MDH Minnesota Department of Health

RADIATION CONTROL, X-RAY UNIT

X-ray Unit Listening Session

STAKEHOLDERS PRE-SESSION SURVEY RESULTS

I'd like MDH to address the following issue/question/concern

Computed Tomography (CT)

- Cone beams use in dentistry.

Equipment Calibrations and Evaluations

- Requirements for CT testing after repairs.
- Methods of measuring CT dose.

Facility Registration

- The definition of a "facility" for registration purposes are items that come to mind.
- Facility registration - allow registration of sites under one management when within a given city as one facility.

Fluoroscopy

- Nurses are trying to obtain privileges to use fluoroscopy equipment.
- Definition of operating fluoroscopy.
- QC of fluoroscopy dose monitoring equipment air KERMA monitors.
- I would like MDH to address the rules for mobile fluoroscopy (c-arm) for surgery separately from stationary fluoroscopy units in x-ray departments.
- Limit interpretation of fluoroscopic images to physicians.
- I'm quite concerned that there is consideration to allow CRNAs, with no formal radiology training, to use fluoroscopy independently. Device use, image interpretation, radiation safety, etc take years of dedicated training to safely and effectively employ. I think allowing CRNAs access to fluoroscopic imaging would be a safety concern and a quality disservice to patients.
- My understanding is that CRNAs are not licensed to perform fluoroscopy. They have claimed they are and there are cases where CRNAs have performed fluoroscopy. I am concerned that they are doing this.

- Should non-physician providers be allowed to use fluoroscopy unsupervised to perform image-guided invasive procedures without an order from a physician. In my opinion, this is practicing medicine without a license. The fluoroscope is a tool for physicians to use in the diagnosis and treatment of medical problems. Non-physicians do not have the training nor the education to use fluoroscopy without supervision to diagnose and treat disease.
- Please ensure that fluoroscopy use is constrained to practitioners who are appropriately trained & qualified to ensure efficacy of use & maintenance of appropriate safety standards for patients.
- The use of fluoroscopy for diagnostic and therapeutic purposes should be reserved for physician providers.
- Physician only use of fluoroscopy for pain procedures.
- There is a push to allow non-physicians to use fluoroscopy guidance for procedures.
- Fluoroscopy guided procedures by non-physician providers.
- I am concerned about the idea of extending fluoroscopy privileges to non MD/DO providers, as I think specialty training for MD's should be required before using fluoroscopy for providers. Particularly pain procedures, as I cannot speak to other specialties.
- The use of fluoroscopy guided interventional pain procedures by improperly trained non-physician providers.
- The use of fluoroscopy to perform interventional medical procedures should be limited to those with extensive training and experience in doing so - Medical Doctors. There is no role for advanced practice nurses of any type to utilize this type of equipment outside of the direct supervision of a physician. The training received by advanced practice nurses is simply not adequate. The decision making and technical skills that go along with fluoroscopic guided procedures take extensive training and study to ensure the safety of the patient - let alone generating positive outcomes. These procedures and technologies should remain in the hands of specialty trained physicians.
- The use of fluoroscopy for Interventional Pain Medicine procedures should be limited to physicians as it represents the practice of medicine.
- I'm not anxious to open rule-making, but if it is to be done, it should be done transparently, thoughtfully, and with the guidance of experts. Updated rules are much preferable to solving problems piecemeal by variance. Thus, I think we should get the rule-making process started to update fluoroscopy rules.
- It would be nice to have fluoroscopy broken down into mobile units or surgery verses stationary units in x-ray departments.
- Provide and allow an RN training course for fluoroscopy procedures only.
- Allowing use of the C-arm within the ASC setting to be handled by the RN circulating under the direct supervision of the physician or PA.
- Don't grant mid-level providers the right to use and interpret fluoroscopic images.

- Please clarify that CRNAs are not licensed to perform fluoroscopy so that these providers will understand that they are not allowed to do fluoroscopy.
- Clarify existing law that states only licensed physicians with proper training can use fluoroscopy independently without supervision.
- Require MD subspecialty board certification (eg., boarding in Pain Medicine, interventional radiology, etc.) as a prerequisite to use of fluoroscopy for guided procedures, as this ensures that patient care will not be compromised.
- Regulations to allow physician only use of fluoroscopy for pain procedures.
- Only physicians are qualified to use fluoroscopy guidance for interventional pain procedures.
- Limit use of fluoroscopy for interventional procedures to MD's/DO's who are specialty trained to perform them.
- Physicians remain the only providers doing fluoroscopically guided procedures - as they are the only group with the proper training.
- Fluoroscopically-guided interventional pain medicine procedures should only be performed by physicians that have been trained to do those procedures in a rigorous academic program. To allow non-physicians to perform fluoroscopically-guided procedures would be irresponsible and would place our patients at risk for hazardous outcomes. Furthermore, non-physicians that perform these injections do not have the appropriate broad training that defines the practice of medicine, including multisystem evaluation, comorbidity interactions, medication interactions, and the inherent risks of the procedure or the medications used in those procedures. Allowing non-physicians to perform fluoroscopically-guided procedures will carelessly waste precious health care dollars as many of these procedures will be inappropriately applied to the patient's care, and thus will be ineffective. Fluoroscopically-guided procedures represent an important portion of the spectrum of the practice of medicine, and should appropriately be limited to physicians.
- I am concerned that CRNAs will run equipment autonomously without physician guidance.
- It is difficult for an ASC to meet the current requirements for the deliverance of radiation during a procedure. Physicians are often so involved in the procedure that they request an RN to push the pedal. If the physician is directly supervising an RN for this procedure, an RN should be able to follow physician directions. Hiring an x-ray tech for limited procedures is cost prohibitive and unnecessary.
- Inclusion of APRNs as LP of healing arts.
- Do not allow CRNAs to run radiology machines autonomously. This should be physician guided or only run by an MD/DO.
- Not to grant nurses what they are looking for.
- We have one of the largest CRNA training programs in the country and they get one half day of pain management training and NO training in procedures or x-ray guided procedures. Qualified fellowship trained physicians who do these procedure undergo a minimum of one year of training AFTER residency and meet American board of medical specialty mandated minimum procedures. It is unconscionable to imagine patients being subjected to treatments

