ALABAMA STATE BOARD OF PHARMACY

BUSINESS MEETING

Wednesday, July 16, 2014

9:03 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
Henry Burks, Chief Inspector
Jim Ward, Board Attorney
Mitzi Ellenburg, Board of Pharmacy
Edward Braden, Board of Pharmacy
Shirley Feagin, Board of Pharmacy
Todd Brooks, Board of Pharmacy
Glenn Wells, Board of Pharmacy
Mark Delk, Board of Pharmacy
Richard Lambruschi, Board of Pharmacy
Mike Garver, Wellness Committee
Chris Ciolko

David Clark
Cara Léos
Jim Easter
Eddie Vanderver
Ben Allen
Bruce Harris
Tracy Davis
Louise Jones
Rick Stephens
Julie Hunter
Kelli Newman
Clemice Hurst
Brannon Powell
Carter English
Tommy Klinner
Jim Bogue
Ronda Lacey
Paul Rengering

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MR. CONRADI: Welcome to the Alabama Board of Pharmacy July 2014 board meeting. To

start this off, we'd like to get a roll call of everybody who's here. We'll start over here with Dr. Garver. Say it loud enough for Ms. Sheri to hear you.

DR. GARVER: Mike Garver, Wellness Committee.

MS. CIOLKO: Chris Ciolko, PipelineRX.

MR. CLARK: David Clark, MediStat Pharmacy.

MS. ELLENBURG: Mitzi Ellenburg, Board of Pharmacy.

MS. LÉOS: Cara Léos, ALSHP.

MR. EASTER: Jim Easter, Baptist Health.

MR. VANDERVER: Eddie Vanderver, CAPS, Incorporated.

MR. ALLEN: Ben Allen, IV, CVS Pharmacy.

MR. HARRIS: Bruce Harris, APCI.

MS. DAVIS: Tracy Davis, Alabama Pharmacy Association.

MS. JONES: Louise Jones, Alabama Pharmacy Association.

MR. STEPHENS: Rick Stephens, Senior Care Pharmacy.

MS. HUNTER: Julie Hunter, Omnicare.

MR. BRADEN: Eddie Braden, State Board of Pharmacy.

MS. FEAGIN: Shirley Feagin, Board of Pharmacy.

MR. BROOKS: Todd Brooks, Board of Pharmacy.

MS. NEWMAN: Kelli Newman, Medicaid.

MS. HURST: Clemice Hurst, Medicaid.

MR. POWELL: Brannon Powell, Medicaid.

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

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

MR. WELLS: Glenn Wells, Board of Pharmacy.

MR. DELK: Mark Delk, Board of Pharmacy.

MR. LAMBRUSCHI: Richard Lambruschi, Board of Pharmacy.

MR. CONRADI: Thank you. I need a motion to adopt the agenda for today.

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

MR. MCCONAGHY: Second.

MR. CONRADI: Okay, all right. We have Dr. Mike Garver here to give us his report on the Wellness Committee, so I'm going to move him up into first place so he can get out of here.

DR. GARVER: Thank you, gentlemen. It's good to be here again. I want to read into the record here the Wellness report. Through June, there are presently 135 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 the professionals that are listed below.

There are currently no pharmacists in treatment. We have one discharging, so that makes us zero as of today. There are two pharmacists that we have in a halfway house.

There are 13 pharmacists who are either being held or who were being held out either for some reason by the treatment center or in the process of being investigated or being made ready for presentation to the Board.

We have no techs in treatment at this time. There are four techs who need disposition of some sort and I've made the staff aware of that through the inspector's report. I have here a late addition, there were no students in treatment but we do -- did have a student from one of the schools surrender this morning and that student will be having an evaluation and we need to -- I need to take a moment to thank the schools for really being proactive in identifying students for us because it's really been great to have them step up and do that.

There are 75 individuals in facility-driven aftercare. That's the aftercare from the treatment centers here in our state. We met -- as I say always, we personally met with all the licensees returning to work to sign contracts and explain how all of this works. All

returning licensees have been placed in a caduceus, either with the pharmacy or a health professional. I can say today that every person who gets out of treatment today does have a mentor assigned to them and that's something we've worked real hard on for the last three years and I have a couple of remarks to make.

One is the -- you know, we identified over -- well, not over but 36 pharmacy health professionals last year. That's a whole lot of people and we're well off that base this year, so I'm happy about that. I know that's only a temporary thing but we're at about half of where we were last year for identification of those individuals, so they're either taking a little time off or we just haven't caught up to them yet.

There have been several exposés on TV in the state of Alabama about errors in prescription filling, people getting the wrong prescriptions, becoming ill, this sort of thing. We had a big one in the Mobile area and I'm happy to say that there were no impaired

1 dentists or the impaired -- impaired dentists,
2 excuse me, impaired pharmacy health
3 professionals mentioned in that. In fact, the
4 one in Mobile was very positive about how the
5 pharmacists and the pharmacy techs spend extra
6 time with the patients getting their
7 prescriptions filled, so I'm hoping that we're
8 not going to see too much more of that. It's
9 been kind of a trend in our state for the press
10 to sensationalize and blame those sorts of
11 things on impaired pharmacists when a lot of
12 them are just mistakes.
13 And lastly, I want to take about two
14 minutes to talk about my mom. My mom is 92.
15 Some of you who were here three years ago will
16 remember me talking at November about my mother
17 catching her cabinets and microwave on fire when
18 she was cooking the last batch of her famous,
19 rock hard, nonedible, extremely toxic
20 fruitcakes. My mother has got some advanced
21 senility. She doesn't have dementia yet. She's
22 still a real Southern bell but she's about as
23 nutty as those fruitcakes are that she makes.

Last week I got a call from her phone and I picked the phone up and I said, hey, mom, but it was a very nice young man who was the pharmacist at the neighborhood pharmacy about 200 yards from where my mother lives. My mother had taken her little buggy and gone down to fill my mother-in-law's, who's 95, to fill her prescription at the pharmacy and it was very hot.

