ALABAMA STATE BOARD OF PHARMACY

BUSINESS MEETING

Wednesday, October 15, 2014

9:14 a.m.

LOCATION: Alabama State Board of Pharmacy
111 Village Street
Hoover, Alabama 35242

REPORTER: Sheri G. Connelly, RPR

APPEARANCES

BOARD MEMBERS:

Mark Conradi, President
Tim Martin, Vice President
Dan McConaghy, Treasurer
Buddy Bunch, Member
David Darby, Member

ALSO PRESENT:

Susan Alverson, Director of Professional Affairs and Secretary
Edward R. Braden, Chief Inspector
Jim Ward, Board Attorney
Dr. Mike Garver, Wellness Committee
Mitzi Ellenburg, Board of Pharmacy
Todd Brooks, Board of Pharmacy
Glenn Wells, Board of Pharmacy
Mark Delk, Board of Pharmacy
Scott Daniel, Board of Pharmacy
Terry Lawrence, Board of Pharmacy
Ronda Lacey
Rick Stephens

Dane Yarbrough

Jeff Freeze

Andy Compton

Al Carter

Tammie Koelz

Matthew Muscato

Paul Rengering

Nancy James

Louise Jones

Tracy Davis

Gary Mount

David Belser

Steve Brickman

Chris Burgess

Lindsay Leon

Clemice Hurst

Kelli Newman

Jim Easter

Thalia Baker

Julie Hunter

Ashley Core

Bruce Harris

T. J. Hester

Thomas Miller
Melanie Smith
Sally Sims
April Marlin
Carly Rhodes
Pamela Jubach
Susan Sidwell
Leslie Payne
Wendy Sprayberry
Scotty Armstead
Cary Wahlheim
David Randall
Bart Bamberg
Jeanna Boothe
Carter English
Stuart Cohen
Melissa Mancini
Tommy Klinner

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MR. CONRADI: Welcome to the October meeting of the Alabama Board of Pharmacy. We're

going to start off like we usually do. Stand up, tell your name and who you represent loud enough for Ms. Sheri to hear you so we'll get an accurate roll call.

MS. LACEY: Ronda Lacey, McWhorter School of Pharmacy.

DR. GARVER: Michael Garver, the Board's Wellness program.

MR. STEPHENS: Rick Stephens, Senior Care Pharmacy.

MR. YARBROUGH: Dane Yarbrough, Turenne PharMedCo.

MR. FREEZE: Jeff Freeze, Turenne PharMedCo.

MS. ELLENBURG: Mitzi Ellenburg, Board of Pharmacy.

MR. COMPTON: Andy Compton, McWhorter School of Pharmacy.

MR. CARTER: Al Carter with Walgreens.

MS. KOELZ: Tammie Koelz with Walgreens.

MR. MUSCATO: Matthew Muscato, Walgreens Pharmacy.

MR. RENGERING: Paul Rengering, Walgreens Pharmacy.

MS. JAMES: Nancy James, PharMerica.

MS. JONES: Louise Jones, Alabama Pharmacy Association.

MS. DAVIS: Tracy Davis, Alabama Pharmacy Association.

MR. MOUNT: Gary Mount, Baptist Health Montgomery.

MR. BELSER: David Belser representing ALAMTA.

MR. BRICKMAN: Steve Brickman, Sirote and Permutt.

MR. BURGESS: Chris Burgess, Heritage Pharmacy.

MS. LEON: Lindsay Leon, Harrison School of Pharmacy.

MS. HURST: Clemice Hurst, Alabama Medicaid.

MS. NEWMAN: Kelli Newman, Alabama Medicaid.

MR. DELK: Mark Delk, Alabama State Board of Pharmacy.

MR. WELLS: Glenn Wells, Alabama State Board of Pharmacy.

MR. EASTER: Jim Easter, Baptist Health System and Cara Leos couldn't be here. They've asked me to take notes and represent Alabama Society of Health-System Pharmacists.

MS. BAKER: Thalia Baker with UAB Medicine.

MS. HUNTER: Julie Hunter with Omnicare.

MS. CORE: Ashley Core, McWhorter School of Pharmacy.

MR. HARRIS: Bruce Harris, APCI.

MR. HESTER: T. J. Hester, CVS Pharmacy.

MR. MILLER: Thomas Miller, CVS Pharmacy.

MS. SMITH: Melanie Smith, BuzzeoPDMA.

MS. SIMS: Sally Sims, Baptist Health System Birmingham.

MS. MARLIN: April Marlin, Baptist Health System.

MS. RHODES: Carly Rhodes, McWhorter

School of Pharmacy.

MS. JUBACH: Pamela Jubach, McWhorter School of Pharmacy.

MR. LAWRENCE: Terry Lawrence, Alabama Board of Pharmacy.

MR. BROOKS: Todd Brooks, Alabama State Board of Pharmacy.

MR. DANIEL: Scott Daniel, Alabama State Board of Pharmacy.

MS. SIDWELL: Susan Sidwell, president of ALAMTA.

MS. PAYNE: Leslie Payne, Calhoun Treatment Center.

MS. SPRAYBERRY: Wendy Sprayberry, Calhoun Treatment Center.

MR. ARMSTEAD: Scotty Armstead, Turenne PharMedCo.

MS. WAHLHEIM: Cary Wahlheim, UAB Health System.

MR. RANDALL: David Randall with UAB Health System.

MR. BAMBERG: Bart Bamberg, Publix Supermarkets.

MS. BOOTHE: Jeanna Boothe, Decatur Morgan Hospital.

MR. ENGLISH: Carter English, Department of Mental Health.

MR. COHEN: Stuart Cohen, UAB Medicine.

MS. MANCINI: Melissa Mancini, UAB Health System.

MR. KLINNER: Tommy Klinner, Department of Mental Health.

MR. CONRADI: Thank you. And this is the largest crowd we've had in a while.

Let's first start off by getting a motion to approve the agenda.

DR. MARTIN: I move we adopt the agenda as proposed.

MR. DARBY: Second.

MR. CONRADI: Okay. I'm going to go off the agenda order. We will have Dr. Mike Garver with the Wellness Program give our report since he is here personally.

DR. GARVER: Thank you, gentlemen. I've submitted the inspector's report to staff

through Ms. Alverson yesterday and they have all of the details concerning the committee and this that I'm about to read into the record just represents our current work.

There are presently 139 people in our screening program with signed contracts and orders. This number includes any individuals on a diagnostic monitoring contract but does not include any of these health professionals listed below.

Currently we have two pharmacists in inpatient treatment. The second is an error -- it was a pharmacist that actually had a suspended Alabama license who the Board heard yesterday and signed a consent order. He actually is not asking for reciprocity but for his license to be reactivated and that was taken care of in yesterday's meeting.

We have 16 pharmacists who are either being held out for some particular reason, a treatment center order, or are in the process of being investigated, evaluated, or made ready for presentation to the Board. At the present time

there are no techs in treatment and that's a record. We do, however, have six techs who have -- who need disposition or that we are following and those have been listed in the inspector's report and will be brought forward probably within the next couple of months. We have two techs that have dropped out and they will be signing permanent surrenders. Mr. Ward knows about those and is already taking care of those for us.

MR. WARD: Those were signed yesterday.

DR. GARVER: Yeah, thank you. There's one student who has completed outpatient treatment but refused recommendations and is no longer in contact with anybody at the school or with me and that person needs disposition and that's also listed in the report yesterday. All these individuals who are in treatment or in evaluation or undecided are presently out of the workplace and without a license. That means their licenses have been voluntarily surrendered.

We have 80 individuals who are in facility-driven aftercare. This is aftercare meetings that they go to outside of AA through Bradford or UAB or whatever treatment center that they've been to and that's basically the report for this month. Are there any questions about any of that from the Board at all?

(No response.)

DR. GARVER: Well, thank you for letting me be up here. I did want to share one small thing. I know you all have been in prayer for my mother. I've got one little thing about math and that's the difference between 911 and 119 is not 792. It's $2,000 and that's the amount of fine that I'm trying to work with from an attorney placed on my mother by the Emergency Management Services of Mobile County for phone calls in the amount of 130 phone calls made to my wife's mother-in-law who was in room 119 at Providence Hospital. So I think -- my mother didn't tell me that she made all these phone calls, only that she was having difficulty getting in touch with her, but after a bunch of

visits by the EMT and then social workers -- nobody called me, of course -- my mother handed me the bill, so I'll let you guys know in November how it works out. Good to see you.

MR. CONRADI: Thank you, Dr. Garver. We have three presentations today. We'll let Morgan -- Decatur Morgan Hospital go first. I think yours is the most straightforward one we have. You sit here and Terry will help you with the technology.

MS. BOOTHE: Okay. Good morning, my name is Jeanna Boothe. I'm the director of pharmacy at Decatur Morgan Hospital.

I'm here to ask about remote order entry for one of our facilities. We already have remote order entry approval between our Decatur General campus and our Decatur West campus, which is our psychiatric facility. We send in the quarterly reports for that and the West campus entries are -- range from five to seven percent of our -- of our orders that our Decatur General campus pharmacists enter.

In January the three facilities were

merged to become Decatur Morgan Hospital, so we added in the Parkway campus, which is still in Decatur. It's about a mile down the street from our West campus. At this time the Parkway campus, it has -- it has a pharmacy where -- a licensed pharmacy was Parkway Medical Center and now it's Decatur Morgan Hospital Parkway campus but it only operates an emergency room and outpatient infusion center.

We need to move some of our inpatients from the Decatur General campus to our Parkway campus because the Decatur facility has some building issues and we need to close some of those rooms and move some of those patients, so the question comes up as to how to handle inpatient pharmacy needs there.

What we'll be moving is our labor and delivery floor. It's 12 to 15 moms and babies is our average daily census there, so that's what will be at the Parkway campus in addition to the emergency department and the outpatient wound care. So we were looking for ways to accommodate this inpatient care, so we had to

think outside the box a little bit.

So we would like to request permission for our Parkway campus to be added in to the remote order entry that our West campus currently has. We will have staff there during the day but we're looking for operations for after hours.

We are on computerized physician order entry, on CPOE. We're all on the same post MEDITECH system. We all are on the same Pyxis console, so all of our Pyxis machines talk to the one facility. So we're one hospital, three buildings, so that is our request today.

MR. CONRADI: Any questions?

DR. MARTIN: When you say you're one hospital, three systems, do you have one provider number?

MS. BOOTHE: We have one Medicare provider number, yes.

DR. MARTIN: And three different campuses?

MS. BOOTHE: Three campuses.

DR. MARTIN: And the ones you already

have remote with are between the mothership and --

MS. BOOTHE: And our West campus, which is our psychiatric.

DR. MARTIN: -- and West and now you want to extend that to Parkway?

MS. BOOTHE: To Parkway.

DR. MARTIN: Okay. And in addition -- the existing relationship is for after hours only and you would like to expand that to work level balancing at all facilities back and forth?

