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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

1 APPEARANCES

2

3 BOARD MEMBERS:

4 Mark Conradi, President

5 Tim Martin, Vice President

6 Dan McConaghy, Treasurer

7 Buddy Bunch, Member

8 David Darby, Member

9

10 ALSO PRESENT:

11 Susan Alverson, Director of Professional

12 Affairs and Secretary

13 Edward R. Braden, Chief Inspector

14 Jim Ward, Board Attorney

15 Dr. Mike Garver, Wellness Committee

16 Mitzi Ellenburg, Board of Pharmacy

17 Todd Brooks, Board of Pharmacy

18 Glenn Wells, Board of Pharmacy

19 Mark Delk, Board of Pharmacy

20 Scott Daniel, Board of Pharmacy

21 Terry Lawrence, Board of Pharmacy

22 Ronda Lacey

23 Rick Stephens

- 1 Dane Yarbrough
- 2 Jeff Freeze
- 3 Andy Compton
- 4 Al Carter
- 5 Tammie Koelz
- 6 Matthew Muscato
- 7 Paul Rengering
- 8 Nancy James
- 9 Louise Jones
- 10 Tracy Davis
- 11 Gary Mount
- 12 David Belser
- 13 Steve Brickman
- 14 Chris Burgess
- 15 Lindsay Leon
- 16 Clemice Hurst
- 17 Kelli Newman
- 18 Jim Easter
- 19 Thalia Baker
- 20 Julie Hunter
- 21 Ashley Core
- 22 Bruce Harris
- 23 T. J. Hester

- 1 Thomas Miller
- 2 Melanie Smith
- 3 Sally Sims
- 4 April Marlin
- 5 Carly Rhodes
- 6 Pamela Jubach
- 7 Susan Sidwell
- 8 Leslie Payne
- 9 Wendy Sprayberry
- 10 Scotty Armstead
- 11 Cary Wahlheim
- 12 David Randall
- 13 Bart Bamberg
- 14 Jeanna Boothe
- 15 Carter English
- 16 Stuart Cohen
- 17 Melissa Mancini
- 18 Tommy Klinner

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

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

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

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

9 MR. STEPHENS: Rick Stephens, Senior
10 Care Pharmacy.

11 MR. YARBROUGH: Dane Yarbrough,
12 Turenne PharMedCo.

13 MR. FREEZE: Jeff Freeze, Turenne
14 PharMedCo.

15 MS. ELLENBURG: Mitzi Ellenburg, Board
16 of Pharmacy.

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

19 MR. CARTER: Al Carter with Walgreens.

20 MS. KOELZ: Tammie Koelz with
21 Walgreens.

22 MR. MUSCATO: Matthew Muscato,
23 Walgreens Pharmacy.

1 MR. RENGERING: Paul Rengering,
2 Walgreens Pharmacy.

3 MS. JAMES: Nancy James, PharMerica.

4 MS. JONES: Louise Jones, Alabama
5 Pharmacy Association.

6 MS. DAVIS: Tracy Davis, Alabama
7 Pharmacy Association.

8 MR. MOUNT: Gary Mount, Baptist Health
9 Montgomery.

10 MR. BELSER: David Belser representing
11 ALAMTA.

12 MR. BRICKMAN: Steve Brickman, Sirote
13 and Permutt.

14 MR. BURGESS: Chris Burgess, Heritage
15 Pharmacy.

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

18 MS. HURST: Clemice Hurst, Alabama
19 Medicaid.

20 MS. NEWMAN: Kelli Newman, Alabama
21 Medicaid.

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

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

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

7 MS. BAKER: Thalia Baker with UAB
8 Medicine.

9 MS. HUNTER: Julie Hunter with
10 Omnicare.

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

13 MR. HARRIS: Bruce Harris, APCI.

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

16 MR. MILLER: Thomas Miller, CVS
17 Pharmacy.

18 MS. SMITH: Melanie Smith, BuzzeoPDMA.

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

21 MS. MARLIN: April Marlin, Baptist
22 Health System.

23 MS. RHODES: Carly Rhodes, McWhorter

1 School of Pharmacy.

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

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

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

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

10 MS. SIDWELL: Susan Sidwell, president
11 of ALAMTA.

12 MS. PAYNE: Leslie Payne, Calhoun
13 Treatment Center.

14 MS. SPRAYBERRY: Wendy Sprayberry,
15 Calhoun Treatment Center.

16 MR. ARMSTEAD: Scotty Armstead,
17 Turenne PharMedCo.

18 MS. WAHLHEIM: Cary Wahlheim, UAB
19 Health System.

20 MR. RANDALL: David Randall with UAB
21 Health System.

22 MR. BAMBERG: Bart Bamberg, Publix
23 Supermarkets.

1 MS. BOOTHE: Jeanna Boothe, Decatur
2 Morgan Hospital.

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

5 MR. COHEN: Stuart Cohen, UAB
6 Medicine.

7 MS. MANCINI: Melissa Mancini, UAB
8 Health System.

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

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

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

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

17 MR. DARBY: Second.

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

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

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

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

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

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

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

11 MR. WARD: Those were signed
12 yesterday.

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

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

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

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

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

23 In January the three facilities were

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

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

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

1 think outside the box a little bit.

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

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

14 MR. CONRADI: Any questions?

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

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

20 DR. MARTIN: And three different
21 campuses?

22 MS. BOOTHE: Three campuses.

23 DR. MARTIN: And the ones you already

1 have remote with are between the mothership
2 and --

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

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

7 MS. BOOTHE: To Parkway.

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

13 MS. BOOTHE: Correct, correct.

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

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

18 MR. CONRADI: What do you consider
19 after hours?

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

1 6:30 to 3:00, to 4:00 kind of time during the
2 week, possibly one day during the weekend. So
3 it would be the late afternoon and evening and
4 some weekend coverage.

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

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

11 MR. CONRADI: What's your --

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

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

19 DR. MARTIN: Yes.

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

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

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

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

20 DR. MARTIN: Right.

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

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

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

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

14 DR. MARTIN: Yeah.

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

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

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

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

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

9 MS. BOOTHE: Correct, correct.

10 MR. CONRADI: Any more questions?

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

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

19 MR. MCCONAGHY: Oh, okay.

20 DR. MARTIN: I move we approve the
21 request.

22 MR. CONRADI: Second?

23 MR. DARBY: Second.

1 MR. CONRADI: All in favor?

2 MR. MCCONAGHY: Aye.

3 DR. MARTIN: Aye.

4 MR. BUNCH: Aye.

5 MR. DARBY: Aye.

6 MR. CONRADI: Thank you.

7 MS. BOOTHE: Thank you very much.

8 Walgreens, who's up, Al?

9 MR. CARTER: Good morning, Al Carter,
10 director of professional affairs and pharmacy
11 quality for Walgreens, and this is -- it's a
12 fairly straightforward request and I think you
13 guys have a list of limited distribution drugs
14 that I provided to you earlier last week.

