cooke, Bureau of Radiation Control
Jorge Laguna, Bureau of Radiation Control
Kevin Kunder, Bureau of Radiation Control
Clark Eldredge, Bureau of Radiation Control
David O'Hara, Bureau of Radiation Control
Leo Bakersmith, Bureau of Radiation Control
Gail Curry, Medical Quality Assurance

AGENDA

MORNING SESSION

AFTERNOON SESSION

RANDY SCHENKMAN, CHAIRPERSON: Good morning everybody.

MEMBERS: Good morning.

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

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

BRENDA ANDREWS: Here's Mark.

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

(Stood at Ease)

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

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

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

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

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

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

ADAM WEAVER: Makes sense.

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

MATTHEW WALSER: Matt Walser, physician assistant, Englewood, Florida, University of Florida.

MARK ROBLESKI: Mark Robleski, basic machine operator and I'm employed by Florida.

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

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

JORGE LAGUNA: Jorge Laguna. I am the

administrator in the inspection section in Tallahassee.

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

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

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

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

CYNTHIA BECKER: Cindy Becker, Bureau of Radiation Control.

BRENDA ANDREWS: Brenda Andrews, Bureau of Radiation Control.

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

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

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

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

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

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

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

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

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

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

KATHLEEN DROTAR: I make a motion to approve.

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

MARK SEDDON: Second.

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

ALL: Aye.

RANDY SCHENKMAN, CHAIRPERSON: Any opposed?

(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.

And he's our northern area field manager.

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

PAUL BARNHART: Yes. For now.

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

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

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

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

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

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

all will have to look at and address.

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

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

CLARK ELDREDGE: I don't know exactly.

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

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

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

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

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

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

and wanted to promote that out there.

There was one other meeting coming up. Any meetings?

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

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

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

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

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

CYNTHIA BECKER: Oh.

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

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

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

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

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

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

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

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

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

Public Service Commission, people from corrections --

CYNTHIA BECKER: That is true.

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

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

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

JAMES FUTCH: I think so.

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

JAMES FUTCH: My good side.

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

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

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

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

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

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

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

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

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

And any questions? Okay. Nice.

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

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

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

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

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

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

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

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

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

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

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

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

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

RANDY SCHENKMAN, CHAIRPERSON: Thank you. Okay. Next, we have Kevin Kunder.

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

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

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

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

safety.

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

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

RANDY SCHENKMAN, CHAIRPERSON: All right. Not bad.

KEVIN KUNDER: Yeah.

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

KEVIN KUNDER: Yes.

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

KEVIN KUNDER: No, radioactive material

licenses.

WILLIAM ATHERTON: Okay.

RANDY SCHENKMAN, CHAIRPERSON: Any other questions?

DR. NICHOLAS PLAXTON: Why do you think we have such a high amount of licenses here in the state?

KEVIN KUNDER: Probably the size and the warm climate. We have more elderly population coming here.

DR. NICHOLAS PLAXTON: Lot of medical staff.

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

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

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

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

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

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

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

KEVIN KUNDER: I don't know.

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

KATHLEEN DROTAR: The population.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Any questions on the IMPEP?

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

CYNTHIA BECKER: Oh, yes. Oh, yes.

RANDY SCHENKMAN, CHAIRPERSON: Okay.

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

final as they say, so --

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

CYNTHIA BECKER: Yes.

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

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

MARK SEDDON: Do they make recommendations on staffing?

CYNTHIA BECKER: Yes.

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

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

JAMES FUTCH: And a replacement can go in our

room, right.

CYNTHIA BECKER: Yeah.

JAMES FUTCH: That was a joke.

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

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

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

Radiation therapy, we have 1,805.

Nuclear medicine technologists, we have 2,505.

And for radiologic assistants, we have 31.

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

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

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

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

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

JAMES FUTCH: We enjoyed it.

CYNTHIA BECKER: It was fun.