My mother got a little tired and fell asleep out in front of the pharmacy while they were all on break and the pharmacist came back and noticed that there was this older lady sitting against the pharmacy wall with her wig pushed down over her nose and he woke her up and she said that she was there to get a prescription filled and he took care of that and she said, I just don't know if I can make it back. And he said, I volunteered to bring her back to the -- to her apartment, and I said, well, thank you so much.

He said, by the way, she's got a lot of stuff with her here. She wanted me to pick

1 up a few things for her and I said, sir? He
2 said, yeah, she bought a whole lot of candied
3 fruit and cherries and flour and sugar and also
4 some M and Ms and he said, I noticed that she
5 has a lot of Glucerna and some Diatest. I said,
6 my mother is a diabetic, she shouldn't be having
7 anything sweet. But I said, all of that stuff
8 sounds like fruitcakes to me and so I related
9 the story about her catching the cabinet -- the
10 kitchen cabinets on fire and he said, well, I
11 guess you want me to take this microwave back as
12 well.
13 So I just was flabbergasted and I
14 really -- this is a true story now and I thank
15 the pharmacy. I told him that I worked with
16 pharmacists and I appreciated that. So he
17 called me yesterday and he said, I got this
18 wonderful note from your mother. She thanked me
19 for helping her. She really was very
20 appreciative and he said, but I want to keep
21 this -- is it okay if I keep this card and the
22 check that's with it? And so my heart just kind
23 of jumped up in my throat. And I said, the

check? He said, yes, there's a $5,000 check here with this. My mother doesn't have a checkbook. She just -- I give her cash, she saves it up, and she spends it. And he said -- I said, a $5,000 check? He said, yeah, it's one of those Bank America nonnegotiable checks that comes in the mail. She signed it over to me and gave it to me.

So that's my story about my mother and the fruitcakes. Once again, they rear their head. Thank, y'all. Good to see all of you.

MR. CONRADI: Thank you. We had a couple of people come in that didn't get on the record. I think -- can you state your name and tell who you represent?

MR. BOGUE: Yeah, Jim Bogue, B-O-G-U-E, Lakeside Pharmacy.

MR. CONRADI: Thank you. Is that down in Slap Out?

MR. BOGUE: Cedar Bluff.

MR. CONRADI: Cedar Bluff, okay. The other way. We have one presentation today, PipelineRx, and I think we're going to let you

1 get out of the way if you want to.
2 MS. CIOLKO: All right, great. If you
3 don't mind, I'll pass these out so everybody
4 knows who I am.
5 MR. CONRADI: Okay.
6 MS. CIOLKO: And hopefully --
7 MR. CONRADI: And how do you say your
8 last name again?
9 MS. CIOLKO: Ciolko, just the way it
10 looks. And gentlemen, you have a copy of the
11 presentation, I hope.
12 DR. MARTIN: Yes.
13 MS. CIOLKO: All right, dynamite.
14 Thank you very much.
15 So my objective for being here today
16 is informative and as well as to see if we can
17 start a dialogue relative to remote pharmacy
18 given the current regs with the State Board, so
19 that's really sort of my objective. If you
20 will, I'm going to share information. Please
21 feel free to ask me questions.
22 I am a hospital pharmacist. I've been
23 one for almost 40 years and hospital as well as

retail, so I practice both. I am one of the founders of the company and what I thought I would do is just go through an overview of who we are, what we do, where we are, and as a side note, I've been to many state boards, please believe me when I tell you I've never seen such a beautiful facility or such a beautiful setting for a state board. You should be very, very proud.

MR. CONRADI: Well, we're beautiful people.

MS. CIOLKO: I've been to a lot of board meetings. So I want to introduce you to Pipeline, overview our services, talk about our work flow and how some of the other state boards have approved us, what our clinical capabilities are because really we are a cognitive clinical pharmacy service, and then I'll share with you some samples of time lines and then maybe tee up -- and it's up to you to tee up a potential pilot with review by the Board, really up to you. I just want to share information and then what you want to do next from my end. Make

1 sense? Okay.
2 So PipelineRx was founded in Q4 of
3 2009. We have 70 clients that is dated. We've
4 just signed on a very large group of hospitals
5 on the West Coast that you may be familiar with,
6 Dignity, CHI, and that adds it to over 100. We
7 have two offices, one in San Francisco because
8 of the IT base it's very -- it's very suitable
9 for us relative to the IT population there and
10 then in Chicago. So as you can see, we really
11 sort of were able to cover the whole country.
12 I'm based out of Chicago and we're approved to
13 operate in 35 states. We are active in 26.
14 Our current hospitals range, and it's
15 really a hospital service, acute care service,
16 from the critical access hospital, rural
17 hospital, all the way up to University of
18 California San Francisco, Bellevue in New York,
19 very, very large medical centers. So our
20 clients really range in size and scope and needs
21 and we have verified over four million
22 medication orders to date. We have 115 active
23 clinical telepharmacists. Twenty percent of

1 them are either PGY1 or PGY2 but all of them are
2 our employees. They are not independent
3 contractors.
4 And then just as an informative phase,
5 we purchased a company called Evolute based out
6 of Denver because this is very IT focused and it
7 really helps us with the plethora of systems out
8 there -- there's Epic, there's Siemens, there's
9 Meditech -- in order to translate those orders
10 for our pharmacists.
11 This is just to share with you where
12 we are currently doing business and where we're
13 coming soon, where we are licensed in states,
14 and working with existing client base. Our
15 guiding principles are is that the nurse on the
16 unit, the physician on the floor, the resident
17 really perceives that we are in the pharmacy
18 because we mirror the exact policies and
19 procedures, everything that the hospital does,
20 and we spend a lot of time before we go live
21 with a client learning and training on those
22 policies and procedures.
23 One great example is what I call the