15 What Walgreens is trying to do is
16 currently with our specialty pharmacies, and we
17 have four specialty pharmacies that deal with
18 mainly limited distribution drugs located
19 throughout the U.S. They're all nonresident,
20 licensed Alabama pharmacies and currently what
21 we do is if a patient has a prescription, most
22 of these are, you know, anywhere from a range of
23 \$1,000 up to \$10,000 or \$15,000 for a 30-day

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

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

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

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

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

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

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

16 MR. CARTER: Yes, sir.

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

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

22 MR. WARD: To another pharmacy?

23 MR. CARTER: To a Walgreens.

1 MR. WARD: Another Walgreens?

2 MR. DARBY: Two different permits
3 though.

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

9 MR. CONRADI: Common ownership.

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

11 MR. CONRADI: Yeah, common ownership.

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

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

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

23 MR. CARTER: Correct, it would

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

4 MR. WARD: Okay.

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

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

1 it to their office to administer to them.

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

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

7 MR. CONRADI: Is that a motion?

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

12 DR. MARTIN: Second.

13 MR. BUNCH: Second.

14 MR. CONRADI: All right. All in
15 favor?

16 MR. MCCONAGHY: Aye.

17 MR. DARBY: Aye.

18 DR. MARTIN: Aye.

19 MR. BUNCH: Aye.

20 MR. CONRADI: Aye.

21 Thank you, Al.

22 MR. CARTER: Thank you. Appreciate
23 that.

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

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

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

8 MR. CONRADI: Yes, ma'am.

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

12 MS. BAKER: Thalia Baker, operations
13 infirmary care.

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

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

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

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

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

17 Just to give you a little bit of a
18 background, this is a pilot program that is run
19 under the jurisdiction and the supervision of
20 the Alabama Board of Medical Examiners. They
21 originally gave UAB Health System permission to
22 start this pilot program back in September of
23 2013. As with every program, it took a little

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 So if for any reason we look at the
7 note and we see that the patient needs to come
8 in and see someone face to face, we refund that
9 \$25 back, we give them instructions back to that
10 secure link that they need to come in and see
11 one of the urgent cares. So that's just the
12 basic operations of how it works.

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

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

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

8 This is just current utilization, so
9 this goes -- we really have only had the service
10 open -- fully open for a little over a month
11 when I took these stats at 9/30, so we've had a
12 little over 1,100 attempted visits, 233 have
13 completed the visit. They've made it through
14 the protocols without any red flags, so that's a
15 20-percent success rate, so 80 percent have
16 bumped out and been suggested to come into an
17 urgent care. 155 prescriptions have been sent
18 electronically, so 66 percent of the completed
19 visits actually got a prescription. Everybody
20 else got over the counter or recommendations for
21 rest and fluids.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 The other --

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

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

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

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

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

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

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

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

1 patients can come into my office and lie to
2 me.

3 MR. CONRADI: But you're seeing them.

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

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

17 MR. CONRADI: Right.

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

1 understand that.

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

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

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

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

23 MR. CONRADI: That's what they're

1 doing now on the Internet.

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

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

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

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

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

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

21 MR. CONRADI: 540-X-9.11.

22 DR. MARTIN: 9.11?

23 MS. BAKER: Yes.

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

3 DR. MARTIN: Is that under
4 miscellaneous?

5 MR. WARD: Yeah.

6 MS. WAHLHEIM: Yes.

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

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

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

1 MS. BAKER: We did. Yes, sir, we did.
2 And I think for your first question, it's a
3 24-month pilot that starts in July of this year,
4 so we'll run until June of 2016 and we're
5 reporting quality data every six months to the
6 Board.

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

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

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

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

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

23 MR. CONRADI: But just taking whatever

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

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

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

18 MR. CONRADI: You never know.

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

21 MR. DARBY: There's a comment.

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

1 questionnaire.

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

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

9 MR. DARBY: Like television
10 advertising?

11 MS. WAHLHEIM: Yeah, newspaper
12 advertising, radio.

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

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

19 MR. CONRADI: Right.

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

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

8 MS. BAKER: No, that's different.

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

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

16 MS. WAHLHEIM: Uh-huh.

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

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

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

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

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

1 one.

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

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

9 DR. ALVERSON: Right.

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

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

18 MS. BAKER: Yes.

19 DR. ALVERSON: -- or even the 233.

20 MS. BAKER: Right.

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

23 MS. BAKER: Yes, the 233s are the

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

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

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

16 MR. CONRADI: You're from Wisconsin.

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

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

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

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

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

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

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

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

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

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

1 you are going to get rich.

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

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

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

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

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

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

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

7 DR. COHEN: Always.

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

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

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

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

23 MR. WARD: And what we do in the

1 future.

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

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

13 MS. BAKER: No, I --

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

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

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

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

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

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

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

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

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

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

1 standpoint.

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

8 MR. CONRADI: Thank you for --

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

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

23 MR. BUNCH: How do you not view it as

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

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

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

7 MR. CONRADI: Right.

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

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

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

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

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

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

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

7 MS. WAHLHEIM: Right.

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

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

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

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

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

22 (Laughter.)

23 MR. BUNCH: I beg to differ on that

1 one.

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

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

20 MR. CONRADI: I think --

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

1 understand they're here today.

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

4 MS. BAKER: Prime.

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

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

17 DR. ALVERSON: Just --

18 MS. BAKER: Yeah, yeah.

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

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

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

5 MR. CONRADI: We appreciate the
6 information.

7 MS. BAKER: Thank you.

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

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

23 But the expenses were 2.417 million

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

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

1 that's all I've got.