GAIL CURRY: The kids are always excited about it.

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

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

JAMES FUTCH: That was pretty much it, right?

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

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

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

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

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

CHANTEL CORBETT: What's the status of getting the CT application running smoothly online?

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

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

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

CHANTEL CORBETT: Yep.

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

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

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

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

GAIL CURRY: Okay.

CHANTEL CORBETT: I'll get those to you.

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

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

CHANTEL CORBETT: Thank you.

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

GAIL CURRY: Thank you, Kathy.

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

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

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

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

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

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

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

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

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

GAIL CURRY: Just --

JAMES FUTCH: Thank you for that.

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

think we're on the right path.

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

GAIL CURRY: Thank you, Randy.

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

Okay. So next we have Christen for supervising radiologist assistant.

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

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

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

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

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

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

CHRISTEN CRANE-AMORES: Sure.

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

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

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

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

WILLIAM ATHERTON: And those programs are how long?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I'm sorry. They need to be readily available

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

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

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

CHRISTEN CRANE-AMORES: It is.

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

CHRISTEN CRANE-AMORES: Yes.

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

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

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

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

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

JAMES FUTCH: Okay.

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

CHRISTEN CRANE-AMORES: Yes.

JAMES FUTCH: Interesting way of doing things.

CYNTHIA BECKER: Right.

JAMES FUTCH: Confusion.

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

JAMES FUTCH: Yeah, it would be because you had

to -- I was pulling up the old --

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

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

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

JAMES FUTCH: Breast localization.

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

JAMES FUTCH: Okay.

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

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

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

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

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

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

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

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

CHRISTEN CRANE-AMORES: Okay.

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

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

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

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

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

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

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

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

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

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

RANDY SCHENKMAN, CHAIRPERSON: What does that mean?

JAMES FUTCH: Medical community.

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

DR. DR. ARMAND COGNETTA: Incident to.

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

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

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

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

DR. NICHOLAS PLAXTON: How is it done right now?

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

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

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

DR. NICHOLAS PLAXTON: Difficult procedures.

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

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

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

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

MARK SEDDON: Exactly.

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

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

CHRISTEN CRANE-AMORES: Okay.

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

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

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

CHRISTEN CRANE-AMORES: I hope so.

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

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

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

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

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

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

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

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

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

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

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

JAMES FUTCH: More than 10,000.

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

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

MATTHEW WALSER: What are they doing?

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

MATTHEW WALSER: I think so.

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

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

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

CHRISTEN CRANE-AMORES: 2003, 5.

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

CHRISTEN CRANE-AMORES: It is.

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

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

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

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

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

lawyers.

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

JAMES FUTCH: Yeah.

MATTHEW WALSER: Because I'm not a doctor.

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

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

KATHLEEN DROTAR: Yeah.

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

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

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

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

GAIL CURRY: James?

JAMES FUTCH: Yes, ma'am.

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

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

JAMES FUTCH: That's a good number.

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

GAIL CURRY: State of Florida.

MATTHEW WALSER: And it gets bigger every year.

GAIL CURRY: Yeah, I'm sure.

JAMES FUTCH: Christen, I think you had another.

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

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

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

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

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

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

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

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

CHRISTEN CRANE-AMORES: Yeah.

(Laughter)

REBECCA McFADDEN: Canned statement.

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

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

CHRISTEN CRANE-AMORES: Yeah.

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

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

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

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

JAMES FUTCH: Ah-ha.

CHRISTEN CRANE-AMORES: Okay.

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

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

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

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

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

CHRISTEN CRANE-AMORES: Is that on here?

JAMES FUTCH: So Matt knows because he does

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

MATTHEW WALSER: That looks different.

CHANTEL CORBETT: That's not it?

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

MATTHEW WALSER: That's not what I use.

GAIL CURRY: And it is different by profession.

MATTHEW WALSER: Okay.