1 brown bag. You have a patient come in through
2 the ED with the brown bag and what does the
3 hospital do with the brown bag and everybody's
4 policies and procedures are very different.
5 Some will store it. Some will send it back with
6 the family. Some hospitals will utilize the
7 patient-owned meds if they're off of formulary,
8 so it really varies. Same thing with renal
9 dosing policies, Vancomycin dosing policies,
10 everybody is a little bit different. So our
11 goal is really to mirror the exact cognitive
12 clinical roles of that client hospital.
13 There is an intimacy that is created
14 and I'm going to do a little bit of show and
15 tell. Every client, we spend a minimum of six
16 weeks getting ready to go live with the client
17 and a lot of time is spent understanding their
18 policies and procedures and you'll see and I'll
19 share with you, we go on site. But one thing
20 that we do, and this is a sample of a critical
21 access hospital, what we do is we do these
22 laminated cards because in the case of a
23 critical access hospital, we'll come on at 4:00

1 p.m. and we'll be on until seven o'clock in the
2 morning and then in some cases we're on Saturday
3 and Sunday for 24 hours.
4 So the nurses need to know who we are
5 and so what we do is we have cards all over the
6 nursing units for the physician as well as the
7 nurse to pick up the phone and call us. We must
8 pick up within two rings. If we're on the other
9 line with a nurse or a physician, then we must
10 return the call back to the nurse within 15
11 minutes because clearly it's patient focused.
12 There is a need and there's a reason that she's
13 calling.
14 The questions range from I've got two
15 IV lines running, I'm worried about cloudiness,
16 to help me with this calculation. So the nurses
17 are constantly calling us as well as physicians
18 and we have these laminated cards all over the
19 units that we provide the client. Then we
20 verify the appropriateness of every single
21 order. Our focus is it's not about the clicks,
22 it's about the focus on the clinical activity.
23 On average we save our clients about $225,000

1 annually relative to the clinical activity and
2 I'll give you some examples of that.
3 Now, the bread and butter for us is
4 really our pharmacists and we call them CTPs.
5 They're clinical telepharmacists and they go
6 through a very, very rigorous training. We
7 are -- on average we hire three out of 100
8 applicants. Clearly, this is a very desirable
9 job but they have to be a fit for PipelineRx.
10 They have to have a minimum of three to four
11 years of acute care experience. We are
12 averaging about seven.
13 They have to have multiple pharmacy
14 information experience. I mean, you can imagine
15 the plethora of systems out there, so the more
16 savvy from an IT perspective the pharmacist that
17 we are interviewing is, the better. They go
18 through three phone interviews. Why? Because
19 that's how they interact with the client. They
20 have to be very articulate but they also have to
21 be very good listeners.
22 When we started the company, I used to
23 be one of the interviewers and listening is

1 something that we really focus in on because all
2 of you as pharmacists know there's always a
3 question behind the question, so you've got to
4 dig and you've got to listen. They go through
5 three professional reference checks, ongoing
6 licensure check, OIG, and state checks on a
7 quarterly basis.
8 They take a clinical competency
9 assessment. What we did is we took ASHP's
10 clinical competency assessment and beefed it up,
11 put some oncology and pediatrics in it. The
12 minimum score every pharmacist must get is 90
13 out of 100. They also take a practical IT exam
14 with our IT folks to see if they can maneuver
15 within the systems because our clients with the
16 advent of CPOE, physician order entry, systems
17 are constantly changing so the pharmacist must
18 be very, very savvy from an IT perspective.
19 And then they go through a nine panel
20 plus drug test, national background check, I-9,
21 and SSN verification. That's before we hire
22 anybody. Any questions?
23 MR. CONRADI: Where do they work, from

1 home or --
2 MS. CIOLKO: Well, it depends on the
3 state, Mr. Conradi. We -- they work majority
4 out of their home. South Carolina is the only
5 state that requires at this point a call center,
6 so they work out of a call center. These folks
7 are residence based and we elected to do that
8 model for a number of reasons. The reason for
9 the residence based is we're able to get the
10 best of the best, so we are not restricted to a
11 50-mile radius of the call center. So if a
12 hospital needs a rehab specialist, they need a
13 geriatric specialist, they need an oncology
14 pharmacist, they need a pediatric pharmacist, we
15 are not restricted to the call center.
16 Additionally, we've lived through
17 Sandy. We've lived through other hurricanes,
18 the snow storms on the West Coast, and there is
19 no -- we have backup to the backups so we don't
20 have to worry about the call center shutting
21 down, though we do have a call center in South
22 Carolina.
23 Every state is very different. The

1 rules and regs are different. NABP is in my
2 back yard. I have -- I went to school with
3 Carmen, so we've been to NABP to share this
4 information, make sure that they're aware of
5 what we're doing as well. Am I answering your
6 question? Okay.
7 And then everybody goes through a very
8 comprehensive, everybody gets signed off on
9 HIPAA. Many times the clients have their own
10 HIPAA, but we've created a HIPAA based on our
11 policies and procedures for sign off, and then
12 there are Pipeline policies and procedures as
13 well as client that they must sign off on and
14 they are quizzed on.
15 Now, you asked about the location of
16 the work. It again depends on the state but the
17 reason we went through a residence-based
18 location is there are no geographic restrictions
19 and we can really pick who we need for the
20 specific hospital and then, you know, the
21 location is -- is very, very safe and there's
22 backup to the backup. And then additionally,
23 the client doesn't get passed on the overhead

1 from the building, so we are able to do this
2 very, very cost effectively.
3 DR. MARTIN: Chris, when you say it's
4 residence-based, are you saying it's residence
5 as in Alabama pharmacists taking care of Alabama
6 sites or are you saying residence from the
7 home --
8 MR. CONRADI: They do it from their
9 home.
10 DR. MARTIN: -- from the home?
11 MS. CIOLKO: They do it from their
12 home.
13 DR. MARTIN: Okay.
14 MS. CIOLKO: Now, again, Dr. Martin,
15 depending on the state, okay, for instance,
16 Indiana requires any licensure. The State of
17 North Carolina -- New York required New York
18 pharmacists. You must be licensed in New York.
19 The State of Georgia requires that the Georgia
20 pharmacists reside in the state though they
21 allow residence based.
22 Now, let me explain residence based.
23 The pharmacists that we double and triple check

this, they must have an office, a room that is able to be locked where there is no ambient noise and we do audit and CQI checks on it and I'll explain that and they get our computer, our voice over IP phone, and our screen. It is a paperless system. So as we connect into the hospital, that computer only acts as a conduit. Nothing is saved on that computer, so clearly no access to anybody and there's no one in the room.