MS. BOOTHE: Correct, correct.

DR. MARTIN: And you've been sending in reports as required by the Board?

MS. BOOTHE: We send those in quarterly, yes, sir.

MR. CONRADI: What do you consider after hours?

MS. BOOTHE: We've still got to look at our staffing based on what our patients are going to be. We suspect we will have a pharmacist there during our day shift, which is

6:30 to 3:00, to 4:00 kind of time during the week, possibly one day during the weekend. So it would be the late afternoon and evening and some weekend coverage.

DR. MARTIN: What's the distances between the campuses?

MS. BOOTHE: The Decatur General campus is about ten miles. It's 9.5 to the Parkway campus. The Parkway campus and West campus are about a mile apart.

MR. CONRADI: What's your --

DR. MARTIN: At the Parkway, I guess this question would go for both West and Parkway -- the procedures you plan to have in place for emergency callback?

MS. BOOTHE: Right. Currently, if there are any questions, they call our staff that is at the Decatur General campus.

DR. MARTIN: Yes.

MS. BOOTHE: We have couriers available if something needs to be taken to another campus after hours. We also try to keep the Pyxis machines stocked with almost

everything that is in a pharmacy. It's going to be in one of the machines in the house so that they have access if they need it. Charge nurses and house supervisors have override access but we would like to keep our overrides down as much as possible. With remote order entry or verification, we can provide that order verification for the nurses to access the patient's specific meds without having to override.

DR. MARTIN: So if you got in a situation where you needed to mix a sterile product for a patient at the Parkway location and it was beyond the -- what you were comfortable allowing the nurse to do, how would the patient get that drug?

MS. BOOTHE: Okay. Right now we have a few nurses who we've put through our aseptic technique validation processes.

DR. MARTIN: Right.

MS. BOOTHE: Generally the charge nurses, it's not every nurse, and they are who are responsible in like the ED after hours right

now, they are responsible for making a medication. We keep loaded in their Pyxis advantage type products for all of the antibiotics and things like that.

DR. MARTIN: Yeah. So in the back of my mind, I think there's a standard that the Joint Commission or CMS has, it may have been a condition for participation, that if you're closed, you have to have somebody who can physically come back.

MS. BOOTHE: Right, and we can put in an on-call system. Right now the only on call is to whoever is at the main campus --

DR. MARTIN: Yeah.

MS. BOOTHE: -- or our West campus but our West campus doesn't have any IVs. Those patients don't have IVs, so it will be a little bit different with Parkway so we'll have to implement that on-call system.

DR. MARTIN: I don't have any other questions for you.

MR. CONRADI: What's the current staffing at Parkway?

MS. BOOTHE: At Parkway we have one pharmacist and one technician who are there about four hours a day to help the ED and the infusion center during the week, so their hours would be extended when we have inpatients though.

MR. CONRADI: So you'll actually be extending hours, not shortening hours?

MS. BOOTHE: Correct, correct.

MR. CONRADI: Any more questions?

MR. MCCONAGHY: Do you have any kind of numbers to show what additional this is going to be added on to?

MS. BOOTHE: We don't believe it will be additional workload because we are moving patients from our main campus to our Parkway campus, so it's patients we're already taking care of.

MR. MCCONAGHY: Oh, okay.

DR. MARTIN: I move we approve the request.

MR. CONRADI: Second?

MR. DARBY: Second.

MR. CONRADI: All in favor?
MR. MCCONAGHY: Aye.
DR. MARTIN: Aye.
MR. BUNCH: Aye.
MR. DARBY: Aye.
MR. CONRADI: Thank you.
MS. BOOTHE: Thank you very much. Walgreens, who's up, Al?
MR. CARTER: Good morning, Al Carter, director of professional affairs and pharmacy quality for Walgreens, and this is -- it's a fairly straightforward request and I think you guys have a list of limited distribution drugs that I provided to you earlier last week.
What Walgreens is trying to do is currently with our specialty pharmacies, and we have four specialty pharmacies that deal with mainly limited distribution drugs located throughout the U.S. They're all nonresident, licensed Alabama pharmacies and currently what we do is if a patient has a prescription, most of these are, you know, anywhere from a range of $1,000 up to $10,000 or $15,000 for a 30-day

prescription. These prescriptions are sent to the patient's home.

In about 35, 36 states, if a patient requests, we have the capability to ship it to our pharmacy where the patient would go and pick it up. Now, the prescription and all of the third-party billing, the counseling and everything, is all done with the specialty pharmacy. The pharmacy located next to them is just serving pretty much as like a depot to protect it, whether they're homeless or whether, you know, they're not going to be home from temperature or just factor -- any of the other obvious reasons to serve as a spot for them to go and just pick it up and then if they have any further questions, they can actually talk to that pharmacist there or we can connect them back to the specialty pharmacy if they don't want to do so.

It's not a -- it doesn't happen a lot. I'd say right now nationwide with the states that we're seeing it, it's probably about two prescriptions per month on average that we're

seeing but it's a service that we want to be able to offer the patients in Alabama and I think per your regulations, and I think it's Alabama Code 34-23-70, our legal interpretation is that it is currently not allowed in the State of Alabama and so we were asking for a waiver from this requirement to be able to provide this service to these patients.

MR. WARD: It's a statute. It can't be waived. We've got to look to see --

MR. CARTER: And that's -- like I said, that's our legal's interpretation. It may not be the Board's same interpretation.

MR. WARD: It's going from a -- you're talking about the pick-up station section?

MR. CARTER: Yes, sir.

MR. WARD: It's going from where? Where is it being shipped?

MR. CARTER: It's coming from a specialty -- it's coming from a Walgreens specialty pharmacy.

MR. WARD: To another pharmacy?

MR. CARTER: To a Walgreens.

MR. WARD: Another Walgreens?

MR. DARBY: Two different permits though.

MR. WARD: I think the intent of that is -- was somewhere other than a pharmacy, so if it's going from one permit holder of this Board to another permit holder of this Board, from one pharmacy to another pharmacy --

MR. CONRADI: Common ownership.

MR. WARD: -- that doesn't apply.

MR. CONRADI: Yeah, common ownership.

MR. MCCONAGHY: Yeah, I would agree, I think public health wise it's probably a good policy to be able to do that because sometimes the patients aren't there and your couriers may not leave them in the ideal position.

MR. CARTER: I think for Medicaid and a couple of other plans they have to sign for it as well, so sometimes it puts a hole in the continuous service to that patient so.

MR. WARD: Well, understand it's limited just to a pharmacy, nowhere else.

MR. CARTER: Correct, it would

specifically be either shipped to the patient's home or if they requested we would ship to a Walgreens pharmacy for pickup.

MR. WARD: Okay.

DR. ALVERSON: Al, do these sometimes require special administration so is it -- are they sometimes items which a home health nurse would pick up?

MR. CARTER: Most of these items, no, ma'am. There may be one or two items that a doctor will request that the patient brings it into the doctor's office for administration there but most of them do not require any special, outside of what the patient would be able to customarily provide to themself or using a provider that they would bring it to. And we have seen in some circumstances where -- because a lot of times providers will try and get the medication shipped to their office but we have seen, especially with these because of the costs, that a lot of the providers are now telling the patient to run through their -- their prescription drug plan and then just bring

it to their office to administer to them.

MR. DARBY: Do they need a vote on that?

DR. MARTIN: I think he needs a vote and I think we need to give him something in writing in case we have loss of memory.

MR. CONRADI: Is that a motion?

MR. DARBY: I'll make a motion that Walgreens be allowed to ship specialty medications to a Walgreens pharmacy to be picked up by the patient there.

DR. MARTIN: Second.

MR. BUNCH: Second.

MR. CONRADI: All right. All in favor?

MR. MCCONAGHY: Aye.

MR. DARBY: Aye.

DR. MARTIN: Aye.

MR. BUNCH: Aye.

MR. CONRADI: Aye.

Thank you, Al.

MR. CARTER: Thank you. Appreciate that.

MR. CONRADI: That was easy. Now, UAB telemedicine.

Good morning, if y'all would introduce yourselves again just so we get it on the record.

MS. WAHLHEIM: Are you ready for us to begin?

MR. CONRADI: Yes, ma'am.

MS. WAHLHEIM: Okay. I'm Cary Wahlheim. I'm general counsel with UAB Health System.

MS. BAKER: Thalia Baker, operations infirmary care.

MR. COHEN: Stuart Cohen, the medical director of primary care at UAB.

MS. WAHLHEIM: And just for the record, also in attendance today with us but in the audience are David Randall, senior vice president of business and strategy for UAB Health System and Melissa Mancini, director of business and strategy for UAB Health System.

I'm going to start off this morning and I want to say first of all, we certainly

appreciate your time this morning. You have a busy agenda and so we appreciate you including us here. Also, we're here today -- UAB eMedicine is here today to provide information. We're not really here to ask for anything but there has been some issues obviously around UAB eMedicine.

We feel like there might be some misconceptions of what it is and how it operates and so when your executive director, Ms. Alverson -- Dr. Alverson reached out to us about concerns about the program and interaction with pharmacy, we met with her and some other members of your staff and we felt like it would be a good opportunity to come and present to you today some more information about the program.

Just to give you a little bit of a background, this is a pilot program that is run under the jurisdiction and the supervision of the Alabama Board of Medical Examiners. They originally gave UAB Health System permission to start this pilot program back in September of 2013. As with every program, it took a little

time to launch that -- this particular program for eMedicine and so we didn't launch until July or August of this year, 2014.

Shortly after we were contacted by Dr. Alverson about some questions and concerns about a regulation that y'all have regarding Internet pharmacies and so we very quickly asked to meet with her and some other members of the staff to kind of go over those concerns and I think one thing we want to emphasize today, this is not an Internet pharmacy. UAB eMedicine in fact sends the prescriptions, if there is one, there's not a prescription in every encounter, but if there is a prescription, the prescriptions get sent out and we'll reemphasize this in Ms. Baker's program, but they get sent out to the local pharmacies. The patients that do actually get a diagnosis and get a prescription are requested to tell us where they want their prescription sent, so it's -- it's wherever they want the prescription sent.

So as I believe y'all are probably well aware, the concern that the Board of

Pharmacy has is with your regulation, 680-X-2-.33, involving Internet pharmacies and the concern, I believe in my interpretation and through our conversations, is over the issue of whether there's a valid or a preexisting patient-physician relationship when there has not been a face-to-face encounter between the provider and the patient.

So we -- in the interim between the time we met in late August and today, we have gone back to the Board of Medical Examiners and gotten a letter, which should be in your packets that's dated September 24, that reaffirms the program and it is a statement by the Board of Medical Examiners that says they believe under this monitored program that an eMedicine visit constitutes a valid patient-practitioner relationship, even when the patient has not been previously physically seen by a UAB practitioner.