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

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

MATTHEW WALSER: It's --

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

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

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

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

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

MATTHEW WALSER: Yes.

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

MATTHEW WALSER: I don't do that anymore.

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

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

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

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

JAMES FUTCH: Would you mind sending whoever is

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

MATTHEW WALSER: Sure.

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

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

(Laughter)

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

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

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

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

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

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

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

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

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

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

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

CHRISTEN CRANE-AMORES: Right.

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

CHRISTEN CRANE-AMORES: Okay.

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

JAMES FUTCH: No.

GAIL CURRY: -- thing to implement.

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

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

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

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

JAMES FUTCH: Less chance of it getting diverted.

CHRISTEN CRANE-AMORES: Yes.

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

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

CHRISTEN CRANE-AMORES: Okay.

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

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

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

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

MATTHEW WALSER: Then you can't practice.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

JAMES FUTCH: You do.

CHRISTEN CRANE-AMORES: We do?

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

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

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

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

CHRISTEN CRANE-AMORES: Okay.

RANDY SCHENKMAN, CHAIRPERSON: Or it says both.

CHRISTEN CRANE-AMORES: It does say change.

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

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

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

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

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

CHRISTEN CRANE-AMORES: Yes.

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

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

JAMES FUTCH: Yeah.

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

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

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

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

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

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

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

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

JAMES FUTCH: Matthew, do you have that currently?

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

JAMES FUTCH: Answer this afternoon after lunch.

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

DR. NICHOLAS PLAXTON: I'm saying they should.

MATTHEW WALSER: I agree.

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

MATTHEW WALSER: The State has it.

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

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

MATTHEW WALSER: License number.

RANDY SCHENKMAN, CHAIRPERSON: License number.

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

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

MATTHEW WALSER: It is. It is.

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

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

DR. NICHOLAS PLAXTON: Yeah.

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

DR. NICHOLAS PLAXTON: Yeah.

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

MATTHEW WALSER: Probably almost an equal

amount, I imagine or more.

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

CHRISTEN CRANE-AMORES: Right.

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

CHRISTEN CRANE-AMORES: Yes.

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

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

CHRISTEN CRANE-AMORES: Right.

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

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

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

REBECCA McFADDEN: Your medical staff also has the exact credentialing process you have gone through.

KATHLEEN DROTAR: You're covered.

REBECCA McFADDEN: You have a physician that signs off on your --

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

REBECCA McFADDEN: The medical staff, right.

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

REBECCA McFADDEN: Yeah.

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

Anybody have any other comments? Thank you.

Okay. Now we're going on to Nicholas.

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

MATTHEW WALSER: I second.

KATHLEEN DROTAR: Third, fourth.

CHANTEL CORBETT: We've asked to keep going.

DR. NICHOLAS PLAXTON: So we're going to --

RANDY SCHENKMAN, CHAIRPERSON: Okay. Onward.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. NICHOLAS PLAXTON: Yttrium-90.

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

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

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

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

radiation on top of that.

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

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

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

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

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

So any other questions?

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

DR. NICHOLAS PLAXTON: Yes.

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

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

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

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

JOHN JORDAN: You just take your wipes and --

CHANTEL CORBETT: Yeah, I mean --

JOHN JORDAN: -- CTYs and everything?

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

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

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

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

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

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

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

they look at, what is this crazy number?

MARK SEDDON: You have to budget.

DR. NICHOLAS PLAXTON: Exactly.

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

DR. NICHOLAS PLAXTON: Lutathera, yeah.

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

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

CHANTEL CORBETT: The what?

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

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

DR. NICHOLAS PLAXTON: Yeah.

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

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

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

The bigger thing is more how are you

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

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

MARK SEDDON: Things change.

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

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

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

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

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

CHANTEL CORBETT: Yeah. Sooner or later, basically.

DR. NICHOLAS PLAXTON: Afterwards, what we do

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

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

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

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

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

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

DR. NICHOLAS PLAXTON: Yeah.