All the computers have embedded cameras. Our pharmacists, because they are employed by us, sign off that at any time we may basically call and say, please turn on your camera. That is a courtesy because that camera can be turned on at any time. What we're looking for is no paper, individual by themselves in the room, no ambient noise, because when that nurse calls, her perception needs to be that we are focused on her needs, there's not a dog barking, there's no traffic noise, et cetera, so we're very focused on the pharmacist where the -- where they're sitting.

1 Now, the call center in South Carolina
2 is based out of an office building where the
3 pharmacists drive in to. Am I answering
4 questions?
5 Now, the methods that we ensure
6 compliance for residence based is they have to
7 submit photos of their work environment, random
8 audits, and then I indicated too that we are a
9 paperless system.
10 Now, the goal really here is that
11 every client gets a dedicated team. These are
12 the same people day in and day out, so Nurse Sue
13 knows that Chris is on Monday, Wednesday,
14 Thursday, Friday. She knows Joe is on Tuesday,
15 Thursday. We even go so far as having pictures
16 of our pharmacists posted up on the nursing
17 units so that there is a relationship.
18 Now, we verify all the med orders,
19 anything that's discontinued or modified, any
20 duplicate orders, clearly patient demographics
21 become an issue, routine recommendations that we
22 do, there is no charge for. From our
23 perspective, that is our job as a hospital

1 pharmacist. It's not just about order entry and
2 review. This is really about giving the client
3 value from our clinical perspective, so we're
4 always interacting with nursing and we're seeing
5 a huge surge in hospitalists across the country,
6 either rent a hospitalist or the hospitalists
7 that are employed by the hospital. We do
8 therapeutic and auto sub, statins, or they may
9 have an antibiotic stewardship program based on
10 Joint Commission, DNV and HFAP. Pain meds are a
11 huge issue relative to duplication. They may
12 have an IV to PO program.
13 We are -- we're them, so any policy,
14 any program that they have, we're doing. Then
15 patient specific analysis, we will not sign on a
16 client if we do not have access to the labs. We
17 have to have access to all the patient
18 information because say, for instance, it's a --
19 I mean, like I said, we need to renally dose it
20 or Vancomycin, we need to be able to take a look
21 at the serum creatinine levels, the weight, the
22 patient, everything.
23 And then clearly we have

1 specialization. Just to give you an example of
2 something that we did in New York state,
3 Bellevue, which is almost 800 beds, cannot get
4 clinical oncology pharmacists into the city,
5 into Manhattan. It's cost prohibitive. So what
6 we did is over a two-month period, we reviewed
7 all of their oncology protocols based on all the
8 most current literature, all the information,
9 and Joint Commission requires that those be
10 constantly reviewed. So what we are doing is
11 we're on retainer to constantly be reviewing
12 those oncology protocols based on the kind of
13 specialists that we have.
14 And then we have seamless transition,
15 so for example, just to give you a little bit of
16 a feel, I'm working for XYZ Hospital. I start
17 at 4:00. I call in a quarter to 4:00 and I say,
18 hey, this is Chris, I'm checking in, what do I
19 need to know, because this is about patient
20 continuity and patient safety. So some of the
21 responses are, we had three accidents on the
22 tollway, we're slammed, I need you picking up
23 the order entry, or I didn't get ahold of

1 Dr. Smith, could you please follow up with him
2 relative to this dosing. So it's very similar
3 to a nursing report but it's a pharmacist
4 handoff.
5 The same thing happens at the end of
6 the shift. When we're done, we're faxing in
7 logout sheets to the hospital pharmacy and
8 basically saying, this is what happened last
9 night, you need to know what we're following up
10 on because it's all about the patient, okay, and
11 the continuity as to what we did. And then just
12 so you know, 95 percent of our clinical
13 recommendations are accepted by the physicians.
14 Our service agreements basically
15 indicate an average turnaround time of eight
16 minutes per med. All the stats are done
17 immediately. They bubble to the top in our
18 queue. And then we follow the exact policies
19 and procedures of the client and any internal
20 follow-up that we need to do.
21 Now, measurement, clearly for the
22 client and for us is very, very important, so
23 they pick what they want -- weekly, daily,

1 monthly, quarterly, do they want access into our
2 Pipeline system so when they walk in in the
3 morning, they can say, I want to know how many
4 orders they did and what they did last night.
5 They have access into our system. If they
6 prefer the reports, we do the reports.
7 Now, they include number of med orders
8 that we entered and clinically verified, our
9 turnaround times, the type of clinical
10 interventions that we did, and the type of calls
11 that were made to and from nursing and
12 physicians. We do weekly call-ins or monthly,
13 depending on the client. Our director of
14 pharmacy or associate director of pharmacy is
15 always calling in to the client and if they need
16 a custom report, we just request that they give
17 us 24 hours notice.
18 Now, this is just an example of the
19 kind of reports a client gets. This is a
20 turnaround report for a hospital that's about
21 130 beds. You will see that the majority of
22 orders are done under 15 minutes. Clearly there
23 are some that took longer but that's because of

1 the intervention that needed to take place. We
2 need to get ahold of the doc. We needed to make
3 sure that something was done but -- and then
4 clearly 90 percent of the meds are done within
5 1.16 here.
6 This is a sample intervention report.
7 Clearly what's very, very important to the
8 client, especially now with all the accountable
9 care happening is that we need to be able to
10 share with them what we did during our shift.
11 Many clients don't have these systems. This is
12 Quantify and we have a business arrangement with
13 Quantify. We took it and exploded it and you
14 will see these are all the type of interventions
15 that we do -- clarifying dose, formulation,
16 frequency, indication, protocols -- and this is
17 a monthly tally for the specific client. Those
18 numbers for cost savings are based on Quantify's
19 database.
20 Some clients have their own numbers.
21 So for example, the cost savings for moving
22 something from IV to PO is 50 bucks, okay. So
23 some clients will want us to input their numbers

here but we track all of the clinical interventions that we do, and then this is just another way that one client wanted to take a look at it for presentation for P and T.