And just to give a little bit of background on that, the Board of Medical Examiners actually has their own regulation

about contact with patients before prescribing. It's -- and I apologize I did not provide it to you in your packets but it is Board of Medical Examiners regulation 540-X-9-.11 and in it, the Board of Medical Examiners recognizes that typically or perhaps optimally or at least historically, the expectation is there is an in-person physical examination for most -- most things but there are some exceptions. It's not an absolute for there to be an appropriate physician-patient relationship and that before you prescribe a drug for a patient, there are instances in which you don't have to have that face-to-face or preexisting relationship and some of those situations are like when you're taking call for your partner or for another -- maybe not even your partner but for another person on call for the emergency department or for whatever service you're on.

Let's see, another one is continuing medication on a short-term basis for a new patient prior to the patient's first appointment and certain things like that and so we feel like

the Board of Medical Examiners has looked at this program very carefully. They will continue to look at this program and supervise it and they have determined that this is again one of those instances where they feel comfortable that a face-to-face preexisting relationship is not required, at least for now until we provide more data. So that's a little bit of the background. We're going to take questions obviously at any time that you wish but I think it might be helpful for Thalia Baker to go through her PowerPoint presentation just to give you a sense of what UAB eMedicine is. Thank you.

MS. BAKER: And as I mentioned in the introductions, I'm responsible for operations. So in primary care, our biggest challenge right now is being able to provide enough access to everybody to have primary care services there. I'm sure you guys have all experienced that yourselves, so we're trying to do everything we can to try to stretch our providers and stretch our access and also, today people really want access on their own conditions. You know, they

want access when they want it, where they want it, how they want it, and so we're trying to be responsive to the population in Central Alabama.

So just a basic overview of how the eMedicine service works, it is simply a software that overlays our medical record at UAB and it's a branch logic protocol, very low acuity issues. So a patient comes in, creates a unique login and password for them. They self-select what they think is going on so they've got a cold or they have a UTI or something along those lines. They follow the branch logic in the protocol.

As they're answering questions, it's creating an evaluation management note, an E and M note, just like we would create in an office visit. It's compiling that information into what Medicare requires us to put into a visit note. At any point should they answer a question with something that creates a red flag, they drop out of the protocol and they're asked to come in for a face-to-face visit and we suggest locations around their zip code that they've provided that would be convenient for

them to come in. Our urgent care at UAB is one of those choices but it's only one out of many, so we're not -- we're not forcing them into our urgent care. We're really offering a choice.

If they successfully go through the protocol without any red flags, they're asked where their pharmacy of choice is, just like we would do in a normal office visit at Kirklin Clinic or anywhere else. That's saved in the software and then that visit document, it's a big note, a very nice note, goes into a queue that is worked by our team of providers within the hour. That's our service response that we're committed to offering.

So they come in. They look at the note. If they are able to treat the patient, either with a prescription or with an over-the-counter medication or simply with recommendation about rest and fluids, the patient is charged $25. So we purposely set it very low. It's lower than all the copays in the state now and there's no insurance claim filed. It's really a way to offer the patient an easy

access point for low acuity visits without them going to the ED to seek that care, which is what a lot of people are doing right now and that's definitely more than a $25 payment when you go to the ED.

So if for any reason we look at the note and we see that the patient needs to come in and see someone face to face, we refund that $25 back, we give them instructions back to that secure link that they need to come in and see one of the urgent cares. So that's just the basic operations of how it works.

So an online interview that's usually evidence-based, branch logic protocols, very low acuity issues. We're doing about seven diagnoses right now. It's only available between the ages of 18 and 65 and it's all managed by providers that are on our medical staff at UAB.

It doesn't autodiagnose. That's one question we've gotten. Anybody that's complex is automatically kicked out for one of those red flags in the logic. We don't treat anything

complex. We don't do any lifestyle drugs, no controlled substances. This is very much low acuity type prescribing and it is not a pharmacy in any way. We actually ePrescribe just like we would for a patient that came in to see us anywhere else and everybody uses their SPI number just like they would use anywhere else.

This is just current utilization, so this goes -- we really have only had the service open -- fully open for a little over a month when I took these stats at 9/30, so we've had a little over 1,100 attempted visits, 233 have completed the visit. They've made it through the protocols without any red flags, so that's a 20-percent success rate, so 80 percent have bumped out and been suggested to come into an urgent care. 155 prescriptions have been sent electronically, so 66 percent of the completed visits actually got a prescription. Everybody else got over the counter or recommendations for rest and fluids.

I want to turn it over to Dr. Cohen and let him talk to you a little bit about it

from the provider perspective and also about our quality goals that we are trying to reach.

DR. COHEN: Thank you, Thalia. I'm really here just to -- to reinforce much of what you've heard. From a physician perspective, again, these are very low acuity problems, very common outpatient issues. The type of issues now that are oftentimes either dealt with over the phone if a patient were to call a primary care physician and/or if there was no established relationship, these patients would be forced to be seen at an urgent care center or simply an ED.

Again, these are evidence-based guidelines, so patients are not going online and getting antibiotics for viral upper respiratory tract infections through this -- through this program and I think that's well reflected actually in the success rate. That is -- many people would look at that and say, well, only 20 percent of people successfully get a prescription. We think that's a very good thing. It means that the program is, one,

evidence based, it's not giving out medication when it's not indicated based on the guidelines, and two, we think it's doing a very good job of selecting for patients who are -- who should be treated or who could be treated through an electronic system.

By that, patients who have a complex medical illness, if you have significant diabetes, congestive heart failure, chronic kidney disease, for example, these are red flags where patients are automatically referred out of this program. Even age, if patients are over the age of 65, this is not -- one cannot make it through.

Also, there's no pediatrics. It's 18 to 65. If someone has a large number of medications, again, because of the possibility for drug-drug interactions, one is -- that's a red flag and they are referred out. So from a medical perspective, I feel very confident that the conditions selected are those that can be dealt with without the use of a face-to-face visit and without the use of diagnostic testing.

I'm very comfortable with the evidence-based guidelines as far as the safety of the process.

So that's really I think what I wanted to state from a physician's perspective, my comfort with this process.

MS. WAHLHEIM: Does the Board have any questions for us?

DR. MARTIN: Do you know what the plans might be for the Board of Medical Examiners to move their letter into a rule?

MS. WAHLHEIM: I do not, no. We didn't ask for a rule and all we know is that they're going to monitor us every six months, so we'll provide data to them in February and they do have a process under their telehealth rules, they have a process for exemptions, but this doesn't really fall under -- under that. It's separate and apart from that. It was approved before those rules went into effect and so, you know, we would say that this is a pilot project and this sort of letter, although it doesn't refer to that regulation, sort of falls under that purview of the Board of Medical Examiners

of determining what is -- what constitutes the physician or provider-patient relationship.

MR. WARD: Here's a problem I have. I'm the Board's lawyer and I'm not talking about the merits of it or whether it's a great thing or not because I think it is. That's not the issue, okay. If you read the very last paragraph or sentence of that rule, it says that a relationship based strictly on a questionnaire is not professional conduct of a physician. That's clear.

So it concerns me as a lawyer that that's a pretty definite declarative statement. There's no -- there's no exception to that and I haven't -- and I haven't had a chance to talk to the lawyers for the medical board who I know well but that's what we're wrestling with because we have consistently advised pharmacists, okay, that if there's not -- if the relationship is based on a questionnaire and that's all, then a valid physician-patient relationship doesn't exist. That's what the pharmacists of this state have been told. That

has been the basis for actions taken by the Board against pharmacists and now all of a sudden we've got them interpreting in different ways so it creates the ripple that it greatly affects what this Board does. So that's what I'm wrestling with.

MS. WAHLHEIM: Certainly, and we're not here to tell you how to interpret or enforce your rules against your membership. I would suggest, however, that we believe it is within your discretion that you're already doing, so to interpret this rule not to prosecute people that may be issuing prescriptions pursuant to telephonic consultations without a preexisting relationship -- patient relationship or a -- or a face-to-face consultation because your rule talks about if you strictly interpret it, you strictly interpret this rule, that would also bring into the prosecution of what you would have to prosecute those situations in which people are taking call for each other. If you're taking call for your partner or not a partner on a service over the weekend, you've

never met a patient and they call you and say, I've got upper respiratory issues and I'm not feeling well --

MR. WARD: That's not -- that's not correct. That's not correct. There's been a patient relationship established with the practice. You told us -- you told us -- you told us you can't tell us how to enforce our rules and now you are --

MS. WAHLHEIM: No, no, I'm not -- I'm just suggesting -- I'm not telling you. I'm suggesting that you can use your discretion and it appears that that discretion has been used before not to prosecute those because we asked the question we brought -- we met with your staff. We asked the question. We said, well, how do you -- how do you have this rule and how do you address call situations because not all call situations are with your partner.

Some people take call for people that are not in the same practice and so we asked that question and all I'm saying is that from the Board of Pharmacy's perspective, we would

suggest and you would have to look at it yourselves, but in our looking at it, we would suggest that this Board would defer to the opinion of the Board of Medical Examiners who through its rules and through its statements have said that those are appropriate times in which you don't have to have a face-to-face examination. That's all I'm saying. I understand the predicament that y'all feel like you're in. I'm just saying we've looked at it and said it's a regulation, it's not a statute, and it would appear that you have discretion in how you prosecute that regulation. But of course, that's -- that's within your comfort.

The other --

MR. CONRADI: There are a lot of times a patient will call a doctor they've had a relationship with and not be seen and get a prescription but this is where they've never even -- you don't even know who it is on the other end. I mean, the patient has never been seen by anybody at UAB possibly, so they're answering a questionnaire. They can be a kid

answering it and put it in there and y'all sending medicine out to them.

Then our pharmacists are filling prescriptions based on a questionnaire that we don't know who answered and y'all don't even know who it is. I mean, you have no idea who is on that computer typing them in. I mean, as far as access to primary care, I hope that's not y'alls definition at UAB what you're training your physicians to do is not have any patient contact. Is that access to patient, I don't know.

MS. WAHLHEIM: Well, unfortunately, I think as, you know, the population grows and as we all struggle with the changes in medicine and with providing access, I mean, we've talked to primary care physicians who have these complicated plans and these managed care plans and they, you know, get so much per month to see patients and they often don't see the patients and their first contact with them is a phone consultation and they issue a prescription, so that's not any different. It's just not

publicized. It's not a program that's online, so I think -- I think there are more situations than eMedicine in which -- which would cause concern about this rule is all I'm saying. I mean --

MR. CONRADI: There's nobody on the other end to examine a patient and put real vital signs or anything in there at all. I mean, I just have a hard time seeing that's good primary care medicine.

DR. COHEN: Well, with all due respect, relative to this process, the interview process, the amount of information that the provider obtains to make a decision on these relatively simple problems is infinitely greater than is achieved in a phone conversation and I would beg to say infinitely greater than is typically obtained with a quick urgent care visit. This is a very, very thorough process grounded in evidence-based guidelines.

Now, to your question, can someone lie and make up stuff, I guess the answer is sure. That is certainly a possibility. However,

patients can come into my office and lie to me.