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

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

ADAM WEAVER: Good planning, James.

RANDY SCHENKMAN, CHAIRPERSON: And we'll --

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

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

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

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

(Gail Curry is not present)

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

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

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

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

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

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

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

CHANTEL CORBETT: Okay. Yes, ma'am.

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

for me.

ADAM WEAVER: It would be different the next time.

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

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

CHANTEL CORBETT: Amen.

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

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

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

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

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

So this system standardizes the system, travel

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

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

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

CHANTEL CORBETT: Got them.

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

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

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

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

ADAM WEAVER: Are they willing to serve again?

RANDY SCHENKMAN, CHAIRPERSON: I am.

MARK SEDDON: I am.

WILLIAM ATHERTON: I move to repeat.

BRENDA ANDREWS: Okay.

MATTHEW WALSER: I second.

CHANTEL CORBETT: All in favor?

ALL: Aye.

CHANTEL CORBETT: Opposed?

(No Response)

(Applause)

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

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

CHANTEL CORBETT: You have to wait three more years.

BRENDA ANDREWS: It's too late.

ADAM WEAVER: It's been voted on.

KATHLEEN DROTAR: The council has spoken.

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

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

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

MARK SEDDON: Yeah.

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

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

So that's it for me. Any questions?

CHANTEL CORBETT: Thank you.

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

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

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

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

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

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

Any questions on the travel? Okay.

RANDY SCHENKMAN, CHAIRPERSON: Okay.

BRENDA ANDREWS: That's it.

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

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

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

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

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

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

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

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

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

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

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

Any questions about the medical events?

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

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

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

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

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

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

CLARK ELDREDGE: Right.

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

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

MARK SEDDON: Exactly.

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

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

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

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

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

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

MARK SEDDON: That makes sense.

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

MARK SEDDON: Yes, 10, 20, 50.

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

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

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

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

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

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

CLARK ELDREDGE: Right.

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

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

MARK SEDDON: Right.

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

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

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

CLARK ELDREDGE: Right.

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

MARK SEDDON: Right.

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

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

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

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

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

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

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

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

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

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

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

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

JOHN JORDAN: So these are ands instead of ors.

ADAM WEAVER: Yeah.

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

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

CHANTEL CORBETT: Refuse the rest of the treatment.

ADAM WEAVER: Yeah.

JOHN JORDAN: The machine breaks down.

ADAM WEAVER: That's not a misadministration.

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

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

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

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

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

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

So in our case, currently with therapy, of

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

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

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

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

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

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

CLARK ELDREDGE: I'm sorry?

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

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

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

MARK SEDDON: Right.

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

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

MARK SEDDON: Right.

CLARK ELDREDGE: You have to -- right.

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

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

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

MARK SEDDON: Yeah.

ADAM WEAVER: It's not totally enclosed.

CLARK ELDREDGE: Enclosed. I mean, although --

ADAM WEAVER: At least from the picture anyway.

CLARK ELDREDGE: From the diagram. But it does

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

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

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

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

ADAM WEAVER: They have like an iso --

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

ADAM WEAVER: Isodose.

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

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

stay away from it.

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

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

CLARK ELDREDGE: Something to that effect, yeah.

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

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

CLARK ELDREDGE: Yeah.

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

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

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

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

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

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

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

just the fact that the machine has been registered.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Another device that you would find in a -- in

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

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

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

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

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

Electron Beam Evaporation Systems.

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

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

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

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

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

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

DAVID O'HARA: Yes.

ADAM WEAVER: It's kind of older technology.

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

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

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

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

WILLIAM ATHERTON: Oh, okay.

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

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

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

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

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

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

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

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

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

CLARK ELDREDGE: Their opinion is they should be registered.

DAVID O'HARA: The manufacturer thought so.

ADAM WEAVER: Are other states registering these devices?