2 DR. ALVERSON: Hear, hear.

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

6 MR. CONRADI: Second?

7 MR. DARBY: Second.

8 MR. CONRADI: All approve?

9 MR. MCCONAGHY: Aye.

10 MR. DARBY: Aye.

11 DR. MARTIN: Aye.

12 MR. CONRADI: Aye.

13 MR. BUNCH: Aye.

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

17 DR. MARTIN: As soon as I find them.

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

20 MR. CONRADI: Second?

21 MR. BUNCH: Second.

22 MR. CONRADI: All in favor?

23 MR. MCCONAGHY: Aye.

1 DR. MARTIN: Aye.

2 MR. BUNCH: Aye.

3 MR. CONRADI: Aye.

4 MR. DARBY: I also move we approve the
5 interview minutes from the September 17
6 meeting.

7 MR. BUNCH: Second.

8 MR. CONRADI: All in favor?

9 MR. MCCONAGHY: Aye.

10 DR. MARTIN: Aye.

11 MR. BUNCH: Aye.

12 MR. DARBY: Aye.

13 MR. CONRADI: Dr. Alverson, your
14 report.

15 DR. ALVERSON: Yes, we received a
16 letter from the State auditor's office saying
17 sorry this is so late but we just wanted to let
18 you know that when Tony Yarbrough left, we did
19 an audit of all equipment and everything that
20 was listed as belonging to the Board of Pharmacy
21 we found, it could be accounted for, you had
22 100-percent compliance, and sorry it took us
23 this long to tell you.

1 MR. CONRADI: When did they do the
2 audit?

3 MS. ELLENBURG: Two years ago.

4 DR. ALVERSON: April 18, 2013.

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

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

11 MR. CONRADI: Great.

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

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

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

19 MS. ELLENBURG: I could take that
20 either way.

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

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

3 MS. ELLENBURG: Exactly.

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

6 DR. ALVERSON: Back then, all right.

7 MR. CONRADI: Even Mitzi's outfit.

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

14 MR. CONRADI: Is that Wisconsin for
15 methadone?

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

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

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

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

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

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

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

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

4 MR. MCCONAGHY: Okay.

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

7 MS. SIDWELL: It is a DEA regulation.

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

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

12 MS. SIDWELL: Susan Sidwell.

13 COURT REPORTER: Thank you.

14 MR. CONRADI: And you heard that?

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

21 MR. CONRADI: Any comments?

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

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

7 MR. CONRADI: Thank you.

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

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

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

23 MR. CONRADI: Thank you, Susan.

1 What's next?

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

12 MR. CONRADI: Projects?

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

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

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

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

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

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

6 MR. CONRADI: Yeah.

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

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

12 MS. ELLENBURG: Yeah, yeah.

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

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

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

3 DR. ALVERSON: Yes, we are.

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

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

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

10 MR. CONRADI: Oh, yeah.

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

13 MR. BUNCH: Yeah.

14 DR. ALVERSON: -- until we switch
15 over.

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

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

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

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

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

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

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

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

15 DR. ALVERSON: Getting the Cadillac,
16 right.

17 MR. CONRADI: Anything else?

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

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

6 DR. MARTIN: And who was she with
7 previously?

8 DR. ALVERSON: Target.

9 DR. MARTIN: Target. Is she here
10 today?

11 MR. CONRADI: Is that Blake's wife?

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

14 MR. CONRADI: Who is we?

15 DR. ALVERSON: Blake, Crystal, and
16 me.

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

19 DR. ALVERSON: Not at this time, no.

20 DR. MARTIN: Okay, thank you.

21 MR. CONRADI: Chief Braden.

22 MR. BRADEN: Yes, sir, Mr. Conradi.

23 Look in your Dropbox, you'll see activity for

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

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

15 MR. CONRADI: Did everybody pass the
16 qualifications?

17 MR. BRADEN: Yes, sir, they did.

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

20 MR. BRADEN: Todd Brooks did.

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

23 MR. BRADEN: Yes, sir, I do.

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

5 MS. ELLENBURG: No, sir.

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

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

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

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

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

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

7 DR. MARTIN: I agree.

8 MR. CONRADI: Huh-uh.

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

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

13 MR. CONRADI: Yeah.

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

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

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

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

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

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

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

1 know that's going to be a problem.

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

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

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

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

6 MR. CONRADI: Right.

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

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

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

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

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

1 preexisting, patient-practitioner relationship.

2 There's no way for them to distinguish it.

3 DR. MARTIN: I don't think --

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

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

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

15 MR. CONRADI: Yeah.

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

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

20 MR. BUNCH: Yeah.

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

1 are very aggressive in their auditing.

2 MR. BUNCH: Very aggressive.

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

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

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

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

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

20 MR. WARD: Absolutely.

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

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

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

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

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

1 MR. DARBY: They can't fill it.

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

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

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

1 y'all okay if we fill that?

2 MR. WARD: I'd tell them no.

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

4 MR. WARD: I'd tell them no.

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

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

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

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

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

22 MS. LACEY: Word it carefully.

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

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

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

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

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

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

5 DR. MARTIN: Okay.

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

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

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

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

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

14 MS. JONES: Okay.

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

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

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

23 DR. ALVERSON: I believe the MSA is

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

3 DR. MARTIN: Yeah.

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

7 MS. NEWMAN: Walker, Walker.

8 MR. BURGESS: Sharp cheddar?

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

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

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

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

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

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

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

8 MR. DARBY: They did say that, yeah.

9 DR. MARTIN: So if you get one --

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

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

21 MR. CONRADI: Thank you. Any more
22 business?

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

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

5 MS. ELLENBURG: From the preceding
6 calendar year.

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

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

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

17 MR. CONRADI: Per renewal cycle?

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

20 DR. ALVERSON: That is what we
21 decided.

22 MR. DARBY: It has to be within --

23 DR. ALVERSON: Within the -- a

1 renewal -- within that two-year time frame.

2 MR. CONRADI: Thirty for two years.

3 MR. DARBY: It would have to be 30 in
4 '13 and '14. It can't be 30 in '14 and '15.

5 DR. ALVERSON: Correct.

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

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

10 DR. ALVERSON: Correct.

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

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

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

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

20 MS. LACEY: Okay, thank you.

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

23 MR. MCCONAGHY: But if anybody is

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

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

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

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

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

12 MR. MCCONAGHY: Uh-huh.

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

16 DR. MARTIN: I would think so.

17 MR. STEPHENS: Okay.

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

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

23 MR. MCCONAGHY: No, not carry over.

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

4 MS. ELLENBURG: Okay.

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

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

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

13 DR. MARTIN: Yeah.

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

16 DR. MARTIN: Correct.

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

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

1 would suggest that we would make the same
2 decision.