MR. CONRADI: But you're seeing them.

DR. COHEN: But the basic tenet is the same, sir. If someone is going to have -- to lie and to give me erroneous information, I don't have any way of checking that, so there is a level of trust, yes. The assumption that simply seeing the patient changes that is one I would say of degree, not of honor.

MS. WAHLHEIM: And just to your point I -- it's fine for you to have concerns about that. We would suggest that that is a question within the jurisdiction of the Board of Medical Examiners whether that is appropriate primary care medicine.

MR. CONRADI: Right.

MS. WAHLHEIM: So -- so I mean, they have determined that at least under supervision, they're willing to assess it. There's no guarantee that this will continue past the pilot program. We realize that and we're committed to providing information about it, so we certainly

understand that.

MR. CONRADI: Yeah. Our problem is that we're prosecuting and taking pharmacists' licenses away or putting them on probation for doing what y'all are asking our pharmacists to do now is to fill prescriptions based off a questionnaire. I mean, we don't see any -- any way you can interpret it any different. I mean, it's never been a face to face, I mean, you have no idea who that patient -- I mean, that's our problem is trying to reconcile that rule with what y'all are doing. So it's putting our pharmacists under jeopardy if they know that patient only answered a questionnaire, so that's why -- that's where our problem is.

DR. COHEN: Yes, sir, I understand. I guess, you know --

MR. CONRADI: It may be okay at the medical board but it's --

DR. COHEN: The questionnaire is simply a set of questions but the answers are reviewed by a provider, so it's not as if --

MR. CONRADI: That's what they're

doing now on the Internet.

MR. BUNCH: UAB is great. Y'all do fine work but our problem is somebody -- a bad -- a bad doctor, you know, a racket that are -- that are prescribing drugs. Now, the controlleds I think have been somewhat dealt with but still, the Viagras, that type of thing, you know, mail or Internet prescriptions, this type thing.

MS. BAKER: I wonder if for the period we're doing this pilot project, because those SPIs are coming in with those prescriptions showing UAB Medicine that they're our faculty that are prescribing, I wonder if that might be a way to give you some way to control it with your pharmacists, so you can say this -- this group, it's a pilot project. We know it's going. We're not going to spread it to everybody in the whole state, you know, it's just for the MSA and Birmingham only, so it's a very confined area. That might be a way to say, we're going to make an exception to our rule to try this and then we report our quality back to

the state and we'll see what they come back with.

DR. MARTIN: Well, I think that would have been -- that would have been a valid idea if we'd have been involved in the pilot to begin with and we could have prepared for that.

MS. BAKER: And I'll tell you from the operations side, you know, we -- we very thoughtfully tried to figure out which groups we need to approach and I did not understand operationally that we needed to approach the Pharmacy Board. That -- I will take responsibility for that. We just didn't see that there would be an issue there because you're tracking it back to our providers, that prescription so.

DR. MARTIN: I understand the citation of 540-X-15 in telehealth but I heard earlier you cited another rule. Would you give that to us one more time? I missed that.

MR. CONRADI: 540-X-9.11.

DR. MARTIN: 9.11?

MS. BAKER: Yes.

MS. WAHLHEIM: Yes, it's called contact with patients before prescribing.

DR. MARTIN: Is that under miscellaneous?

MR. WARD: Yeah.

MS. WAHLHEIM: Yes.

MR. WARD: That's the one where she says they say if it's an all outpatient or something you can --

MS. WAHLHEIM: It just says prescribing for a patient whom the physician has not personally examined may be suitable under certain circumstances. Any other questions?

MR. MCCONAGHY: Yeah, I guess procedural type, easy questions: When does the pilot study end and did you check and see if third parties were going to consider this legal to fill these on them because we have to deal with auditors that would probably deem this not a legal prescription and will take the money back if somebody filed it. Did you check with any Blue Cross, Medicaid, or anybody to see if they were going to be willing to file -- pay?

MS. BAKER: We did. Yes, sir, we did. And I think for your first question, it's a 24-month pilot that starts in July of this year, so we'll run until June of 2016 and we're reporting quality data every six months to the Board.

On the second question, we have addressed it with Viva and with Blue Cross, which are two of our biggest payers. We actually are going to start in January offering it at an even reduced rate to just our employees, most of which are existing patients, and Viva is very supportive of that.

MR. MCCONAGHY: How do you insure that the patient is from the Birmingham area?

MS. BAKER: By zip codes. It's limited to a very restrictive zip code area.

MR. CONRADI: So if it's with your existing patients, that's -- I mean, that's a whole new ball of wax. That's my problem.

MS. BAKER: Yeah, that's what I'm hearing, yeah.

MR. CONRADI: But just taking whatever

comes in, it's hard for us to reconcile. I mean, I'm not meaning to go off on y'all but it's just -- you know, y'all put us in a bad spot. We're sitting here prosecuting pharmacists for doing the same thing. How do we reconcile, you know, not -- not prosecuting them for filling these.

MR. MCCONAGHY: Is there any way to designate that these prescriptions are coming from an Internet-based questionnaire?

MS. BAKER: I don't know how within e-prescribing. Do you? Because the SPI is actually assigned to each provider and so no matter -- you know, they could be working at our Inverness Clinic or downtown at Kirklin Clinic and it's coming from that same provider number.

MR. CONRADI: You never know.

MR. MCCONAGHY: They could put it in the directions in the SIG line --

MR. DARBY: There's a comment.

MR. MCCONAGHY: -- as a comment on there that it came from an Internet-based

questionnaire.

MR. DARBY: How do patients find out about the service?

MS. WAHLHEIM: We have marketed the service and it started with our own employees, you know. We internally marketed it and rolled it out and then it's just -- we have a marketing program.

MR. DARBY: Like television advertising?

MS. WAHLHEIM: Yeah, newspaper advertising, radio.

MR. CONRADI: No push back from your graduates out there that they're being replaced by a computer?

MS. WAHLHEIM: Well, they're not being replaced. A provider is looking at every one of these.

MR. CONRADI: Right.

MS. WAHLHEIM: So it takes as much manpower to do this as it -- as it would be -- there's nothing automated about this except filling in their answers to the questions. I

mean, a provider is looking at every one of these making a determination using their clinical judgment and deciding what should be done, so there's nothing automated about it. The more successful this gets, the more staff we have to hire, so it -- so it's not about -- it's not about saving personnel time at all.

MS. BAKER: No, that's different.

MR. CONRADI: Well, if I'm a physician in Clanton it may be because you're taking all my patients away -- all my acute care patients so. But anyway, I mean, that's not my problem now. Susan, I'm sorry.

DR. ALVERSON: You said you're doing reports every six months, was it?

MS. WAHLHEIM: Uh-huh.

DR. ALVERSON: Is there going to be a way to track down patients who were serviced by the program? Is that part of your study?

MS. BAKER: Yes, actually what we're doing, Susan, is we actually -- let's just say that you came in and you were an eMedicine visit and you had never interacted with UAB Health

System before. That's not super common but just say it happened. We actually go in and create a medical record within our electronic chart for you. All of that information from that visit comes in. Your med list comes in. Your allergies come in. That chart is complete because what we're getting prepared for is that somewhere down the line if you interact with another component of the health system, we know you. We at least know those pieces about you and we know it was prescribed in treating that visit, so it's treated record wise just like you came in person.

DR. ALVERSON: Are you ever going to know the antibiotic that you prescribed for my UTI was successful?

MS. BAKER: Well, a three-day follow-up is what's suggested within the visit. So we attempt to make contact three days follow-up on them. We also say that if you're not satisfied within that period, you come back and reach back out to us, so they have the ability to come back to us electronically or they can call us, either

one.

DR. ALVERSON: So three days you call the patient?

MS. BAKER: We can call them or they can call us, either way. So they could call us earlier if they're not satisfied within that period. The other thing we're doing is taking that 1,100 visits -- that attempted visits.

DR. ALVERSON: Right.

MS. BAKER: We're bumping them up against, as part of a quality process, any interaction within our health system at all to see if that patient subsequently came to the ED, for instance. We want to know that because sometimes patients won't --

DR. ALVERSON: I guess my concern is the 66 percent of the 233 --

MS. BAKER: Yes.

DR. ALVERSON: -- or even the 233.

MS. BAKER: Right.

DR. ALVERSON: Is someone going to reach out and contact those 233 people?

MS. BAKER: Yes, the 233s are the

complete ones. The 1,183 would be the ones we would try to electronically -- it's just physically impossible to call all of those patients, so those are electronically being bumped to see if they touched us at any other point because our goal here is that we want to treat them and for them to be better, not for them to go to the ED two days later. So we're trying to monitor that to see if any of that occurs and that's part of what we'll report back to the state.

DR. ALVERSON: I guess I'm dense but --

MS. BAKER: I may not be answering your question.

MR. CONRADI: You're from Wisconsin.

DR. ALVERSON: That is true. It's all that beer and cheese after a while. I will be making a call this afternoon for a cholesterol drug.

MS. WAHLHEIM: I think the answer is that of the 233 completed visits, we are -- we do have a process in place to reach back out and

make sure that they're better, to make contact, to answer questions.

MR. DARBY: How about the 950 though, those are the ones that really need the follow-up it would seem like.

MS. BAKER: And I tell you, here's our challenge and this is a challenge across the country with this type of service is that if that -- if those 1,183 touch our system anywhere, we can find them. If they go to American Family Care down the street, they're lost to us because the charts don't talk to each other. That's going to get better as we go through the next few years but right now, we can only electronically track them in our own system.

MR. BUNCH: How many other states or organizations are doing this type of thing?

MS. BAKER: This is actually -- especially in the western U.S., it's very common. You know, Blue Cross is currently also trying a program with a teledoc so -- for specific plans within their insured, so there's

a lot out there. It's definitely coming. I think that it's good Alabama is being cautious and we're testing it as we go to make sure it really pays off.

DR. COHEN: Mr. Darby, to comment on your point, you are right, 80 percent of people don't get treated through this method, so it's, you know, if they're a patient, they can come on and try it but if you don't -- you're not treated then there are, you know, warnings and the recommendation is please proceed. This is not right for you. This is really a very small segment of the population of patients who really can be treated. So for the doctors out in the community, I don't think many of us are really threatened too much by this because this is really the otherwise healthy, relatively young patient with no significant problems who has a minor acute illness.

MR. BUNCH: Is this just a very humanitarian thing UAB is doing or do you look for this to be a profitable item down the road at some point. For $25 a head, I don't think

you are going to get rich.

MS. BAKER: I wish it could be. It's not.

MR. BUNCH: So is this something you're doing just for the -- you know, just for the residents of Alabama?

MS. BAKER: Well, I mean, my goal from the operation side of primary care, so Dr. Cohen has a PACT practice. What I'm hoping is that some of this stuff that he was spending time on the telephone trying to treat, the low acuity stuff, that he can now use that time to manage our more sicker, complex patient or see new patients. This is not a money-making venture and we're actually talking about lowering that price for our own employees to try to help keep them out of other urgent cares or EDs, so it's not in any way profitable.