by clearly unqualified individuals just interested in making money, not to mention the cost to payers who will be paying for procedures that in many cases will not be indicated and/or done properly and safely. Interventional pain procedures constitute the practice of medicine and require specialized and proper training to learn when and where to use them and how to do them safely to minimize harm. We cannot allow untrained/poorly trained providers to do these procedures on our patients who may not understand the lack of qualifications and training.

Healing Arts Screening (Human Use)

- Dose requirements for CT screening.

Individual Monitoring Devise Use

- PPE for veterinary facilities.
- I approve of the PPE requirements as written.
- Dosimetry correction factors - Allow use of accepted national standards (NCRP, etc.).
- How do you determine which employees require radiation badge monitoring (determining the amount of exposure)?
- The use of a whole body barrier vs. lead apron when appropriate, the dosimetry correction factor for individuals wearing aprons.

Operator Qualifications (Human Use)

- I would like to talk more about limited authorization dental hygienists and ordering of x-rays.
- Operator education/certification standards for examinations beyond radiography (such as fluoroscopy, CT, nuclear medicine) along with non-ionizing (ultrasound and MR).
- Would the MDH support a licensure bill for those individuals who use radiation on humans, whether they were registered radiologic technologists, limited scope operators or x-ray operators?
- X-ray operation by certain groups (CVT, Nurse practitioners, APRNs,...).
- A strong state licensure program for operators of medical imaging and radiation therapy equipment.
- Redefine assurance if it is to be quality assurance program and work with the Minnesota Society of Radiologic Technologists to create a licensure bill that would not legislate people out of work but allow time to become qualified with continued education and renewal as part of the legislative statute. This to protect the people of MN!

Operator Training (Human Use)

- Implement LXMO clinical and didactic training requirements.

- Require continuing education for LXMOs.
- Small facilities with small staff should have training they can easily access, or be allowed to operate under the supervision of a physician.
- Inclusion of APRNs as LP of healing arts and as perhaps limited x-ray operators if training and safety requirements met.
- Dental for Humans, Sunset for X-ray Operators, Nuclear Medicine Technologists in Diagnostic CT, Working with the Federal Government concerning training for operators of airport, Federal, State and Local screening of courthouse and jails...operator training and RSO responsibilities, Licensure for x-ray technologists and LMXO.

Quality Control

- MDH stance on a site following CR/DR vendor recommendations as some vendors have no QC while others have a detailed program.
- Whole body barrier - recommending following CRCPD SSR language.
- If a vendor recommends QC they must not only perform the action, but also have the action documented as well as sites should follow recommends as shared by the medical physics group/department.
- MDH stance on a site following CR/DR vendor recommendations as some vendors have no QC while others have a detailed program.
- We also note that many of the regulations are based upon old technology (film, etc.) and could use an update.

Record Retention

- With many sites moving to record a human holder in a computed network system (i.e. Radiant, Meditech, etc.), what is the MDH stance to help the facility still ensure there is a rotation of a human holder (note: when a site is recording a human holder in a computed network the staff does not have access to review and ensure there is a rotation of human holder)? Basically, to these facilities I have recommended that those site recording a human holder in a computed network system that they have either the on-site Radiology Manager or the RSO review the holding log at least quarterly (signing and dating when reviewed) to ensure there is a proper rotation or that a site would print the log quarterly and post so all could look at a past report to help them ensure there is a rotation of holders. However, an MDH stance/recommendation of expectation would be appreciated.

Shielding

- I would like to know what is considered a high radiation area and shielding required for that. Is surgery with c-arm use considered a high radiation area? Our facility only has mobile units no stationary units and travel all over the facility for x-ray. What rules apply to facilities that are different from your normal hospital etc. in areas like shielding plans etc.

- Is patient shielding required for c-arm fluoroscopy procedures?
- Shielding for veterinary facilities.
- I would like to know what is considered a high radiation area and shielding required for that. Is surgery with c-arm use considered a high radiation area? Our facility only has mobile units no stationary units and travel all over the facility for x-ray. What rules apply to facilities that are different from your normal hospital etc. in areas like shielding plans etc.
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Other

- Modification of current standards to allow limited use of scanning equipment in jails and prisons to detection contraband.
- Use of low-dose x-ray technology for security screening purposes.
- Modify statutes and standards as necessary to allow limited use of scanning equipment by jail and prison personnel as it relates to contraband detection and prevention.
- Continued collaboration in development of MDH rules to allow use of low dose x-ray technology for security screening.
- We work with many research facilities and they are currently inspected under industrial regulations. And they really do not fit into that category. Also, discrepancies between vet x-ray rules and human rules need to be resolved. There needs to be some mechanism for letting facilities know when an interpretation of a section of the rule has been changed, or when a small section has been changed. I know it was decided that the x-ray updates were no longer necessary, but that would have been a good place to include info like this.