3 MR. MCCONAGHY: I agree.

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

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

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

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

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

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

23 MR. CONRADI: One and two.

1 MR. WARD: Two and one.

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

4 DR. ALVERSON: Three total, one live.

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

10 MR. WARD: No.

11 MR. CONRADI: One live.

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

14 MR. CONRADI: Two live and four --

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

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

21 MR. CONRADI: Second.

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

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

6 MR. WARD: It's interpretation.

7 MS. ELLENBURG: Okay.

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

10 MS. ELLENBURG: All right.

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

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

17 MR. CONRADI: Do we have a second?

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

20 MR. CONRADI: Okay. All in favor?

21 MR. MCCONAGHY: Aye.

22 MR. DARBY: Aye.

23 DR. MARTIN: Aye.

1 MR. BUNCH: Aye.

2 MR. CONRADI: Aye.

3 Okay. Any more business?

4 MS. LACEY: May I have a point of
5 clarification for the students that will be
6 taking the MPJE?

7 MR. CONRADI: They go by what's in the
8 law.

9 MS. LACEY: I'm good. Thank you,
10 Mark.

11 DR. MARTIN: You skipped -- well,
12 you're about to go to Jim, okay.

13 MR. CONRADI: Jim had no report he
14 said.

15 DR. MARTIN: He didn't.

16 MR. CONRADI: I don't see any more
17 business we have to do. We will go into
18 executive session at 11:10, and we've got
19 students at 11:30, to discuss competency of
20 pharmacists, permit holders, and pending cases.
21 We will come out at 11:25. No more business
22 will be conducted after that other than acting
23 on the cases and -- that we reviewed in

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

3 DR. MARTIN: Second.

4 MR. CONRADI: Mr. McConaghy?

5 MR. MCCONAGHY: Aye.

6 MR. CONRADI: Mr. Darby?

7 MR. DARBY: Aye.

8 MR. CONRADI: Dr. Martin?

9 DR. MARTIN: Aye.

10 MR. BUNCH: Aye.

11 MR. CONRADI: Aye. Thank y'all.

12

13 (Whereupon, a recess was taken for
14 executive session from 11:05 a.m. to
15 11:29 a.m.)

16

17 MR. CONRADI: Case number 14-0080,
18 14-0087, 14-0081, and 14-0088, 14-0094,
19 recommendation, letter of warning and proof that
20 all physician information was reversed with
21 insurance and PDMP. Do y'all accept that
22 recommendation?

23 DR. MARTIN: I move we accept the

1 recommendation as made.

2 MR. DARBY: Second.

3 MR. CONRADI: All in favor?

4 MR. MCCONAGHY: Aye.

5 DR. MARTIN: Aye.

6 MR. DARBY: Aye.

7 MR. BUNCH: Aye.

8 MR. CONRADI: Aye.

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

13 DR. MARTIN: Second.

14 MR. CONRADI: All in favor?

15 MR. BUNCH: Aye.

16 MR. MCCONAGHY: Aye.

17 DR. MARTIN: Aye.

18 MR. DARBY: Aye.

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

1 mental ability -- mental condition and ability
2 to return to work in a pharmacy setting.

3 Does that get a second?

4 DR. MARTIN: Second.

5 MR. CONRADI: All in favor?

6 MR. MCCONAGHY: Aye.

7 DR. MARTIN: Aye.

8 MR. DARBY: Aye.

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

14 DR. MARTIN: Second.

15 MR. CONRADI: All in favor?

16 DR. MARTIN: Aye.

17 MR. DARBY: Aye.

18 MR. MCCONAGHY: Aye.

19 MR. BUNCH: Aye.

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

1 refills. I make a motion we accept the
2 recommendation.

3 MR. DARBY: Second.

4 MR. CONRADI: All in favor?

5 MR. MCCONAGHY: Aye.

6 DR. MARTIN: Aye.

7 MR. DARBY: Aye.

8 MR. BUNCH: Aye.

9 MR. CONRADI: And then case number
10 14-0144, recommendation, letter of warning and
11 proof that all physician information was
12 reversed with insurance and PDMP. Make a
13 recommendation -- I make a motion we accept the
14 recommendation.

15 MR. DARBY: Second.

16 MR. CONRADI: All in favor?

17 DR. MARTIN: Aye.

18 MR. MCCONAGHY: Aye.

19 MR. DARBY: Aye.

20 MR. BUNCH: Aye.

21 MR. CONRADI: And then case numbers
22 14-0145, make a motion we accept recommendATION,
23 assign permanent surrender to present to the

1 Board. All in favor?

2 MR. MCCONAGHY: Aye.

3 DR. MARTIN: Aye.

4 MR. DARBY: Aye.

5 MR. BUNCH: Aye.

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

8 DR. MARTIN: We're already out.

9 MR. CONRADI: I make a motion we
10 adjourn.

11 DR. MARTIN: Move we adjourn.

12

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

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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

WORD INDEX

< \$ >

\$1,000 21:23
\$10,000 21:23
\$15,000 21:23
\$2,000 12:14
\$25 34:20 35:4, 9
 59:23 92:22

< 1 >

1 85:6
1,100 36:12 56:8
1,183 57:1 58:9
1.845 72:13
1.9 72:15
100 76:9
100.49 73:2
100-percent 75:22
11:05 113:14
11:10 112:18
11:25 112:21
11:29 113:15
11:30 112:19
11:33 117:14
111 1:19
119 12:14, 19
12 14:18 76:17
 105:4
13 106:4
130 12:18
139 10:5
14 106:4, 4
14-0080 113:17
14-0081 113:18
14-0087 113:18
14-0088 113:18
14-0094 113:18
14-0097 114:10
14-0107 114:19
14-0111 115:9
14-0125 115:20
14-0144 116:10
14-0145 116:22
15 1:10 14:18
 106:4
153 69:6
155 36:17 69:6
16 10:19
17 75:5

18 35:17 38:15
76:4

< 2 >

2.417 72:23 73:1
20 37:20
2013 28:23 76:4
2014 1:10 29:3
 72:11
2015 118:22
2016 51:4
20-percent 36:15
22 88:2
23 88:3
233 36:12 56:17,
 19, 22 57:22
233s 56:23
24 30:13
24-month 51:3
25 92:6

< 3 >

3:00 17:1
30 36:11 95:19
 106:3, 4 109:18
 118:22
30-day 21:23
34-23-70 23:4
35 22:3
35242 1:20
36 22:3