MR. DARBY: Are physicians reviewing this or is nurse practitioners or is it a combination of both?

MS. BAKER: It's a combination. We actually -- nurse practitioners probably review

the majority of the visits and then we have a review process that occurs on the back end just like you do for the collaborating agreements with the State for the Board of Nursing.

DR. MARTIN: Is the decision to prescribe always made by an individual?

DR. COHEN: Always.

DR. MARTIN: So it's not through an algorithm?

DR. COHEN: No, all the algorithm does is obtain the information, which is then put forth to the provider to review and make a decision of treatment.

MR. BUNCH: I think all of that is good information and all. I still -- I'm not sure where we are legally on the -- to put --

MR. CONRADI: There's a lot of telepharmacy telehealth out West. I guess we're slow getting it. Our problem, I guess right now, is just trying to reconcile how we do -- what we tell our pharmacists being able to prosecute people for doing --

MR. WARD: And what we do in the

future.

MR. CONRADI: And that's -- that's the bad part.

MR. WARD: The hardest dilemma legally is let's say everybody just loves this. It's great. We allow it to happen and next month someone else is in here. Well, you're letting UAB do it. Pretty soon it will be -- the one exception becomes the rule and without any standard for doing it, so legally it's just -- it's just a quicksand of -- I know you don't understand that, I'm sorry, but it is.

MS. BAKER: No, I --

MR. WARD: You can't treat -- you can't treat people differently, so if we allow this to happen, the Board says this is fine, then -- then next month someone else wants to do it. They're going to say, well, this is a pilot program and the Medical Board said it's okay. That way it's okay but yours is not and it just creates legal issues for how a -- how a regulatory board acts and to act consistently or try to.

MS. WAHLHEIM: And I understand that. I do think the history of that regulation, I understand the genesis of it and the concerns about Internet pharmacies. I just feel like maybe it was drafted without -- you know, without -- too broadly and it takes in things that don't -- this is not an Internet pharmacy and that's really all we're trying to convey is that we're -- you know, we're trying to send prescriptions that we think are appropriate to your members.

MR. BUNCH: You are but it is an Internet pharmacy in the respect that if there's other -- there's other -- this same thing happens with -- with Joe Doe contacting an Internet site and a doctor and the doctor had written a prescription and then sent it in, I guess. I don't see the difference.

MS. WAHLHEIM: Right. Well, right now, I mean, I think we -- you know, that's why it's a pilot project. I think -- I think we are trying to find standards and we're trying to work through the Board of Medical Examiners to

find those standards and if we had understood that this rule would have applied to that, we would have come to you as well. We just honestly, we did not understand that, and so we're playing catch-up and we apologize for that.

MR. CONRADI: And I think y'all are doing it correctly. I mean, I don't mean to go off on you but it's just kind of -- it's put us in real bad position as far as some of the cases we've got out there right now prosecuting it. Of course, I don't think any of them have a Board of Medical Examiners approval to do it so I mean, that may be what we have to hang our hat on.

DR. COHEN: My sense from the Board's perspective in just meeting with them early on was they did see that things are changing in medicine and I think they want to be cautious. They want to be sort of methodical, so granting this pilot program to UAB, being a major established medical center that has the ability to look at some of the quality metrics and maybe

some other smaller groups, putting a limited time frame on it I think was their way to say, let's put our foot in the water and see. So I agree that making an exception is an exception, you know. If you make an exception for one, you make the exception for all.

On the flip side is there's -- from the Board's perspective, how do you test. How do you see if this is good. Maybe the rest of the country is doing it but do we want to do it in Alabama, maybe yes, maybe no, but let's -- let's look at it, you know, critically and methodically. I think that's what they're doing.

DR. MARTIN: And we totally agree that it needs to progress, that there are patients out there, this is possibly the only access they're going to have. We understand you've got other issues you need to get to that are more important for patients who had more serious conditions, there's no question about any of that and we understand that now we have a dilemma that we have to deal with from a legal

standpoint.

There's another aspect of this that we haven't talked about and that is the implications for whatever action we take will have the implications beyond this Board of Pharmacy and potentially beyond the State of Alabama that you need to know exists.

MR. CONRADI: Thank you for --

MR. MCCONAGHY: I've got one more. Do you have anything from the FDA as far as -- because I did have some experience with the Internet part of it and they are the ones charged with regulating that on a federal level and kind of shutting down the Internet pharmacy teams. Do you have any kind of -- anything from them and did you consult with anybody, even your employees that was a pharmacist in this process?

MS. BAKER: Yes, our lead in pharmacy was actually involved in giving us feedback on this. I think -- I think the piece that we're -- we don't view it as an Internet pharmacy. That's where we're kind of --

MR. BUNCH: How do you not view it as

an Internet pharmacy if you're doing it all on the Internet?

MS. BAKER: Because we're not -- we're not selling any medication.

MS. WAHLHEIM: We're not selling them medication via the Internet.

MR. CONRADI: Right.

MS. WAHLHEIM: We're sending a script out as we would any normal scripts, so it's an online survey.

MR. WARD: Yeah, I agree with you, you're right. I agree.

MS. WAHLHEIM: But we're not selling pharmaceuticals.

MR. MCCONAGHY: No, that's not what I meant. But the FDA is going -- when they find one of the Internet pharmacy things, they're going and tracking back to see what doctors were prescribing to that pharmacy and tracking them down, so I just didn't know if you had cleared that with the FDA.

MS. WAHLHEIM: We have not cleared -- we have not asked for a clearance or a license

or anything from the FDA. I have reviewed FDA materials and I have not seen where they would have jurisdiction or a concern over this program because we're not dispensing drugs.

MR. CONRADI: The pharmacist is not paying the physician to write prescriptions.

MS. WAHLHEIM: Right.

MR. CONRADI: So they can dispense them. I think that's where some of the confusion comes in on that rule. It's actually -- the pharmacy is actually contracted with the physicians to -- to get them to write the prescriptions.

MS. WAHLHEIM: Correct, right, right, and we're -- we're deferring to the patient's choice, so we don't have a relationship with the physicians that -- I mean with the pharmacists that dispense the prescriptions and that's -- that's how we distinguish ourselves from the Internet as a pharmacy.

MR. MCCONAGHY: Okay. Back to just the technical and legal part of it, because I'm going to have some folks here. I know I did ask

Medicaid and they said at this point they would not pay for a claim if it came from here because as it states in the law right now, it's not a legal prescription and if we have pharmacies that if it picks up and gets to be a big issue, you've got 153 or 155, would we have a list of who those went to because if they got paid in the Express Scripts instead of Blue Cross or decides to come back and recoup the money because it's an illegal prescription, then we're telling our pharmacies it's okay to fill it but now they're going to get into a legal issue with third parties.

MS. BAKER: If -- we've talked to our biggest payers, so they're very aware of what we're doing, so we shouldn't have that issue with those guys. But for instance, if you had a small payer who came back and said, I'm going to recoup that, normally what they would do is make that chargeable back to the patient. It would be a patient responsible amount.

(Laughter.)

MR. BUNCH: I beg to differ on that

one.

MS. BAKER: I'm glad it could end on a laughing note.

MR. BUNCH: No, I tell you -- no, that's not true. I've been audited. I've been, you know -- let me tell you this: When you have a third party that comes back and they want to recoup money from a community independent pharmacy because -- because in the law maybe it said that the information -- all the information is supposed to be on the front side of the -- of the prescription and the pharmacy put the sticker on the back side and they want to recoup Humulin insulin and Lantus SoloSTARs for, you know, a year's worth of prescriptions of that every month because you put a label on the back of the prescription, believe me, they'll recoup it. If they think that it is an illegal prescription, they'll attempt to recoup it, yes.

MR. CONRADI: I think --

MS. WAHLHEIM: And just to -- just to -- we have not been contacted by Medicaid so I'm not aware of that but we'll find out. I

understand they're here today.

DR. ALVERSON: You said you contacted Blue Cross Blue Shield. Did you contact Prime?

MS. BAKER: Prime.

DR. ALVERSON: Prime is the company that makes the decisions about what will be paid and what won't be paid, not Blue Cross Blue Shield.

MS. BAKER: No, we work through -- we have designated people we work through at Blue Cross that work only with UAB and those are the people we work through. We have a separate contract with Blue Cross, so those people actually go back through whoever their subcontractors are for different components, they go back to those people.

DR. ALVERSON: Just --

MS. BAKER: Yeah, yeah.

DR. ALVERSON: We have found that that doesn't work either. When Prime says no, we're taking the money back, it makes no difference what Blue Cross says.

MS. BAKER: Well, and again we've got

to remember, Blue Cross also has a telemedicine project that is underway under their own auspices, so we're not alone in this right now.

MR. CONRADI: We appreciate the information.

MS. BAKER: Thank you.

MR. CONRADI: Treasurer's report, Mr. McConaghy. Thank y'all for coming.

MR. MCCONAGHY: All right. We're -- this report is for -- through September 2014, which is our year-end report. I am reporting the revenues that -- that we show about 1.845 million if you want to call them revenues. We had budgeted for 1.9 and I just want to tell y'all that that was a bad mistake because we thought we were budgeting for a whole lot less and I didn't think we would get to within a half a million of that budget but due to more license, more people, the influx of things going on, we actually ended up getting fairly close to it.

But the expenses were 2.417 million

and we budgeted 2.417 million, so -- and a tiny bit, so we were actually at a 100.49 percent of budgeted on expenses, so we -- it did show a negative balance so we -- we're down from where we were at the checkbook at the beginning of this year but that's the -- that's the normal process because you had -- this year is kind of the lower year because you have mostly technicians. Next year is pharmacists, you get more, so it balances out. It works out to be a real good thing.

I'd like to just say that I'm really good at budgeting but the really important part of it is that when you can have your expenses that close, it just -- it's really impressive and we have to give that credit to Mitzi Ellenburg, the director of operations, because sometimes I think some folks might not get paid for this to come out this close. I don't know how it -- how it stays that close but when any organization I've ever been in that can hold their expenses to that close of what it is is impressive and we owe that to Mitzi on that, so

that's all I've got.

DR. ALVERSON: Hear, hear.

DR. MARTIN: Do we need a motion to receive the report? I move that we receive the report as submitted from the treasurer.

MR. CONRADI: Second?

MR. DARBY: Second.

MR. CONRADI: All approve?

MR. MCCONAGHY: Aye.

MR. DARBY: Aye.

DR. MARTIN: Aye.

MR. CONRADI: Aye.

MR. BUNCH: Aye.

MR. CONRADI: Board minutes, we need to approve the Board minutes separately from last month. Have I got a motion on those?

DR. MARTIN: As soon as I find them.

MR. DARBY: I move we approve the Board minutes from the September meeting.

MR. CONRADI: Second?

MR. BUNCH: Second.

MR. CONRADI: All in favor?