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

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

RANDY SCHENKMAN, CHAIRPERSON: Why is the

manufacturer recommending that they be registered?

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

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

ADAM WEAVER: Scatter all over the place.

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

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

KATHLEEN DROTAR: Not necessarily.

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

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

might necessarily be.

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

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

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

ADAM WEAVER: Otherwise, how --

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

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

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

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

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

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

machines.

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

So does anybody have anything to say about these?

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

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

MARK SEDDON: Do you have a criteria?

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

DAVID O'HARA: Pardon?

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

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

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

ADAM WEAVER: The definition.

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

MARK SEDDON: Gotcha.

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

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

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

LEO BAKERSMITH: Pepsi Cola. Lays has them.

CLARK ELDREDGE: You have a certain distance. They have a certain safety area where you can't get that close to where that spot is and that's basically how -- they will have some beam block on the other side and the main way to control the scatter is you have an industrial distance you have to be away from it. And if somebody crosses the boundary, it usually shuts down the production line.

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

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

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

MARK SEDDON: Like an estate sale.

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

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

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

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

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

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

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

MARK SEDDON: I see them both.

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

MARK SEDDON: Yeah.

RANDY SCHENKMAN, CHAIRPERSON: All right.

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

a veterinarian?

CLARK ELDREDGE: It's non-human.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

64E-3.

Since then, that's pretty much everything that's changed in the past year. And the page makes reverence to 64E-4 updates and there are essentially none, but I will probably be working to update the reverence to the American National Standard that's used in the laser regulation to the current ANT036, voluntary national standard that's used in the rest of the country, and which they're training ocean inspectors all over the country to use when they go into laser facilities to see if there are any violations of OSHA regulations. Okay. So that's it for the rule update.

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

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

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

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

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

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

So this is a snapshot where things have been the last year with Rad Tech enforcement cases. I'll start out at the top. As of May last year, roughly the time of the last meeting, there were about 80

open enforcement cases against Rad Techs of all different types and varieties. Since then, they've opened -- a few more complaints have been filed. Nine new complaints since May of 2018 have been brought to our attention and filed because of unlicensed activity found during BRC inspections. One AHCA exemption request that turned into an unreported crime that turned into a complaint against someone, AHCA exemption requested. Does everybody know what that is? So a different agency, the Agency for Health Care Administration has a different statute under Chapter 435. They license hospitals and certain other facilities.

So the Legislature, several years back, told them, look, you need to be reviewing staff in certain levels of administration, doing background checks to see if there are unreported crimes. And AHCA has been doing that for, I think like ten years now. Maybe a little bit less. And when they find someone who is in a facility -- and there's a certain list of higher level crimes, felony stuff; things of this nature, crimes against people especially, they find someone who's an employee in this facility, that person is essentially, as of the date that AHCA notifies the facility, they can't

work. They can still work for the facility, but they can't work doing that job dealing with patients as of that point. At that stage, AHCA can grant exemptions. They can actually go and look at the facts and say, okay, well, you know, this is, yes, we know this is a qualifying crime, but it's been 20 years and, you know, all of -- you're not a threat anymore.

For any licensed professions in which AHCA is not the licensing agency which, of course, is all the health care professions, that has to come back to the licensing agency, which is the Department of Health. And then we have to go and evaluate whether or not to actually grant that person an exemption underneath this part of the statute.

In nine times out of ten, we do because usually the person has reported a crime to us when they initially became licensed. We made a determination it wasn't a patient safety issue. So we let them into the practice and they get caught in this at the back end.

By the way, they do this every five years. We've now had people that are caught in this the first time and then five years later, they come back to this again, no crime, no nothing has changed. We

have to give them an exception or we have to look at that time it again anyway. In the meanwhile, they can't work in the capacity of patient caregiver.

Sometimes, in this case, with this one person, they didn't tell us about the crime when they first were licensed with the department. So what we do, we still look and see whether or not it's something that's related to patient safety now and it's not one of the flat out, you cannot work in this profession. Like there's certain levels of sex offender crimes. It doesn't matter how long it's been, you're not going to work in this.