< 4 >

4:00 17:1
439 118:22

< 5 >

540-X-15 49:18
540-X-9.11 49:21
540-X-9-.11 31:4

< 6 >

6:30 17:1
65 35:17 38:13, 16
66 36:18 56:17
680-X-2-.33 30:2

< 7 >

792 12:14

797 88:8

< 8 >

80 12:1 36:15
 59:6

< 9 >

9 36:11 118:22
9.11 49:22
9.5 17:8
9:14 1:12
90 88:1
911 12:13
950 58:3

< A >

a.m 1:12 113:14,
 15 117:14
AA 12:3
ability 55:22
 64:22 86:3 115:1,
 1
able 23:2, 7 24:14
 25:15 32:17 34:16
 61:21 82:18 88:9
 100:17 103:21
 106:16
absolute 31:10
Absolutely 95:20
accept 89:18
 113:21, 23 114:12,
 20 115:12 116:1,
 13, 22
access 18:3, 4, 8
 32:17, 22, 23 33:1
 35:1 44:8, 11, 16
 65:17 78:17, 19
accommodate 14:23
accounted 75:21
 76:10
ACCR 118:22
accurate 5:4
achieved 45:16
act 62:22
acting 112:22
action 66:4 115:11
 118:16
actions 41:1
activity 87:23
acts 62:22

acuity 33:7 35:1,
 15 36:3 37:6
 60:11

acute 54:11 59:19

add 82:1

added 14:2 15:3
 20:13

addition 14:20
 16:8

additional 20:12, 15

address 42:18

addressed 51:8

adjourn 117:10, 11

administer 26:1

administration

25:6, 12 79:3

adopt 9:15

advantage 19:3

advertising 53:10,
 12

advise 89:13

100:12

advised 40:18

Affairs 2:12 21:10

affect 90:22

aftercare 12:2, 2

afternoon 17:3

57:19

age 38:12, 13

agenda 9:14, 16, 19

28:2

ages 35:17

aggressive 95:1, 2

ago 76:3 94:13

agree 24:12 65:4,

15 67:11, 12 90:7

109:3

agreements 61:3

ahead 99:12

ain't 109:14

AI 3:4 5:19 21:8,

9 25:5 26:21

ALABAMA 1:2, 18,

20 4:23 6:4, 6, 18,

20, 22 7:1, 6 8:4, 6,

8 10:14 21:20

23:2, 4, 6 28:20

33:3 59:2 60:6

65:11 66:7 79:17

81:2 118:3

ALAMTA 6:11 8:11 80:23	anybody 11:16 35:21 43:22 50:22 66:16 88:18 106:23	16, 21 67:23 81:9 82:5 83:21 90:10 107:3	11, 12 111:21, 22, 23 112:1, 2 113:5, 7, 9, 10, 11 114:4, 5, 6, 7, 8, 15, 16, 17, 18 115:6, 7, 8, 16, 17, 18, 19 116:5, 6, 7, 8, 17, 18, 19, 20 117:2, 3, 4, 5
algorithm 61:9, 10	anymore 102:10	asking 10:16 23:6 47:5 89:8 93:19 103:16 104:11	< B >
allergies 55:6	Anytime 78:19	asks 101:1	babies 14:18
allow 62:6, 15	anyway 54:12	aspect 66:2	back 16:11 19:5, 10 22:18 28:22 30:11 35:9, 9 48:23 49:1, 15 50:21 53:13 55:21, 21, 22 57:10, 23 61:2 67:18 68:21 69:9, 18, 20 70:7, 13, 16 71:14, 16, 21 77:5, 6, 13 82:20 83:8 91:19 94:9 100:21 101:3 104:14 106:12
allowed 23:5 26:9 80:2	anywise 118:16	assess 46:20	backed 88:5
allowing 18:15	APA 100:11	assign 116:23	background 28:18 30:22 32:8
altruistic 91:16	apart 17:10 39:18	assigned 52:13	bad 48:4, 4 52:3 62:3 64:10 72:16 93:13
Alverson 2:11 10:1 25:5 28:11, 11 29:5 54:14, 17 55:14 56:2, 9, 16, 19, 21 57:12, 17 71:2, 5, 17, 19 74:2 75:13, 15 76:4, 7, 12, 16, 21 77:6, 8, 16 79:22 80:5, 8, 15 81:2 82:1 83:2, 13, 21 84:10, 15 85:3, 6, 11, 14, 20 86:8, 15, 18 87:8, 12, 15, 19 102:23 103:4, 9 104:6, 10 105:20, 23 106:5, 10, 18 108:10, 14, 17 110:4, 15	APCI 7:13	Association 6:5, 7 81:1	Baker 3:19 7:7, 7 27:12, 12 32:11, 14 48:10 49:7, 23 51:1, 16, 21 52:11 54:8, 20 55:17 56:4, 10, 18, 20, 23 57:14 58:6, 19 60:2, 7, 22 62:13 66:18 67:3 69:14 70:2 71:4, 9, 18, 23 72:7
amend 90:5	apologize 31:2 64:5	assuming 104:4	Baker's 29:16
amended 90:12	appear 43:12	assumption 46:8	balance 73:4
American 58:11	APPEARANCES 2:1	attempt 55:19 70:19	balances 73:10
amount 12:15, 18 45:13 69:21 85:23 105:14	approach 49:10, 11 82:6, 7	attempted 36:12 56:8	balancing 16:11
Anderson 86:21	Approach 26:22 28:1, 2 72:5 82:16 100:7	attendance 27:17	ball 51:20
Andy 3:3 5:17	approach 49:10, 11 82:6, 7	Attorney 2:14 12:16 89:13	Bamberg 4:13 8:22, 22
annual 88:14	approaching 85:2	audience 27:18 90:4 110:23	Baptist 6:8 7:3, 19,
answer 33:18 45:22 57:21 58:2 93:20 95:9 96:22 97:14 100:14 107:2, 5	appropriate 31:10 43:6 46:15 63:10	audit 75:19 76:2, 8 94:10, 11 99:15	
answered 44:5 47:14	approval 13:16 64:13	audited 70:5 91:18	
answering 33:13 43:23 44:1 57:14	approve 9:14 20:20 74:8, 15, 18 75:4	auditing 95:1	
answers 47:21 53:23 89:9 118:9	approved 39:18 89:23	auditor 94:13, 16	
antibiotic 55:15	April 4:4 7:21 76:4 85:21 86:9	auditors 50:19	
antibiotics 19:4 37:16	area 48:21 51:15, 17 79:9, 9, 21, 23 95:18 96:9, 12 97:20 102:17, 22 103:15, 18 104:12	auditor's 75:16	
	areas 104:19	August 29:3 30:10	
	arguing 94:12, 12	auspices 72:3	
	Armstead 4:10 8:16, 16	authority 89:18	
	aseptic 18:18	autodiagnose 35:20	
	Ashley 3:21 7:11	automated 53:22 54:4	
	asked 7:5 29:7 33:20 34:6 42:14,	automatically 35:22 38:11	
		available 17:21 35:16	
		average 14:19 22:23	
		aware 29:23 69:15 70:23	
		Aye 21:2, 3, 4, 5 26:16, 17, 18, 19, 20 74:9, 10, 11, 12, 13, 23 75:1, 2, 3, 9, 10,	