MR. MCCONAGHY: Aye.

DR. MARTIN: Aye.
MR. BUNCH: Aye.
MR. CONRADI: Aye.
MR. DARBY: I also move we approve the interview minutes from the September 17 meeting.
MR. BUNCH: Second.
MR. CONRADI: All in favor?
MR. MCCONAGHY: Aye.
DR. MARTIN: Aye.
MR. BUNCH: Aye.
MR. DARBY: Aye.
MR. CONRADI: Dr. Alverson, your report.
DR. ALVERSON: Yes, we received a letter from the State auditor's office saying sorry this is so late but we just wanted to let you know that when Tony Yarbrough left, we did an audit of all equipment and everything that was listed as belonging to the Board of Pharmacy we found, it could be accounted for, you had 100-percent compliance, and sorry it took us this long to tell you.

MR. CONRADI: When did they do the audit?

MS. ELLENBURG: Two years ago.

DR. ALVERSON: April 18, 2013.

MS. ELLENBURG: I thought it was further than that.

DR. ALVERSON: And we have -- Terry has recently done another audit within the last few months and again, everything was 100 percent accounted for so.

MR. CONRADI: Great.

DR. ALVERSON: Mitzi makes sure none of us walk out with chairs or --

MR. CONRADI: I've tried to get that copy machine in my truck but.

DR. ALVERSON: You just won't get it. I have 12 years of Catholic education. The nuns had nothing on Mitzi.

MS. ELLENBURG: I could take that either way.

DR. ALVERSON: Just that you're very religious and you like wearing black and white.

MR. CONRADI: She grew up with General McClain here.

MS. ELLENBURG: Exactly.

MR. CONRADI: Everything was black and white back then.

DR. ALVERSON: Back then, all right.

MR. CONRADI: Even Mitzi's outfit.

DR. ALVERSON: All right. I put in your Dropbox proposed guidelines for methadone programs and if you want paper copies, I'll be glad to give them to you. And I don't know if anyone with methadone is here and would like a copy. Can I impose on you? We go way back.

MR. CONRADI: Is that Wisconsin for methadone?

DR. ALVERSON: Yes. This is starting to look like harassment, although I deserve it after what I did to Mitzi.

So I have met with various representatives of methadone programs with lawyers. I've spoken to Colonial and we've discussed some of this, so they have not seen this document until today, and the Department of

Mental Health has not seen this document until today and so I feel we can't make a final decision until we've heard from Mental Health that it meets their requirements for the program but my -- I've tried to interpret what I felt the Board was saying, that the Board sees its responsibility as being responsible for take-home medication and that it will not be responsible for supervising medication, which is given in-house based on doctor's orders very much as though it was within a clinic.

So I've suggested that take-home medication would be stored within a safe and we would treat that safe as though it were the pharmacy, all right. In that instance then, a pharmacist would have the key, the combination, whatever access, and take-home medication would be under the supervision and the pharmacist would have access to it. Anytime take-home medication was being prepared or dispensed, a pharmacist must be present, that the pharmacist would have to at some point inventory and make sure that medications were not being lost, and

we discussed various ways to record each time a medication went home and so I've put in here that working with program administration, there will be a way for the pharmacist to document each dose that goes out in some -- in some method. So it would be like a pharmacy and then everything that left the pharmacy would be documented in the process, that because part of that total area -- only part of that area would be used for pharmacy and not that we're designating square footage in any way but consequently nurses would not have to be technicians because they would be operating there under a clinic function, not as a pharmacy function, and that we would ask that take-home medications be labeled in compliance with Alabama pharmacy law, so that's what I have proposed.

MR. MCCONAGHY: On the safe, per se, do you intend that to literally mean a safe or could it be an area that's lockable and --

DR. ALVERSON: I had originally mentioned an area that would be lockable but the

feedback I got was that that would not be allowed under present DEA regulations or requirements by Mental Health.

MR. MCCONAGHY: Okay.

DR. ALVERSON: So they said we -- we couldn't do that. Am I right in saying that?

MS. SIDWELL: It is a DEA regulation.

DR. ALVERSON: So it would have to be a safe.

COURT REPORTER: What was your name, ma'am?

MS. SIDWELL: Susan Sidwell.

COURT REPORTER: Thank you.

MR. CONRADI: And you heard that?

DR. ALVERSON: The people from the methadone programs had originally planned to do a presentation today but after we met, they decided to forego their presentation and just participate in comments on what the proposal was.

MR. CONRADI: Any comments?

MR. BELSER: It's just for the record, I'm David Belser and I represent ALAMTA, which

is the Association of Methadone Clinics in Alabama. I met with Susan Alverson about this matter before. After I had made the request to make a presentation, after I met with her I was satisfied with what she was going to propose to this Board and we still are satisfied.

MR. CONRADI: Thank you.

MR. MCCONAGHY: Mark, just -- y'all had asked me if I could to go and tour some and just my impression from that and I just went to two different ones who did it two different ways and I thought that's probably pretty much what I was told, that's the way everybody did it around the state but after I saw how their operations work there, I'm not sure our inspectors have got a whole lot of place to do anything other than just make sure the inventory is correct because they -- they take inventory before they start the day, at the end of the day. There's cameras. There's -- there's just so much double-check going on that, you know, as far as our inspectors inspecting, check the inventory would just be my opinion.

DR. ALVERSON: I would like to add a comment to that. Some of you involved with this know there's been a lot of hoopla and so on and so forth over the last six or eight months and when I was asked by our inspectors how should we approach this, it was my decision that they should approach it the way they would a retail pharmacy and you know, they have done that and I know they've taken a lot of heat but it's because I told them to do what they were doing and so they were very cooperative, you know, so -- so I just want you to know who was behind that decision and if someone is mad about something, who they should be mad at, and it should be me.

But I appreciate the job that they did and we know where we stand and we know what's going on. We've been able to make a decision based on that and I hope our inspectors will be welcome when they go back, particularly Glenn who I'm worried about never setting foot in a methadone pharmacy again.

MR. CONRADI: Thank you, Susan.

What's next?

DR. ALVERSON: In your Dropbox you had a proposal from a computer company, what they would charge us to implement a totally new system. We are going to Montgomery this upcoming week to look at the program that the Board of Nursing has. I plan to write a letter back to the people who sent us that proposal outlining things such as, you know, what do you charge per hour for support once things are implemented, is there a charge for individual --

MR. CONRADI: Projects?

DR. ALVERSON: Or the individual person who is actually using the system and to list all the things we would expect to be done once we go live because I think we need a commitment that this long list will be done.

MR. CONRADI: We need some references who they've done that we can go out and talk to.

DR. ALVERSON: Actually we asked for those references and Rhonda Coker has called a number of them. I think we've called about

eight different references and have gotten really good feedback from everyone we've called.

MR. CONRADI: We did with GLS too, so.

MS. ELLENBURG: And it depends on who you talk to.

MR. CONRADI: Yeah.

MS. ELLENBURG: If it's the ultimate user you're talking to or the person that -- that would kind of be like me and you.

DR. ALVERSON: Right. You don't know what's really going on.

MS. ELLENBURG: Yeah, yeah.

DR. MARTIN: Is it too early to be talking a time line?

DR. ALVERSON: No. They say it would take them about eight to ten months to implement a new system to have it where we would want it and my concern is we will be registering technicians next fall and so if we're going to make a decision, we want to be sure we have that capability in place by next fall and we're not scrambling like we were last fall and this fall.

DR. MARTIN: So that's -- so we're approaching the optimal window to do this --

DR. ALVERSON: Yes, we are.

DR. MARTIN: -- is that what you're saying?

DR. ALVERSON: I'd say by January 1 we need to make a decision.

MR. BUNCH: Can we get out of that GL Suites and then just drop them at any time?

MR. CONRADI: Oh, yeah.

DR. ALVERSON: Well, we'll have to keep GL Suites --

MR. BUNCH: Yeah.

DR. ALVERSON: -- until we switch over.

MR. BUNCH: Yeah, I know, but is there --

MR. CONRADI: Once we change, what we've got is all we're going to get probably.

DR. ALVERSON: Well, we have a contract until April with GL Suites. If we've decided to make a change, I think we should take the very lowest amount of input we would get

from GLS because right now we have the Cadillac of plans and we don't want to be paying for the ability to have a lot of projects and a lot of work done when we won't be using that.

DR. MARTIN: So we won't have an opportunity to declare a breach and escape from the -- if we wanted to?

DR. ALVERSON: We could but no matter who we go with, they won't be ready by April.

DR. MARTIN: Yeah, that's a good point.

MR. MCCONAGHY: You might want to say that we're paying for the Cadillac of services but we're not necessarily getting it.

DR. ALVERSON: Getting the Cadillac, right.

MR. CONRADI: Anything else?

DR. ALVERSON: No, I would say that's it. Oh, we've hired a new pharmacist, I'm sorry, for the people who are here, Crystal Anderson, who comes to us from Target. She'll be starting next Monday and her primary responsibilities initially are going to be

compliance, developing systems for the way we handle cases, keeping track of those cases, and then I can use some help with inspecting compounding facilities, and so that will also be part of it so.

DR. MARTIN: And who was she with previously?

DR. ALVERSON: Target.

DR. MARTIN: Target. Is she here today?

MR. CONRADI: Is that Blake's wife?

DR. ALVERSON: It is. We've had long talks about --

MR. CONRADI: Who is we?

DR. ALVERSON: Blake, Crystal, and me.

DR. MARTIN: She's not present today, is she?

DR. ALVERSON: Not at this time, no.

DR. MARTIN: Okay, thank you.

MR. CONRADI: Chief Braden.

MR. BRADEN: Yes, sir, Mr. Conradi. Look in your Dropbox, you'll see activity for

the month of September. We completed 90 inspections. We received 22 complaints. We completed 23 complaints. There's still more complaints outstanding because we still have a number of complaints that are backed up from a couple of months.

We assisted the FDA on an inspection that lasted a week at a compounding 797 facility. We were able to dispose of a large number of drugs that we had in our evidence facility and the DEA Birmingham office assisted us with that having it transported to their office for destruction and we completed our annual qualifications last month also.

MR. CONRADI: Did everybody pass the qualifications?

MR. BRADEN: Yes, sir, they did.

MR. CONRADI: Did anybody shoot the roof out or anything?

MR. BRADEN: Todd Brooks did.

MR. CONRADI: Do you have anything for executive session?

MR. BRADEN: Yes, sir, I do.

MR. CONRADI: Any new business? Hold on, any old business first? Do we have any? No old business. Any new business? Mitzi, do you have something?

MS. ELLENBURG: No, sir.

MR. MCCONAGHY: Mark, I don't know -- I guess it's new business now but what we just got through asking a lot of questions from UAB but we didn't -- we didn't get any answers and we may need to discuss what -- what are we going to tell a pharmacist when they call Susan.

MR. CONRADI: I think we've got to have our attorney research that and advise us at the next meeting. I don't know that we can do it today. There's a lot of things I think we learned today.