Now, when we implement a client, there's a lot of time and effort put on it and I know this is a very busy slide but I want -- everything is very project focused. From the time the contract is signed to when we go live, you'll see further down go live, daily conference calls with the director of pharmacy, twice conference calls, ongoing calls, everything is timed so that the hospital knows exactly when everything is happening. We're really doing all the work but they need to know exactly the timing and everything from a project basis.

And then just to share with you, we do an on-site visit. I used to do them when we started. We spend time with the pharmacy understanding their policies and procedures. We have a format that we follow and then the rest of the time is spent up on the units. So if

1 we're covering two shifts, we'll be there from
2 9:00 p.m. until six o'clock in the morning if we
3 need to to make sure that we are in-servicing
4 all the nurses, that they know how this thing
5 works, share cards with them, you know, just
6 listen to them and historically, ICU really
7 wants to chat. The intensive care units want to
8 chat because they have a very challenging job.
9 Then what we do is we do an additional
10 WebEx where we're sitting on the shoulder of a
11 pharmacist in the hospital inputting orders, so
12 if there was something we didn't catch, we're
13 catching it. And then we put together a manual
14 and very happy to share a sample so you have it
15 on file but the goal is to really exceed Joint
16 Commission, DNV, HFAP accreditation. We've been
17 through Joint Commission, HFAP, and DNV with
18 multiple clients and passed with flying colors
19 because everything is documented. The client
20 gets a policy and procedure manual that has
21 everything in it. It's a live document that
22 we're constantly updating.
23 Then I wanted to share with you, we

1 also do KPIs, key performance indicators, with
2 who our client is, the nurse. Now, you can
3 imagine a critical access hospital or a rural
4 hospital that did not have pharmacy staff on
5 third shift. The nurses are thrilled, so these
6 numbers will look inflated because the kind of
7 client that we're dealing with.
8 So we used three sites. We pulled 100
9 random charts and overall we saw an increase of
10 ten percent in nursing satisfaction. They're
11 less worried about the med errors. No nurse
12 wants to be a pharmacist. They're very -- they
13 feel very comfortable with palpation safety and
14 the timeliness of our service because all the
15 stats bubble to the front. If she has a stat
16 and she normally calls the pharmacy during the
17 day, she'll do the same thing with us. Don't
18 change policies and procedures for the nurses.
19 They've got enough change going on right now.
20 And then the interventions clearly
21 skyrocketed. All the high-risk meds, the
22 adverse drug events were totally eliminated
23 because we're really focused in on those and

1 then the average cost savings for every -- for a
2 client, even a small critical access hospital,
3 is going to be in the quarter of a million
4 range. Now, a CFO will tell you those are soft
5 costs but those are patient care costs.
6 And then this is just our time line.
7 Usually from date of collection through to go
8 live is about six weeks. It's a very, very
9 intensive process with the team and that's it.
10 Did I help a little bit?
11 MR. CONRADI: Mr. Martin, this is your
12 bailiwick. Do you have any questions?
13 DR. MARTIN: Well, you know, Chris and
14 I could talk for probably a half a day or more.
15 MR. CONRADI: Let's don't do that.
16 DR. MARTIN: Offline.
17 MS. CIOLKO: I'm fun to talk to.
18 DR. MARTIN: But I think I'm going
19 to -- I'm going to presume that -- state how we
20 did this for the group in Chicago that talked
21 to -- and I can't remember their name. What was
22 the name of that group, CPI?
23 MS. CIOLKO: Oh, CPS Remote Solutions?

DR. MARTIN: Yeah.

MS. CIOLKO: Oh, they've been here, oh.

DR. MARTIN: So they've been here, so the way we tend to do it is we don't particularly endorse, support, license, qualify any individual group, but if you have a hospital in the state and they're interested in doing business with you, at that point they would come before the Board and say, we really need somebody to, for example, cover our third shift while we're closed and we're thinking of using PipelineRx. Obviously you having been here helps us to understand who that is and what you bring to the table but we will be holding the hospital responsible for that relationship that they maintain with you and any outcomes, you know, related to that.

So we've seen it happen where a hospital says, we want to do remote and whoever is on the other end of the remote process would join the hospital at a presentation to the Board and the Board would, you know, take action.

1 We've -- we've been doing in-state remote for
2 several years. Last -- just in this last year,
3 we allowed remote to go out of state and also to
4 a provider not part of that organization like
5 the CPI or PipelineRx.
6 MS. CIOLKO: Now, and I apologize for
7 this, we were going to have -- we are the only
8 provider for Community Health Systems. They are
9 a very large hospital group across the United
10 States. We are their only provider. They have
11 a number of hospitals in the State of Alabama
12 and CHS and they are not ready to pull the
13 trigger yet, otherwise they would have been here
14 with us.
15 DR. MARTIN: Okay.
16 MS. CIOLKO: So we elected to come
17 just to give you information. I think that's a
18 courtesy to all of you so you know what we're
19 doing.
20 DR. MARTIN: And so when they're
21 ready, you know, they'll call the Board, they'll
22 talk to Susan or someone here at the Board and
23 say, we'd like to do a presentation and they'll

present us with -- the things that we're looking for are things that give us comfort saying, you know, are your policies in place, are your supervisory people in place, you know, other basic questions that we're going to be concerned about and we'll -- we'll schedule that at the presentation and you or someone else might choose to join them, you know, when that happens.

The other issue though that we are in a new area here is the from home. So far with CPI, they're using a call center, if I'm not mistaken --

MS. CIOLKO: That's correct.

DR. MARTIN: -- to do that, so this would be the first time we've considered allowing this process to be done from someone's house.

MR. DARBY: Also, wouldn't their pharmacist need to be licensed in Alabama?