21	16:15 24:6, 7	73:13	18, 22 19:13, 15, 16
Bart 4:13 8:22	28:20 29:23 30:11,	building 14:13	20:16, 17
based 16:21 38:1,	14, 22 31:3, 5 32:1	buildings 15:13	campuses 15:21, 22
2 40:9, 20 44:4	39:6, 9, 23 40:16	bumped 36:16	17:6
47:6 78:10 82:19	41:2, 5 42:23 43:3,	57:5	capability 22:4
101:21	4 46:14 47:19	bumping 56:10	84:21
basic 33:4 35:12	49:12 51:6 61:4	Bunch 2:7 12:23	Cara 7:4
46:4	62:16, 19, 22 63:23	21:4 26:13, 19	Care 5:10 10:18
basically 12:5	64:13 66:5 74:14,	48:2 58:17 59:20	11:9 14:22, 23
basis 31:21 41:1	15, 19 75:20 78:6,	60:4 61:14 63:12	20:18 27:13, 15
beer 57:18	6 81:6 83:7 89:23	66:23 69:23 70:4	32:16, 18 34:1, 4
beg 45:17 69:23	90:11 95:17, 18	74:13, 21 75:2, 7,	35:2 36:17 37:10,
beginning 73:5	99:13 100:15	11 85:8, 13, 16	12 44:8, 17, 18
believe 20:14	102:17 103:13	94:9, 16, 20 95:2,	45:10, 18 46:16
29:22 30:3, 15	104:1 111:3	10 112:1 113:10	54:11 58:11 60:8
41:10 70:17 97:20	115:11 117:1	114:7, 15 115:19	careful 100:14
98:7 102:23	Board's 5:8 23:13	116:8, 20 117:5	carefully 32:2
105:12 108:19	40:4 64:16 65:8	BURGE 104:12	98:22
belonging 75:20	bona 96:16	Burgess 3:14 6:14,	cares 35:11 60:17
Belser 3:12 6:10,	Boothe 4:14 9:1, 1	14 102:14, 14	Carly 4:5 7:23
10 80:22, 23	13:11, 12 15:18, 22	103:8, 11, 18	carry 105:4 107:6,
benefit 103:14	16:3, 7, 13, 16, 20	BUSINESS 1:8	8, 21, 23
better 57:7 58:1,	17:7, 16, 20 18:17,	27:19, 21 89:1, 2, 3,	carrying 105:1
13	21 19:11, 15 20:1,	3, 7 104:22 112:3,	Carter 3:4 4:15
beyond 18:14 66:5,	9, 14 21:7	17, 21	5:19, 19 9:3 21:9,
6	box 15:1	busy 28:2	9 23:11, 16, 19, 23
Bible 97:4	Braden 2:13 87:21,	BuzzeoPDMA 7:18	24:17, 23 25:9
big 34:11 69:5	22 88:17, 20, 23		26:22
biggest 32:16 51:9	Bradford 12:4	< C >	Cary 4:11 8:18
69:15	branch 33:7, 12	Cadillac 86:1, 13,	27:9
bill 13:3	35:14	15	case 26:6 101:12
billing 22:7	breach 86:6	calendar 105:6, 8	113:17 114:9, 19
Birmingham 7:20	Brickman 3:13	Calhoun 8:12, 15	115:9, 20 116:9, 21
48:20 51:15 88:11	6:12, 12	call 5:4 17:17	cases 64:10 87:2, 2
birth 98:11, 15	bright 102:8	19:12 31:16, 18	100:10 112:20, 23
bit 15:1 19:18	bring 25:16, 23	37:9 41:21, 22	catch-up 64:5
28:17 30:21 32:8	41:19 100:9	42:1, 18, 19, 20	Catholic 76:17
36:23 73:2	brings 25:11	43:17 55:23 56:2,	cause 45:3 118:17
black 76:22 77:4	broadly 63:6	4, 5, 5 57:3, 19	cautious 59:2
96:10 98:5	Brooks 2:17 8:6, 6	72:14 89:11	64:19
Blake 87:15	88:20	callback 17:15	caveat 90:1
Blake's 87:11	brought 11:5	called 13:2 50:1	CE 109:17 110:7
Blue 50:22 51:8	42:15	83:22, 23 84:2	census 14:19
58:21 69:8 71:3, 3,	Bruce 3:22 7:13	96:16	Center 8:13, 15
7, 7, 10, 13, 22 72:1	Buddy 2:7	calls 12:18, 18, 22	10:21 12:4 14:6, 9
BOARD 1:2, 18	budget 72:19	cameras 81:20	20:4 37:12 64:22
2:3, 14, 16, 17, 18,	budgeted 72:15	campus 13:17, 18,	Central 33:3
19, 20, 21 4:23	73:1, 3	20, 22 14:2, 4, 5, 7,	certain 31:23
5:15 6:23 7:2 8:5,	budgeting 72:17	11, 12, 20 15:3, 4	50:13
7, 9 10:14, 23 12:7		16:3 17:8, 9, 9, 10,	