MR. MCCONAGHY: Do we have any authority to accept a pilot program?

MR. CONRADI: I mean, we don't -- our only problem is we're prosecuting pharmacists for doing the same thing today. Now, I think the difference is they're -- what they're doing has not been approved by the Board of Medical

Examiners and I think that might be our caveat to --

MR. WARD: I'm not sure you can -- and there's some good lawyers out in the audience. I'm not sure you can in effect amend a rule by a letter.

DR. MARTIN: I agree.

MR. CONRADI: Huh-uh.

DR. MARTIN: I'm not a lawyer but that's why I asked.

MR. WARD: Which is what the Board has done, amended a rule by a letter.

MR. CONRADI: Yeah.

MR. WARD: Which I don't think you can do and we can't look at it in the vacuum of just this pilot program regardless of how wonderful it may be, we're not -- whatever you think about it makes the rule -- makes no difference.

MR. CONRADI: Yeah, I think someone has got to talk about it.

MR. WARD: What you decide is going to affect the future and how you deal with these things. It needs to be thought about in maybe

executive -- I don't know what's going to happen, so I think you need to table it and wait to discuss it.

MR. MCCONAGHY: I guess my point is we've got all the inspectors here and Susan. They're fixing to get hammered with questions on -- on can I fill this prescription and --

MR. CONRADI: How are they going to know the difference? It's just going to be on a UAB e-scribe, I mean, just like any other doctor. He reads these charts and sees these, I don't know if the pharmacist would know unless he talked to the patient.

MR. WARD: Not only that, you raised the points that, you know, while UAB was altruistic they say, you were more practical about what the pharmacist is going to do, starts filling these prescriptions, he gets audited a year later and he's got to pay the money back. I think when this comes up we need some -- some -- that needs to be -- that's a factor that needs to be looked at because they don't -- they don't have to -- you know, that's just -- you

know that's going to be a problem.

MR. CONRADI: Kelli, what would the Medicaid stance be on that if they didn't see a physician and got a prescription?

MS. NEWMAN: Well, if a Medicaid patient were to pay the 25 or lower dollars, and that's not being derogatory, I'm just saying if they were to pay that because they have -- I have heard fourth hand, not through them because we have not had contact with them, but in our defense neither have they contacted us, which I think would have been the correct way to handle it. However, fourth hand I have heard that they have made a statement that Medicaid is not eligible for the program. Subsequent prescriptions would be because the NPI is unrecognizable at this point, just as Mr. Ward has said today in the law it's illegal, so you know, if we were to go after that, it is recoupable.

MR. CONRADI: Of course, I don't think many of them will pay $25. They won't pay three dollars for a cough syrup for their sick kid so.

MS. NEWMAN: I would rather -- I don't want to -- I am not going to be stereotypical but I do know that there are Medicaid clients that are on Medicaid for various reasons and I do know of some that would use this program.

MR. CONRADI: Right.

MS. NEWMAN: Because it's very difficult to get into a physician, I understand that, but at this time, the law is the law and it is illegal to fill these prescriptions if it's recognizable.

MR. CONRADI: It puts pharmacists in a bad position.

MS. NEWMAN: Yes, sir, it certainly does and it --

MR. CONRADI: Louise, do you have a comment?

MS. JONES: Just that I'm getting questions from the pharmacists now asking for am I supposed to fill this or not and my answer has been no, but the problem is they don't know how to distinguish that from another e-prescription that a -- that does come from a valid,

preexisting, patient-practitioner relationship. There's no way for them to distinguish it.

DR. MARTIN: I don't think --

MS. JONES: The pharmacists are in a no-win situation here.

DR. MARTIN: It's not realistic to expect a pharmacist to have to make that decision.

MR. BUNCH: Well, going back to the audit deal, if it's indistinguishable if you had an audit and it's a UAB prescriber and I'm kind of arguing against what I was arguing a while ago I guess, if an auditor comes in and they pull that prescription, they don't know.

MR. CONRADI: Yeah.

MR. BUNCH: I mean, Medicaid's auditor wouldn't know where the prescription came from.

MS. NEWMAN: Not today but as I just told Clemice, a year from now, it might be.

MR. BUNCH: Yeah.

MS. NEWMAN: And you know, Medicaid is Three Plus One. I hear from several other pharmacies that the Primes and the other PDMs

are very aggressive in their auditing.

MR. BUNCH: Very aggressive.

MR. MCCONAGHY: I just think you've got like Walgreens has got to make a corporate decision. You can't distinguish them are you going to fill them or not fill them, you know. I mean, you've got that kind of thing to deal with, so I just feel like we need to get a pretty solid answer pretty quick.

MR. BUNCH: Yeah, what are y'all going to do?

MS. LACEY: I'm sure they're going to comply with the law.

MR. CONRADI: I've got to ask Dan what we're going to do. I don't think we can make a decision today what to do.

DR. MARTIN: I think the Board -- I think the Board is in a very gray area for at least the next 30 or so days.

MR. WARD: Absolutely.

DR. MARTIN: And so -- and I -- I don't know that the -- that we can promise this in this kind of a setting but I would be

surprised if, for example, an inspector went into a pharmacy and tried to establish whether the patient-physician relationship in fact existed prior to that pharmacist filling that prescription, so I don't see any pharmacists getting hanged between now and when this gets resolved over that issue.

MR. MCCONAGHY: Maybe not but I don't think we're in a gray area at all. I think it's all black and white.

DR. MARTIN: Well, I think we're putting the pharmacist in a gray area because -- because if they get a prescription that comes through electronically, they cannot distinguish if it is a result of a -- what we have heretofore called a bona fide patient-physician relationship or not and I think it's unreasonable to expect a pharmacist to have to go to the extent to try to make that decision.

MR. MCCONAGHY: Okay. Let's say that pharmacist did go to that extent and they know it is coming from that. What's Susan's answer to them?

MR. DARBY: They can't fill it.

DR. MARTIN: Right. I think if that pharmacist feels compelled to ask that patient now, you know, put your hand on the Bible and swear whether you saw this physician and that pharmacist has to make a decision if they're going to fill that prescription or not. Now personally, I'd be like really surprised if there would be any consequences of filling that but I understand some pharmacists would be uncomfortable doing that.

MR. MCCONAGHY: I'm not talking about consequences, Tim. I'm talking about they've got to give them an answer. This is going to be a lot of questions on that and they've got to --

MS. LACEY: Let me throw it another way. The patient comes in and goes, this is sweet, man, all I did was just fill out a questionnaire and they sent the prescription here, not a gray area but can you believe this, I just filled out a questionnaire, didn't have to go to the doctor, had a sinus infection, come in here and the prescription is waiting. Are

y'all okay if we fill that?

MR. WARD: I'd tell them no.

MR. CONRADI: No, that's a no.

MR. WARD: I'd tell them no.

MR. CONRADI: That's pretty black and white there.

MR. DARBY: You have reason to believe that it came from an Internet pharmacy or Internet doctor.

MR. CONRADI: Like, if I get one from Puerto Rico for birth control pills, I mean, I ask the girl did you go see the doctor yesterday at Puerto Rico. I know good and well they didn't.

MS. LACEY: Obviously it's a birth control pill.

MR. CONRADI: I mean, that's an example. I mean, I've had that real life example but Puerto Rico is one thing but when it's UAB, I mean, it's a hard one. Louise, I hear you jumping over there.

MS. LACEY: Word it carefully.

MS. JONES: Here's where I am --

MR. WARD: Don't do it. Just don't do it.

DR. MARTIN: Let me -- let me just mention this. As a possibility, we can just throw this out here, this is part of the discussion. This is not a decision. I mean, the cleanest but the most difficult thing to say would be, don't fill them. If you know they come -- if you get an electronic prescription from UAB, don't fill it.

MR. WARD: Don't fill them. If they go ahead and fill them, it's at their own risk. Both for what may happen with the Board and/or whether they're going to get paid for it, whether it's going to be an audit.

MS. JONES: So what I -- what I'm understanding, the rule says and I don't have it in front of me, but the rule says if the pharmacist knows or should have known under the circumstances that the prescription is as a result of and it's got the little list of the three or four things and Internet-based questionnaire is in there or an Internet-based

consultation or a telephonic consultation and is not derived from a valid, pre-existing patient-practitioner relationship, they are not to fill it?

DR. MARTIN: Okay.

MS. JONES: So I think to me -- first of all, let me say this: I appreciate the nongray because even though you can say we're probably not going to have inspectors bring these cases, as an organization, I can't legally -- I'm putting APA in a liable position if I advise someone to do something that's against the law, so I can't -- I have to be very careful how I word the answer to questions just as Susan does from the Board of Pharmacy perspective.

So I don't like being able to say, well, you're not supposed to but they probably won't come after you if you do, so understand that, right. So I think the -- to me it goes back to if they know or should have known. So if the patient comes in and voluntarily discloses that, then they know it. If the

pharmacist asks questions that have it disclosed, then they know it. I think to me it comes back to if they know or should have known.

So the question to me -- from me to you is is should have known because to me that's the gray -- should they know it because we've now put things out to the pharmacists of this state. There's been a marketing department from UAB pushing it out to the public. Where does that should have known come in because to me that's the gray.

MR. WARD: Can't -- each case has to be on its own.

MS. JONES: Okay.

MR. WARD: Sometimes it's going to be real obvious and sometimes it's not. Those are decisions pharmacists make every single day about whether they should fill a script or not. Well before there was ever such thing as an Internet, you guys made decisions about whether you would fill it or not based on who the -- the doctor who wrote it, you knowing -- the pharmacist knowing who -- who the doctor was,

what kind of practice that doctor had, what he usually wrote for, or where the patient lived, were the prescriptions look -- the date, there's three of them and they just didn't look right. I mean, that's every single day pharmacists do that and you know, I think their judgment usually is, you know, right -- right on but it's unfair to ask these guys to give you a bright line what should have known. I wish we don't have to talk about this anymore. This -- just don't fill the damn things if you should have known. If you should have known, don't do it. That's the safest course.

MR. BURGESS: Chris Burgess, Heritage Pharmacy, Mobile. As a pharmacist owner in Mobile, I am pretty positive I am outside of the zip code area. Can the Board of Pharmacy get with the program and give us a list of the zip codes so that when an e-scribe from UAB comes in from that zip code, we can question the patients? That will eliminate some of the gray area for the pharmacists in the state.

DR. ALVERSON: I believe the MSA is

five counties: Jefferson -- I don't know geography here. Jefferson, is Shelby a county?

DR. MARTIN: Yeah.

DR. ALVERSON: Now, I know the counties in Wisconsin. Saint Clair, what's above us?

MS. NEWMAN: Walker, Walker.

MR. BURGESS: Sharp cheddar?

DR. ALVERSON: Sharp cheddar, we've got Potawatomi.

MR. BURGESS: Well, as a Louisiana kid, I'm still looking for the parishes but if the Board of Pharmacy could list those on the website, that would be of benefit to the pharmacists in the area.