DR. MARTIN: Yes.

MS. CIOLKO: My recommendation to every board that I've talked to, because we've

helped provide information always like in Idaho, they call it the Pipeline rule because we -- we are very focused -- we don't want mom and pops out there. There is risk here to doing this. Somebody can't just be doing this, okay, and sitting at home in their jammies. That's not what this is all about.

So from our perspective, my recommendation to any board is make sure that they're licensed in the state because then you have control over the pharmacist. My other recommendation is, is if you elect to proceed further, license us as a nonresident because then you also have control over us and we -- you know, you require that we submit you policies and procedures. That's up to you but we are very happy to share. We would -- we would prefer to be transparent and make this hard.

DR. MARTIN: Up until now we've not chosen to require the licensing as a nonresident; isn't that correct?

MR. CONRADI: Correct.

MR. DARBY: I mean, would they not

need a pharmacy services permit?

MR. WARD: Yes.

DR. MARTIN: So we have a permit. It's called a pharmacy services permit that's used for sites where there are no drugs stored on site.

MR. WARD: It's site-specific, so it can't be -- you don't give them to a home.

DR. MARTIN: Yes, that's right, so up -- that's why you're kind of breaking new ground here that when we have issued that in the past, it's been for a location where people like the call center.

MS. CIOLKO: Right.

DR. MARTIN: So when you're --

MS. CIOLKO: But please understand, we are willing to do -- it depends on how you want to go with this. We are willing to set up a call center here in Alabama but I am adding for your consideration that there is another feasible method.

DR. MARTIN: Uh-huh, so the -- we are going to have to identify where our comfort zone

is with that and at the point where your hospitals are ready to move forward, we'll have some dialogue and we'll say we're comfortable with call center or if we feel comfortable going beyond that, we'll let that be known also.

MS. CIOLKO: So may I in the meantime apply for pharmacy services permit without the hospital just to get the paperwork going?

MR. CONRADI: Do you have a location?

MS. CIOLKO: We are licensed -- we have a licensed location in Chicago. Do I have to have a location here? I mean, we'll set one up.

DR. MARTIN: We would allow you to have -- I think it would be fine for you to have a nonresident pharmacy services permit.

MR. DARBY: Our rule number on that if you want to look it up, it's 680-X, like x-ray, -2.41.

MS. CIOLKO: 680.

MR. DARBY: X.

MR. WARD: 2.4.

MR. DARBY: 2.41.

MR. WARD: It's a relatively new rule.

MS. CIOLKO: Yes, sir, I'm a little hard of hearing, so okay. 680-X-2.41, okay.

DR. ALVERSON: Tim, we don't have a nonresident pharmacy services permit.

MS. ELLENBURG: We either have nonresident or we have pharmacy services.

MR. WARD: Well, that's what it would be. It would be a nonresident pharmacy services.

MR. DARBY: Yeah, in the event the application for a pharmacy services permit is by a nonresident pharmacy so would they have to be a nonresident pharmacy and then get a pharmacy services permit.

MR. WARD: Do you have drugs at the location up in Chicago?

MS. CIOLKO: I'm sorry?

MR. WARD: Do you have drugs at the location?

MS. CIOLKO: No, absolutely not.

MR. WARD: No, then it's a pharmacy services permit.

MS. CIOLKO: And inspected by the State Board because we have -- we will share -- because we've had inspections -- multiple inspections by the State Board.

MR. WARD: Pharmacy services permit.

DR. MARTIN: So we need to determine if we have it or don't have it.

DR. ALVERSON: Yes.

DR. MARTIN: We think -- it looks like we do but y'all --

DR. ALVERSON: Well, we have a nonresident permit but that's a retail operation.

MR. WARD: Nonresident service permit, that's what you're looking for.

DR. MARTIN: We'll have this resolved before we have someone who's --

MS. CIOLKO: Yeah, and the reason I think -- I'm trying to be timely because everything takes time, okay.

DR. MARTIN: Sure.

MS. CIOLKO: And processes in the state, so we want to be very up front about

everything. Okay. Thank you.

DR. MARTIN: Thank you. Appreciate it.

MS. CIOLKO: Thank you for the privilege of presenting and you should be very proud.

MR. MCCONAGHY: Hey, can I ask you one question on the business side?

MS. CIOLKO: Sure.

MR. MCCONAGHY: Why were Alabama and Wisconsin last on your list?

MS. CIOLKO: Why were Alabama and Wisconsin --

MR. MCCONAGHY: Susan would be interested in this.

DR. ALVERSON: I'm from Wisconsin, yeah, I want to know that.

MR. DARBY: They've got Michigan. Michigan is going to be after us.

MS. CIOLKO: This is what I will tell you, everything is depending on the clients where the biggest needs are, who needs it the most, and I will tell you, New York state for

some reason has been crazy. The West Coast, Pacific Northwest has been from a rural perspective really needed. It just depends on the clients. That's where we've gone.

DR. ALVERSON: They just have cows out there in Wisconsin.

MS. CIOLKO: Well, I'm from Illinois so come on.

DR. ALVERSON: What part?

MS. CIOLKO: So thank you, it was a privilege and I can't say how I appreciate the time.

MR. CONRADI: Thank you so much.

MS. CIOLKO: So Mitzi -- is it Mitzi or who am I following up with? Okay. So if you don't mind, I'll follow up with you.

MS. ELLENBURG: Okay, that's fine.

MS. CIOLKO: Thank you.

DR. ALVERSON: Thank you for being here today.

MS. CIOLKO: No, it was wonderful. I really appreciate it.

MR. CONRADI: Thank you.

MS. CIOLKO: Thanks.

MR. CONRADI: Dan, do you have a treasurer's report for us?

MR. MCCONAGHY: I do. This report goes through the end of June, which would give us three quarters of our fiscal year and we are -- if you're looking at it from a normal business trying to operate, we've lost $421,000 this year, but --

MR. CONRADI: Is that all?

MR. MCCONAGHY: So far and through June. That will continue to add up --

MR. DARBY: It's going to get worse.