<p>certainly 27:23 41:7 45:23 46:23 93:14 CERTIFICATE 118:1 Certified 118:6 certify 118:7, 14 chairs 76:13 challenge 32:16 58:7, 7 chance 40:15 change 85:18, 22 105:3 changes 44:15 46:9 changing 64:18 Charge 18:3, 21 83:4, 10, 11 chargeable 69:20 charged 34:20 66:13 chart 55:3, 6 charts 58:12 91:11 check 50:16, 21 81:22 checkbook 73:5 checking 46:7 cheddar 103:8, 9 cheese 57:18 Chief 2:13 87:21 choice 34:4, 7 68:16 choices 34:2 cholesterol 57:19 Chris 3:14 6:14 102:14 chronic 38:9 circumstances 25:17 50:13 99:20 citation 49:17 cited 49:19 claim 34:22 69:2 Clair 103:5 Clanton 54:10 clarification 112:5 clarify 103:22 clean 107:10 109:8 cleanest 99:7 clear 40:11 clearance 67:23 cleared 67:20, 22</p>	<p>Clemice 3:16 6:18 94:19 clients 93:3 Clinic 34:9 52:15, 15 78:11 79:14 clinical 54:3 Clinics 81:1 close 14:13 72:21 73:15, 19, 20, 22 closed 19:9 CMS 19:7 Code 23:4 33:22 51:17 102:17, 20 103:18 codes 51:16 102:19 Cohen 4:16 9:5, 5 27:14, 14 36:22 37:3 45:11 46:4 47:16, 20 59:5 60:8 61:7, 10 64:16 Coker 83:22 cold 33:10 collaborating 61:3 Colonial 77:21 combination 60:21, 22 78:16 come 19:10 28:15 33:21 34:1, 15 35:7, 10 36:16 46:1 49:1 55:6, 21, 22 59:8 64:3 69:9 73:19 93:23 97:22 99:9 100:19 101:10 112:21 117:7 comes 14:15 33:8 52:1 55:5, 5 68:10 70:7 86:21 91:20 94:13 96:13 97:17 100:22 101:3 102:19 103:20 104:17 comfort 39:5 43:14 comfortable 18:15 32:5 39:1 coming 23:19, 20 48:12 52:9, 16 59:1 72:9 96:22 103:19</p>	<p>comment 52:21, 22 59:5 82:2 93:17 comments 80:19, 21 Commission 19:7 commitment 83:17 committed 34:14 46:22 Committee 2:15 10:2 Common 24:9, 11 37:7 55:1 58:21 community 59:15 70:8 company 71:5 83:3 compelled 97:3 competency 112:19 compiling 33:16 complaints 88:2, 3, 4, 5 complete 55:6 57:1 completed 11:14 36:13, 18 57:22 88:1, 3, 13 complex 35:21 36:1 38:7 60:13 compliance 75:22 79:16 87:1 complicated 44:18 comply 95:13 component 55:9 components 71:15 compounding 87:4 88:8 Compton 3:3 5:17, 17 computer 44:7 53:15 83:3 computer-aided 118:11 computerized 15:8 concern 29:23 30:3 45:4 56:16 68:3 84:18 115:10, 21 concerning 10:2 concerns 28:12 29:5, 9 40:12 46:12 63:3 concluded 117:13</p>	<p>condition 19:8 115:1 conditions 32:23 38:21 65:21 conduct 40:10 conducted 112:22 confident 38:20 confined 48:21 confusion 68:10 congestive 38:9 connect 22:17 Connelly 1:23 118:6, 20, 21 Conradi 2:4 4:22 9:11, 18 13:5 15:14 16:18 17:11 19:22 20:7, 10, 22 21:1, 6 24:9, 11 26:7, 14, 20 27:1, 8 43:16 45:6 46:3, 17 47:2, 18, 23 49:21 51:18, 23 52:18 53:13, 19 54:9 57:16 61:17 62:2 64:7 66:8 67:7 68:5, 8 70:20 72:5, 8 74:6, 8, 12, 14, 20, 22 75:3, 8, 13 76:1, 11, 14 77:1, 4, 7, 14 80:14, 21 81:7 82:23 83:12, 18 84:3, 6 85:10, 18 86:17 87:11, 14, 21, 22 88:15, 18, 21 89:1, 12, 19 90:8, 13, 19 91:8 92:2, 21 93:6, 12, 16 94:15 95:14 98:3, 5, 10, 17 104:21 105:10, 17 106:2, 11 107:5 109:4, 14, 23 110:11, 14, 21 111:17, 20 112:2, 7, 13, 16 113:4, 6, 8, 11, 17 114:3, 8, 14, 19 115:5, 9, 15, 20 116:4, 9, 16, 21 117:6, 9 consent 10:15</p>
---	---	--	---

<p>consequences 97:9, 13</p> <p>consequently 79:12</p> <p>consider 16:18 50:17</p> <p>consistently 40:18 62:22</p> <p>console 15:11</p> <p>constitutes 30:17 40:1</p> <p>consult 66:16</p> <p>consultation 41:16 44:22 100:1, 1</p> <p>consultations 41:14</p> <p>contact 11:16 31:1 44:11, 21 50:2 55:19 56:22 58:1 71:3 92:10</p> <p>contacted 29:4 70:22 71:2 92:11</p> <p>contacting 63:15</p> <p>continue 32:2 46:21</p> <p>continuing 31:20 105:1</p> <p>continuous 24:20</p> <p>contract 10:8 71:13 85:21</p> <p>contracted 68:11</p> <p>contracts 10:6</p> <p>control 48:15 98:11, 16</p> <p>controlled 36:2</p> <p>controlleds 48:6</p> <p>convenient 33:23</p> <p>conversation 45:16</p> <p>conversations 30:4</p> <p>convey 63:8</p> <p>cooperative 82:11</p> <p>copays 34:21</p> <p>copies 77:10</p> <p>copy 76:15 77:13</p> <p>Core 3:21 7:11, 11</p> <p>corporate 95:4</p> <p>correct 16:13, 13 20:9, 9 24:23 42:5, 5 68:14 81:17 92:12 105:13 106:5, 10 108:16</p>	<p>118:12</p> <p>correctly 64:8</p> <p>costs 25:21</p> <p>cough 92:23</p> <p>counsel 27:10 118:15</p> <p>counseling 22:7</p> <p>counter 36:20</p> <p>counties 103:1, 5</p> <p>country 58:8 65:10</p> <p>County 12:17 103:2 118:4</p> <p>couple 11:6 24:18 88:6</p> <p>couriers 17:20 24:15</p> <p>course 13:2 43:14 64:12 92:21 102:13</p> <p>COURT 80:10, 13 118:7</p> <p>coverage 17:4</p> <p>CPOE 15:9</p> <p>create 33:15 55:2</p> <p>creates 33:8, 19 41:4 62:21</p> <p>creating 33:14</p> <p>credit 73:16</p> <p>critically 65:12</p> <p>Cross 50:22 51:8 58:21 69:8 71:3, 7, 11, 13, 22 72:1</p> <p>crowd 9:12</p> <p>Crystal 86:20 87:15</p> <p>current 10:4 19:22 36:8</p> <p>Currently 10:11 15:5 17:16 21:16, 20 23:5 58:21</p> <p>customarily 25:15</p> <p>CVS 7:14, 16</p> <p>cycle 105:9, 17 106:9 110:8</p> <p>< D ></p> <p>daily 14:19</p> <p>damn 102:11</p> <p>Dan 2:6 95:14</p>	<p>107:4</p> <p>Dane 3:1 5:11</p> <p>Daniel 2:20 8:8, 8</p> <p>Darby 2:8 9:17 20:23 21:5 24:2 26:2, 8, 17 52:21 53:2, 9 58:3 59:5 60:19 74:7, 10, 18 75:4, 12 97:1 98:7 104:8, 23 105:7, 22 106:3, 6 107:7 110:2 111:22 113:6, 7 114:2, 6, 18 115:8, 17 116:3, 7, 15, 19 117:4</p> <p>data 32:8 39:14 51:5</p> <p>date 102:3</p> <p>dated 30:13</p> <p>dates 104:13</p> <p>David 2:8 3:12 4:12 6:10 8:20 27:18 80:23</p> <p>Davis 3:10 6:6, 6</p> <p>day 15:6 16:23 17:2 20:3 81:19, 19 101:17 102:5</p> <p>days 55:19 56:2 57:8 95:19</p> <p>DEA 80:2, 7 88:11</p> <p>deal 21:17 50:18 65:23 90:22 94:10 95:7</p> <p>dealt 37:8 38:22 48:6</p> <p>Decatur 9:1 13:7, 13, 17, 17, 22 14:1, 3, 7, 11, 12 17:7, 18</p> <p>decide 90:21 108:22</p> <p>decided 80:18 85:22 105:21</p> <p>decides 69:9</p> <p>deciding 54:3</p> <p>decision 45:14 61:5, 13 78:3 82:6, 13, 18 84:20 85:7 94:8 95:5, 16 96:19 97:6 99:6</p>	<p>105:13 108:20, 23 109:2</p> <p>decisions 71:6 101:17, 20</p> <p>declarative 40:13</p> <p>declare 86:6</p> <p>deem 50:19</p> <p>defense 92:11</p> <p>defer 43:3</p> <p>deferring 68:15</p> <p>definite 40:13</p> <p>definitely 35:4 59:1</p> <p>definition 44:9</p> <p>degree 46:10</p> <p>delivery 14:18</p> <p>Delk 2:19 6:22, 22</p> <p>dense 57:12</p> <p>Department 9:4, 10 14:21 31:18 77:23 101:8</p> <p>depends 84:4 105:10</p> <p>depot 22:10</p> <p>derived 100:2</p> <p>derogatory 92:7</p> <p>deserve 77:17</p> <p>designate 52:9</p> <p>designated 71:10</p> <p>designating 79:11</p> <p>destruction 88:13</p> <p>details 10:2</p> <p>determination 54:2</p> <p>determined 32:4 46:19</p> <p>determining 40:1</p> <p>developing 87:1</p> <p>diabetes 38:9</p> <p>diagnoses 35:16</p> <p>diagnosis 29:18</p> <p>diagnostic 10:8 38:23</p> <p>differ 69:23</p> <p>difference 12:13 63:18 71:21 89:22 90:18 91:9</p> <p>different 15:20 19:18 24:2 41:3 44:23 47:8 54:8</p>
---	--	---	---