DR. MARTIN: What are you asking us to list?

MR. BURGESS: The zip code of the area that the patients are coming from. That way when the e-scribe comes in, the pharmacists would be able to ask the patient and maybe clarify this because it sounds like the payers may or may not pay for it and could recoup it.

The Board may or may not inspect us and then also how long is the program.

DR. MARTIN: Let me see if I get this right. So it -- we're assuming that the e-scribing pilot at UAB is limited to the MSA?

DR. ALVERSON: That's what they said, I thought.

MR. DARBY: They did say that, yeah.

DR. MARTIN: So if you get one --

DR. ALVERSON: That's what he's asking, what is the MSA.

MR. BURGE: Right. What's the area and how long are the dates for so that way if the pharmacy feels like they need to go back through their old records and verify to make sure it's part of that program or not part of that program or anything that comes in, they can question the patient. That would help eliminate some of the gray areas for the pharmacists in the state.

MR. CONRADI: Thank you. Any more business?

MR. DARBY: Mark, we've had a question

on continuing education and the carrying over the hours and the question is: Is there a -- has there been a change in it? Can the pharmacists still carry over 12 hours a year?

MS. ELLENBURG: From the preceding calendar year.

MR. DARBY: From the preceding calendar year or does it have to be within the two-year renewal cycle?

MR. CONRADI: It depends on if it's Tuesday or Wednesday.

DR. MARTIN: I believe we made the decision, somebody correct me if I'm wrong, that the pharmacists could get the total amount within the two years. They did not have to have it per year.

MR. CONRADI: Per renewal cycle?

DR. MARTIN: That's what -- that was my understanding but I can't promise that I --

DR. ALVERSON: That is what we decided.

MR. DARBY: It has to be within --

DR. ALVERSON: Within the -- a

renewal -- within that two-year time frame.

MR. CONRADI: Thirty for two years.

MR. DARBY: It would have to be 30 in '13 and '14. It can't be 30 in '14 and '15.

DR. ALVERSON: Correct.

MR. DARBY: It would have to be within --

DR. MARTIN: It zeros out at the end of the renewal cycle.

DR. ALVERSON: Correct.

MR. CONRADI: Otherwise you never could get back up to where it was.

DR. MARTIN: Right. I think that's where we were but do you need us to be more specific about that?

MS. LACEY: Would y'all be able to post that as a policy statement for us?

DR. ALVERSON: I put that in the newsletter that just went to NABP.

MS. LACEY: Okay, thank you.

MS. ELLENBURG: But that doesn't publish until November.

MR. MCCONAGHY: But if anybody is

reciprocating and taking the law exam, that's not the answer to the question.

MS. LACEY: Yeah, I've already asked Dan on that.

MR. CONRADI: The answer to the question is you can't carry over by statute.

MR. DARBY: In the statute you can't carry over. In the rule, you can. The rule has it in there.

DR. MARTIN: So we need to clean that up?

MR. MCCONAGHY: Uh-huh.

MR. STEPHENS: Does that two-years apply to the live as well, six hours over two years?

DR. MARTIN: I would think so.

MR. STEPHENS: Okay.

MR. WARD: Do y'all sit up at night thinking of this stuff?

MS. ELLENBURG: The rule used to say that you couldn't carry over live so -- but we're going to?

MR. MCCONAGHY: No, not carry over.

You can get the six hours in one year or the other. You don't have to get them three and three.

MS. ELLENBURG: Okay.

MR. WARD: As long as you do it all in the two years.

DR. MARTIN: I think that's -- and does that mean we need to move in that direction for technicians also?

DR. ALVERSON: We did -- that's what prompted this when we got to prosecuting or disciplining technicians.

DR. MARTIN: Yeah.

DR. ALVERSON: We had people who had all their hours --

DR. MARTIN: Correct.

DR. ALVERSON: -- but they weren't in one and one.

DR. MARTIN: Well, I believe we made the decision to go forward with that interpretation for pharmacists. Now it's our opportunity to decide if we want to go forward with that same decision for technicians and I

would suggest that we would make the same decision.

MR. MCCONAGHY: I agree.

MR. CONRADI: Are you going to make that in a motion, Tim, so it will be on the record?

DR. MARTIN: Okay. Let's see, do you want to really clean it up at one time?

MR. MCCONAGHY: Yeah, because I don't think anything is on the minutes.

DR. MARTIN: All right. Let me throw this out. We may have to do this a time or two to get it right.

MR. CONRADI: We ain't got time to do it.

DR. MARTIN: All right. I move that the CE requirements for pharmacists be interpreted as being 30 hours within the two-year renewal period, six of which during the renewal period must be live, and that -- somebody help me with the tech numbers, three and one?

MR. CONRADI: One and two.

MR. WARD: Two and one.

MR. DARBY: Three hours total, one hour live.

DR. ALVERSON: Three total, one live.

DR. MARTIN: And that's per year, right, three and one, okay, and that -- and that for our technicians, the CE requirements be six hours within the two-year renewal cycle, two of which must be live.

MR. WARD: No.

MR. CONRADI: One live.

MR. WARD: One live, two -- one live, two nonlive.

MR. CONRADI: Two live and four --

DR. ALVERSON: It's two live within the two-year period.

DR. MARTIN: Okay. So a total of three within the two-year period -- I'm sorry, a total of six within the two-year period, two of which must be live.

MR. CONRADI: Second.

DR. MARTIN: We have some discussion. I think we have a question in the audience.

MS. ELLENBURG: I was just going to ask Jim, do we have to make it a policy and the Board president has to sign it or are we just going to do it from the minutes or how are we going to do that?

MR. WARD: It's interpretation.

MS. ELLENBURG: Okay.

MR. WARD: Interpreting the rule to mean that. That's what it means.

MS. ELLENBURG: All right.

MR. WARD: And we can reasonably interpret the rules.

MS. ELLENBURG: Okay. I just know that at one we had policies that we printed out but this is just going to be an interpretation, okay.

MR. CONRADI: Do we have a second?

DR. MARTIN: I think there was already a second.

MR. CONRADI: Okay. All in favor?

MR. MCCONAGHY: Aye.

MR. DARBY: Aye.

DR. MARTIN: Aye.

MR. BUNCH: Aye.
MR. CONRADI: Aye.
Okay. Any more business?
MS. LACEY: May I have a point of clarification for the students that will be taking the MPJE?
MR. CONRADI: They go by what's in the law.
MS. LACEY: I'm good. Thank you, Mark.
DR. MARTIN: You skipped -- well, you're about to go to Jim, okay.
MR. CONRADI: Jim had no report he said.
DR. MARTIN: He didn't.
MR. CONRADI: I don't see any more business we have to do. We will go into executive session at 11:10, and we've got students at 11:30, to discuss competency of pharmacists, permit holders, and pending cases. We will come out at 11:25. No more business will be conducted after that other than acting on the cases and -- that we reviewed in

executive session. I need a second on that and then a voice vote.

DR. MARTIN: Second.

MR. CONRADI: Mr. McConaghy?

MR. MCCONAGHY: Aye.

MR. CONRADI: Mr. Darby?

MR. DARBY: Aye.

MR. CONRADI: Dr. Martin?

DR. MARTIN: Aye.

MR. BUNCH: Aye.

MR. CONRADI: Aye. Thank y'all.

(Whereupon, a recess was taken for executive session from 11:05 a.m. to 11:29 a.m.)

MR. CONRADI: Case number 14-0080, 14-0087, 14-0081, and 14-0088, 14-0094, recommendation, letter of warning and proof that all physician information was reversed with insurance and PDMP. Do y'all accept that recommendation?

DR. MARTIN: I move we accept the

recommendation as made.

MR. DARBY: Second.

MR. CONRADI: All in favor?

MR. MCCONAGHY: Aye.

DR. MARTIN: Aye.

MR. DARBY: Aye.

MR. BUNCH: Aye.

MR. CONRADI: Aye.

I'd like to make a motion on case number 14-0097, THE recommendation is no evidence of violation. I make a motion we accept that.

DR. MARTIN: Second.

MR. CONRADI: All in favor?

MR. BUNCH: Aye.

MR. MCCONAGHY: Aye.

DR. MARTIN: Aye.

MR. DARBY: Aye.

MR. CONRADI: Case number 14-0107, I make a motion that we accept the recommendation of required technician to provide medical records in reference to her treatment and letter from her psychiatrist as to the technician's

mental ability -- mental condition and ability to return to work in a pharmacy setting. Does that get a second?

DR. MARTIN: Second.

MR. CONRADI: All in favor?

MR. MCCONAGHY: Aye.

DR. MARTIN: Aye.

MR. DARBY: Aye.

MR. CONRADI: Case number 14-0111, the recommendation is letter of concern and refer to the Board of Medical Examiners, the action of the physician. Make a motion to accept recommendation.

DR. MARTIN: Second.

MR. CONRADI: All in favor?

DR. MARTIN: Aye.

MR. DARBY: Aye.

MR. MCCONAGHY: Aye.

MR. BUNCH: Aye.

MR. CONRADI: 14-0125 case number, recommendation, letter of concern to the district pharmacy supervisor regarding the oversight of pharmacy staff in regard to early

refills. I make a motion we accept the recommendation.

MR. DARBY: Second.

MR. CONRADI: All in favor?

MR. MCCONAGHY: Aye.

DR. MARTIN: Aye.

MR. DARBY: Aye.

MR. BUNCH: Aye.

MR. CONRADI: And then case number 14-0144, recommendation, letter of warning and proof that all physician information was reversed with insurance and PDMP. Make a recommendation -- I make a motion we accept the recommendation.

MR. DARBY: Second.

MR. CONRADI: All in favor?

DR. MARTIN: Aye.

MR. MCCONAGHY: Aye.

MR. DARBY: Aye.

MR. BUNCH: Aye.

MR. CONRADI: And then case numbers 14-0145, make a motion we accept recommendATION, assign permanent surrender to present to the

Board. All in favor?

MR. MCCONAGHY: Aye.

DR. MARTIN: Aye.

MR. DARBY: Aye.

MR. BUNCH: Aye.

MR. CONRADI: No more. Do I have a motion to come out of --

DR. MARTIN: We're already out.

MR. CONRADI: I make a motion we adjourn.

DR. MARTIN: Move we adjourn.

(Whereupon, the meeting was concluded at 11:33 a.m.)

CERTIFICATE

STATE OF ALABAMA
SHELBY COUNTY

I, Sheri G. Connelly, RPR, Certified Court Reporter, hereby certify that the above and foregoing hearing was taken down by me in stenotype and the questions, answers, and statements thereto were transcribed by means of computer-aided transcription and that the foregoing represents a true and correct transcript of the said hearing.

I further certify that I am neither of counsel, nor of kin to the parties to the action, nor am I in anywise interested in the result of said cause.

/s/ Sheri G. Connelly
SHERI G. CONNELLY, RPR
ACCR No. 439, Expires 9/30/2015