MR. MCCONAGHY: -- until October but it's -- we run on a two-year cycle, you know that, so the next year is higher. Last year was higher. It -- when you add them together, we've still got a positive balance in the checkbook and I think that's probably the most important thing that -- and the expenses, we should be at 75 percent at this point and we're at 75.29.

Some of those expenses are all paid at once, so by the end of the year, I believe we'll

be a little bit below the -- what we budgeted for expenses. So overall it's an extremely good report in my opinion and if you just look at the straight numbers, like I say, it looks like we're losing money this year, which we are.

MR. CONRADI: We are.

MR. MCCONAGHY: We'll make it up next year, so that's all I've got.

MR. CONRADI: Thank you, Dan.

MR. DARBY: I move we accept the treasurer's report.

MR. BUNCH: Second.

MR. CONRADI: All in favor?

MR. DARBY: Aye.

MR. MCCONAGHY: Aye.

MR. BUNCH: Aye.

MR. CONRADI: Aye.

Next we need to approve the minutes from the last meeting and interviews. Do I have a motion on that? I need them separate.

MR. DARBY: I move that we approve the Board meeting minutes from June 18, 2014.

MR. BUNCH: Second.

MR. CONRADI: All in favor?
MR. DARBY: Aye.
MR. BUNCH: Aye.
MR. MCCONAGHY: Aye.
MR. DARBY: I move we approve the interview minutes from June 14, 2014.
MR. BUNCH: Second.
MR. CONRADI: All in favor?
MR. DARBY: Aye.
MR. MCCONAGHY: Aye.
MR. CONRADI: Aye.
MR. BUNCH: Aye.
MR. CONRADI: Next we have the chief inspector's report, Mr. Burks.
MR. BURKS: During the month of June, there were 68 inspections completed. From January 1 through June of 2014, 556. We received 25 complaints in June, completed 18, and currently have 31 that's under investigation, and then I do have a couple of things to go over in executive session along with some cases.
MR. CONRADI: Is Mr. Daniel still out?

MR. BURKS: He's back.

MR. CONRADI: When did he come back? I just noticed he only had two inspections last month.

MR. BURKS: Right, but what you have to take into consideration though is also he had several complaints that he completed and worked on cases. We had conferences and conventions that were attended, along with 797 training and other issues that they did.

MR. CONRADI: Okay.

MR. BURKS: That's one of the things I want to discuss also.

MR. CONRADI: Okay, thank you. I have the secretary's report, Ms. Alverson.

DR. ALVERSON: Yes, I wanted to give you have the monthly update on the computer system.

MR. CONRADI: Has it changed since last month, any progress?

DR. ALVERSON: Yes, so the people in licensing have been working very closely with GLS. They've always been trying to work closely

1 but put in a lot of effort this past month. The
2 system to register to renew licenses for
3 pharmacists, which should begin September 1 is
4 completed and will be tested within the next
5 week to slightly over a week. We've looked at
6 it, proofed it I think three or four times
7 already, and I am confident that system is going
8 to be ready to go.
9 We have gone through all possible
10 changes for all the business renewals down to
11 where should the commas go. That has all been
12 submitted. GLS goes through a process of
13 measuring how much work it is to be sure they're
14 not going to charge you any projects. That's
15 all -- we're through all of that stage and it's
16 now gone to the people who are actually writing
17 the programs. We've scheduled to begin business
18 renewals September 15.
19 We've been assigned a new technical
20 person from GLS and it seems we've gotten their
21 top person for now, probably due to a lot of
22 moaning and groaning and threatening on our part
23 and she's really been great, so I'm anticipating

that we'll be able to do all business renewals online except for the pharmacy services. I haven't used a project to set that up for renewal but we don't have that many of them right now, so that will be the only one that we won't renew online, and nuclear because I believe there's data that has to be submitted with nuclear inspections. There's some extra things that have to be done with nuclear and so not all of that will be done online but other than that, we should be ready to go. We will be sending out postcards within the next couple of weeks to notify all pharmacists and all businesses when the exact renewal date is coming up and where to go online to do that.

The other thing I wanted to mention is it's required by law for anyone who wants to reciprocate into Alabama to appear before the Board for an interview. Since we are implementing the law that requires every out-of-state business to have a licensed Alabama pharmacist and we have approximately 800 businesses like that, we were trying to find a

way to keep 800 people from having to fly to Alabama for that interview and so we've been working with the Department of Health videotaping office and they will work with us at no charge. There will be someone here today at 11:30 to videotape that interview with people who are here reciprocating or getting a license for the first time.

That department then at the Health Department will edit that, make it very professional looking, and help set it up that we can provide that at specific times. Because it has to be live, someone will have to be available during that showing and it's been recommended that we have one or two board members there and so --

MR. CONRADI: The law says two, so we'll have to have two.

DR. ALVERSON: Two, all right. So we would like to do that in conjunction with Board meetings for all the months coming up through December and then we will -- we will notify those businesses of the dates that we will do

those showings but I believe that will take a vote on behalf of the Board for us to be able to do that and that way we can get all those people done without bringing them into town.

MR. CONRADI: Mr. Ward, would that --

MR. WARD: Well, we're thinking outside the box, so I'm sure the auditors will have a coronary or two but that's the only -- practically the only way you can do it, so I say we do it and in this day and age to say that we have to -- everybody has to come somewhere to meet is just not practical. So as long as it's a meeting of the Board --

DR. ALVERSON: All right.

MR. WARD: -- appearing -- they are appearing, so I say to do it.

DR. ALVERSON: All right.

DR. MARTIN: So you'd like a board action -- a motion and vote to proceed --

DR. ALVERSON: Yes, I would like a vote to approve that process.

DR. MARTIN: I missed some of the earlier discussion so I'm going to -- I'll

attempt to make the motion. If I get it wrong, somebody help me get it right. I move that we allow -- that we videotape the interview process and allow nonresident candidates for licensure --

MR. CONRADI: Reciprocity.