In this case, this person didn't tell us about it, so that becomes a disciplinary complaint. That's obtaining a license by fraud. And then that goes into this whole process and it will eventually come out the back end. So that's just new activity.

And the non-payment of student loans. Somewhere in the middle of 2017, I think it was, there was some statutory changes and the Department of Education, I think, went to the Legislature and said we have an awful lot of student loans and we can't get these folks to pay them back and you've got licenses issued by various licensing issues in Florida that is allowing them to earn a living. We

need to come together some place and figure this out. So now there's statutory authority to charge not just Rad Techs, but any licensed health care professional.

And so in May of 2018, 16 new cases of student loans were entered as complaints into this system. And I'll show you the outcome down here, some of this. So that's a snapshot of May 2018, 80 cases, new activity, another 26 cases or something like that.

Fast forward, since that same time period, 25 of those cases you saw above, have turned in to final orders. So they have now become -- they've gone through all the legal process, appeal and all the rest of that kind of stuff, and this is the outcome of that. And we've kind of broken it down for you by type of offense and number of incidences of those offenses.

So the first one, ARRT acted against somebody, revoked them, reprimanded or fined them. That person was acted against in Florida for the same person. We usually do what ARRT does in the process.

The whole next section is conviction-related stuff. Convictions not reported on the original

license application. Convictions for batteries, conviction either against people or things somehow related to radiologic technology.

Impairment, that's a huge one. Usually these result in someone going into a treatment monitoring program, which is for Florida, Physicians Recovery Network, which is PRN. I forget what it is. They're both in Fernandina Beach. And you try and give the person, you know, the proper treatment to get their problem fixed while restricting them from practice as need be by the doctors.

Non-compliance, this is what happens, for example, one of those six people stopped complying with the PRN folks, they come back to us to act against them.

The rest of this in the middle is unprofessional conduct. Some of those it -- I think Lynn has listed a couple of the things that happened. Somehow they violated the scope of practice in the process of administering various things that usually they didn't have or they didn't do it in the proper way.

Sexual misconduct, that's not convicted for it. That's on a patient in the course of their duties somehow.

Unlicensed activity cases from the BRC inspections. So the ones you saw above resulted in these kind of penalties in five cases. And then another ULA case from somebody who just filed and went straight with the department.

So here's the current population. Same kind of breakdowns you saw before, but this is fast forward to now. There's 51 cases remaining. I'm not going to go through each of these. It's the same topics. These are just different case numbers. Different numbers in each of those and in the bottom, we just had a meeting not too long ago with the prosecutors, and of these 51, 11 more of them are going into the prosecution phase now.

Anyway, I think that's it. Yep, that's it. So just an enforcement snapshot. So we haven't had much interaction at this level of detail. We can do it now. And I wanted you to be aware of it, just from the standpoint of, hey, this is part of the, you know, the Advisory Council. But also, so maybe you can take back to your facility that there are a lot of things happening. And I would highly advise anybody who's a member of this or any other profession, to go to your licensing website page and pull down those disciplinary guidelines and look at

them. They're changing. The statutes change over the years.

The student loan stuff is just, you know, that wasn't there ten years ago, seven years ago. So people have been practicing for a while, you know, everybody is going to try to stay out of trouble, of course. But people who have been practicing for a while may not be aware of things that are changed that are out there. And more importantly, you may know somebody in your facility has done this and doesn't want to have it reported and we'll find out about it that way. So that's it.

WILLIAM ATHERTON: Is that based on the 22 files or so licensures?

JAMES FUTCH: Yes.

WILLIAM ATHERTON: That's the 22 percent. That's not too bad.

JAMES FUTCH: Yeah. It's very small.

RANDY SCHENKMAN, CHAIRPERSON: Okay. Any other questions for James? Okay.