DR. MARTIN: -- for reciprocity to view video as a live event and that there will be at least one Board member -- excuse me, two Board members --

DR. ALVERSON: I thought you said two.

MS. ELLENBURG: Two.

MR. CONRADI: The law says two. If we're going to do it on Board day, it won't matter, we'll all be here.

DR. MARTIN: A minimum of two Board members present and available during the viewing to speak and to respond to questions.

MR. CONRADI: Second that motion. All in favor?

DR. MARTIN: Aye.

MR. DARBY: Aye.

MR. MCCONAGHY: Aye.

MR. BUNCH: Aye.

MR. CONRADI: Motion passed.

DR. ALVERSON: Thank you. Is that all?

MR. BUNCH: Susan, that's the first positive report I've ever heard on GLS. What --

DR. MARTIN: And I missed it.

MR. BUNCH: Why do you think the turnaround, just pressure?

DR. ALVERSON: Well, for one thing I told our contact that I was looking at other companies and that whether they got this done on time was my do or die, so if they don't have it done, ready, and perfected in the time they said they could, that that was my sign that we need to leave them.

MR. BUNCH: Yeah, very good.

DR. ALVERSON: And they said we figured that out. Well, just to confirm, you figured it out correctly and then -- so they gave us this hotshot technical person for the pharmacy renewal process and when they said, well, we'll see who you get for the business

part, we put up quite a stink and so -- so I think that's what happened.

MR. BUNCH: Well, good.

MR. CONRADI: Thank you. Anything else?

DR. ALVERSON: No. We're doing a consulting program at Auburn on Friday. A number of the inspectors are going also, not to speak but to get updated on long-term care pharmacy law.

MR. CONRADI: Okay. Mr. Ward, do you have a report?

MR. WARD: No, I have something for executive session but nothing other than that.

MR. CONRADI: Okay. I don't have anything listed on any old business. Do we have any old business left over we need to take care of that y'all know of?

DR. MARTIN: I don't know of any.

MR. CONRADI: How about any new business?

MR. DARBY: We have the Mobile Infirmary thing on the agenda.

MR. CONRADI: Well, I think they -- that's worked out.

MR. DARBY: Okay.

MR. CONRADI: I think it was a doctor so it's out of our jurisdiction.

MR. DARBY: All right.

MR. CONRADI: If I'm not mistaken.

MS. ELLENBURG: That's correct.

DR. MARTIN: Okay.

MR. CONRADI: If nothing else then we will go into executive session for the purpose of discussing professionalism, competence, general reputation, and character of licensees and registrants of the Board. My motion includes we'll go into executive session at -- let's say -- let's say 10:15 because I know we're going to chat out there a minute and then we will come back out of session at 10:30.

After that we'll vote on what we discussed in executive session. No more business will happen and we will adjourn. If any of y'all are wanting to stay after executive, you can, but I need an individual

vote for that.

Mr. McConaghy, how do you vote?

MR. MCCONAGHY: Aye.

MR. CONRADI: Mr. Darby?

MR. DARBY: Aye.

MR. CONRADI: Dr. Martin?

DR. MARTIN: Aye.

MR. CONRADI: Mr. Bunch?

MR. BUNCH: Aye.

MR. CONRADI: And aye.

Thank y'all.

(Whereupon, a recess was taken for executive session from 10:05 a.m. to 10:56 a.m.)

MR. CONRADI: I'd like to make a motion that we come out of executive session.

MR. WARD: You don't have to make a motion.

MR. CONRADI: Well, I thought you said we did.

MR. WARD: We've come out, so you're

out now. We're out of it.

MR. CONRADI: We're out of executive session. We're going to vote on the items discussed in executive session.

Case number 14-0090 and case number 14-0072, consent order. I make a motion we accept that.

MR. BUNCH: Second.

MR. CONRADI: All in favor?

DR. MARTIN: Aye.

MR. DARBY: Aye.

MR. MCCONAGHY: Aye.

MR. BUNCH: Aye.

MR. CONRADI: Complaint number 14-0091, 0062, letter of concern. I make a motion we accept that recommendation.

MR. BUNCH: Second.

MR. CONRADI: All in favor?

MR. DARBY: Aye.

DR. MARTIN: Aye.

MR. MCCONAGHY: Aye.

MR. BUNCH: Aye.

MR. CONRADI: Complaint number

14-0036, 0069, 0071, and 0093, no violation. I make a motion we accept that recommendation.

MR. BUNCH: Second.

MR. CONRADI: All in favor?

MR. DARBY: Aye.

MR. MCCONAGHY: Aye.

DR. MARTIN: Aye.

MR. BUNCH: Aye.

MR. CONRADI: I make a motion we adjourn.

DR. MARTIN: Second.

MR. DARBY: Were we going to change the --

MR. MCCONAGHY: We want to make a liar out of you. You were out of the room a while ago when we were talking about it.

MR. WARD: Well, we might not have to change it depending on what the auditors say, so.

MR. DARBY: Just wait.

MR. WARD: Yeah, if the auditors say it's okay to do it that way, then we need to change. If the auditors say we can't do it that

way --

MR. DARBY: It's null and void anyway.

MR. WARD: Then we couldn't do it.

MR. DARBY: Why don't we just not change it.

DR. ALVERSON: Yeah, but what if they say we can and we don't have the one-time deal only, then I've got to call all of you and get --

MR. DARBY: What would be the harm of going ahead and changing it now and --

MR. WARD: Well, because it's not -- we told everybody no business was going to be discussed so we would be discussing business.

MR. CONRADI: And she's typing away over there.

MR. WARD: Yeah, so -- stop typing.

(Whereupon, a discussion was held off the record.)

MR. CONRADI: Now, can I make a motion

to adjourn?

DR. MARTIN: Second.

MR. CONRADI: All in favor?

MR. MCCONAGHY: Aye.

MR. DARBY: Aye.

DR. MARTIN: Aye.

MR. BUNCH: Aye.

MR. CONRADI: Aye.

(Whereupon, the hearing was adjourned at 11:01 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 9/30/2014

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