DR. NICHOLAS PLAXTON: I had a question, backing up a little bit. You were talking about the, the nuclear medicine techs versus the radiology techs getting CT certification.

JAMES FUTCH: Right.

DR. NICHOLAS PLAXTON: So with the nuclear medicine techs, were they able to get certified before or now are they able to get certified?

CHANTEL CORBETT: Only if they went through the ARRT CT exam.

DR. NICHOLAS PLAXTON: But now there's a different exam.

CHANTEL CORBETT: Now there's an NMTCB exam as well. So they can get either and apply for both.

JAMES FUTCH: And slightly different philosophies apply for different organizations and qualifying.

CHANTEL CORBETT: They're getting more closer together.

DR. NICHOLAS PLAXTON: Are they getting closer together? Okay.

JAMES FUTCH: Chantel, so at the end of this, all this, is it going to be exactly the same?

CHANTEL CORBETT: I'm afraid it's going to be almost exactly the same.

JAMES FUTCH: All right. Well, it was fun doing it.

CHANTEL CORBETT: I was not a happy camper. Me and Katy O'Neill had a long talk.

JAMES FUTCH: When the first -- my recollection

is one the first fusion devices was a GE system with a hawkeye option.

CHANTEL CORBETT: SPECT-CT.

JAMES FUTCH: Yeah, that was like when I recall it was in 2000, the societies all kind of all came together and said, look, what's happening with the manufacturers of these devices. And we had, you know, silliness like, you have to have two people to operate this machine. One is a radiographer and one is a nuclear med tech. I attended a couple meetings, my staff attended some of the meetings in '01 or 02 I think, with the societies and they decided, ARRT decided to retool their CT exam from an educational perspective to nuclear medicine background who have to do some qualifying stuff.

CHANTEL CORBETT: Right.

JAMES FUTCH: NMTCB did a similar thing with the PET exam.

DR. NICHOLAS PLAXTON: PET/CT.

JAMES FUTCH: So the people from radiography backgrounds could qualify for --

CHANTEL CORBETT: In certain states.

JAMES FUTCH: -- yeah, the PET certification. And so there was this kind of like, oh, well. We'll change and your folks can come over here and take

our tests and we'll change and you can come over here and I guess maybe the end result of that was a much taller hill to climb if you're a radiographer trying to get into the nuclear medicine side of being certified than the other way around. So we modified the scope of practice of the nuclear medicine techs in the Legislature to be able to do a limited version of this and it took five years to do that. And by the time we did it, there was this huge population of nuclear techs who wanted to do full CT, not the limited version the scope allowed them in the statute.

So they started marching over to the ARRT and taking the CT. I think every nuclear medicine tech in the State of Florida called me at one point or another saying, how do I get into the CT thing. Then what they wanted to know when were done with it is how do I become licensed.

So anyway, there's a lot of history to this. And for a long time, there was just the one certification. Now there's two. They will be back to two, but they are exactly the same. I don't know.

CHANTEL CORBETT: The only reason -- the main benefit to Florida techs, to the NMTCB, was the

problem with ARRT required clinical competencies and in Florida, as a nuclear tech, you can't push the CT button. And to technically be comped for ARRT, you had to push that button. So you couldn't do that without going back to school. And so most of these text were already full time in the clinic, working, and they don't have time or whatever to go back to school as an x-ray tech just to be able to push the x-ray button. They were hoping that it would do that. It was that when we pushed this through for the last three years. And now they're changing it to pretty much read what the ARRT does. So we're probably going to be in the same original position.

JAMES FUTCH: I would be interested to know what the existing population of nuclear med techs who wants to get CT certified haven't yet by this point in time.

CHANTEL CORBETT: There's a lot.

RANDY SCHENKMAN, CHAIRPERSON: Is it going in the direction that they can't push the button?

CHANTEL CORBETT: We're going backwards.

JAMES FUTCH: When does the, when did the population of new people coming out of our programs who hopefully being trained to do this from --

CHANTEL CORBETT: Most will have the

competencies during the school. But that doesn't put them in a good light with the old techs that are already out there doing jobs. Because then they are like, that's not fair because they can walk out and do it and I've been out here trying; had all the experience.

RANDY SCHENKMAN, CHAIRPERSON: Okay. We have one more thing. We have to figure out when we're going to have our next meeting.

BRENDA ANDREWS: You have a calendar, September and October calendars in the very back, the last page of the packages.

RANDY SCHENKMAN, CHAIRPERSON: I know I'm not going to be here from the 2nd through the 24th of September.

BRENDA ANDREWS: So what does September look like for everyone?

RANDY SCHENKMAN, CHAIRPERSON: I won't be here from the 2nd through the 24th.

BRENDA ANDREWS: That's the entire month.

MATTHEW WALSER: That takes care of September.

MARK SEDDON: I'll be around -- is there some stuff going around in Orlando the second week?

JAMES FUTCH: I don't know.

MARK SEDDON: I think there is. I'm supposed

to be working with you guys on some stuff.

CYNTHIA BECKER: Yes, please.

MARK SEDDON: So the third week is fine. Or we can wait until the fourth week.

JAMES FUTCH: If you wait until the crossover week, I won't be available, which is fine with me. You can do the whole thing, yourselves.

BRENDA ANDREWS: Okay. So the first two weeks are out in September, right? So far.

CHANTEL CORBETT: The first three.

BRENDA ANDREWS: The first three?

CHANTEL CORBETT: Randy won't be back until the 24th.

RANDY SCHENKMAN, CHAIRPERSON: I'll be back on the 24th.

CLARK ELDREDGE: Which is Wednesday, Thursday.

CHANTEL CORBETT: The 8th of October.

BRENDA ANDREWS: Do you want to try and go back to Tuesdays, because some people were having difficulties with Thursday. I know Alberto has a problem with that. Tuesdays, go back to Tuesdays?

KATHLEEN DROTAR: That's fine. That's okay.

BRENDA ANDREWS: Are we down into October?

CHANTEL CORBETT: Yeah, pretty much.

LEO BAKERSMITH: If you would like Tuesdays,

sure. October 8th, that looks good.

RANDY SCHENKMAN, CHAIRPERSON: That looks good for everybody. October 8th?

KATHLEEN DROTAR: Looks good.

BRENDA ANDREWS: Okay. October 8th it is and location?

RANDY SCHENKMAN, CHAIRPERSON: Here is -- seems to be convenient. Is it convenient for everybody or is some place else better?

KATHLEEN DROTAR: Lunch was good.

MATTHEW WALSER: I think you said Key West.

RANDY SCHENKMAN, CHAIRPERSON: That would be bad.

JAMES FUTCH: Are you going to fly us down in a helicopter?

CHANTEL CORBETT: In October?

BRENDA ANDREWS: So we'll be here in Tampa? Tampa it is.

RANDY SCHENKMAN, CHAIRPERSON: That's okay for everybody?

KATHLEEN DROTAR: Yes.

RANDY SCHENKMAN, CHAIRPERSON: Okay. So we'll all see each other again October 8th, same place.

(Proceedings concluded at 3:03 p.m.)

CERTIFICATE OF REPORTER

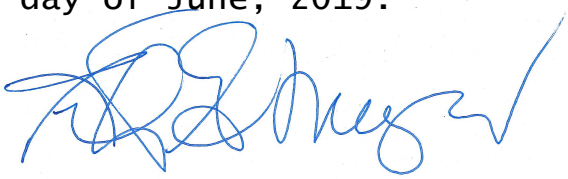
STATE OF FLORIDA:

COUNTY OF HILLSBOROUGH:

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

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

DATED this 11th day of June, 2019.



RITA G. MEYER, RDR, CRR, CRC

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