71:15 81:11, 11 84:1 differently 62:15 difficult 93:8 99:7 difficulty 12:22 dilemma 62:4 65:23 direction 108:8 directions 52:20 Director 2:11 13:12 21:10 27:15, 20 28:10 73:17 disciplining 108:12 disclosed 101:2 discloses 100:23 discretion 41:11 42:12, 13 43:12 discuss 89:10 91:3 112:19 discussed 77:22 79:1 discussion 99:6 110:22 disease 38:10 dispense 68:8, 18 dispensed 78:20 dispensing 68:4 dispose 88:9 disposition 11:3, 17 distances 17:5 distinguish 68:19 93:22 94:2 95:5 96:14 distribution 21:13, 18 district 115:22 doctor 25:11 43:17 48:4 63:16, 16 91:11 97:22 98:9, 12 101:22, 23 102:1 doctors 59:14 67:18 doctor's 25:12 78:10 document 34:10 77:23 78:1 79:4 documented 79:8 Doe 63:15	doing 35:3, 15 38:3 41:11 47:5, 12 48:1, 11 52:5 54:14, 21 56:7 58:18 59:21 60:5 61:22 62:10 64:8 65:10, 14 67:1 69:16 82:10 89:21, 22 97:11 dollars 92:6, 23 dose 79:5 double-check 81:21 downtown 52:15 Dr 2:15 5:7 9:15, 19, 22 11:13 12:9 13:5 15:15, 20, 23 16:5, 8, 14 17:5, 12, 19 18:11, 20 19:5, 14, 20 20:20 21:3 25:5 26:4, 12, 18 28:11 29:5 36:22 37:3 39:8 45:11 46:4 47:16, 20 49:3, 17, 22 50:3 54:14, 17 55:14 56:2, 9, 16, 19, 21 57:12, 17 59:5 60:8 61:5, 7, 8, 10 64:16 65:15 71:2, 5, 17, 19 74:2, 3, 11, 17 75:1, 10, 13, 15 76:4, 7, 12, 16, 21 77:6, 8, 16 79:22 80:5, 8, 15 82:1 83:2, 13, 21 84:10, 13, 15 85:1, 3, 4, 6, 11, 14, 20 86:5, 8, 10, 15, 18 87:6, 8, 9, 12, 15, 17, 19, 20 90:7, 9 94:3, 6 95:17, 21 96:11 97:2 99:3 100:5 102:23 103:3, 4, 9, 16 104:3, 6, 9, 10 105:12, 18, 20, 23 106:5, 8, 10, 13, 18 107:10, 16 108:7, 10, 13, 14, 16, 17, 19 109:7, 11, 16 110:4, 5, 15, 17, 22 111:18,	23 112:11, 15 113:3, 8, 9, 23 114:5, 13, 17 115:4, 7, 14, 16 116:6, 17 117:3, 8, 11 drafted 63:5 drop 33:20 85:9 Dropbox 77:9 83:2 87:23 dropped 11:7 drug 18:16 25:23 31:12 57:20 drug-drug 38:18 drugs 21:13, 18 36:1 48:5 68:4 88:10 due 45:11 72:19 < E > earlier 21:14 49:18 56:6 early 64:17 84:13 115:23 Easter 3:18 7:3, 3 easy 27:1 34:23 50:15 ED 18:23 20:3 35:2, 5 37:13 56:13 57:8 EDs 60:17 education 76:17 105:1 Edward 2:13 effect 39:19 90:5 eight 82:4 84:1, 16 either 10:19 25:1 34:17 37:8 55:23 56:5 71:20 76:20 electronic 38:6 55:3 99:9 electronically 36:18 55:23 57:2, 4 58:15 96:14 eligible 92:15 eliminate 102:21 104:18 Ellenburg 2:16 5:15, 15 73:17 76:3, 5, 19 77:3 84:4, 7, 12 89:5	105:5 106:21 107:20 108:4 111:1, 7, 10, 13 eMedicine 28:4, 7 29:2, 11 30:16 32:13 33:5 45:3 54:22 Emergency 12:16 14:8, 21 17:15 31:18 emphasize 29:10 employees 51:12 53:5 60:16 66:17 EMT 13:1 encounter 29:13 30:7 ended 72:21 enforce 41:8 42:8 English 4:15 9:3, 3 enter 13:22 entries 13:20 entry 13:15, 16 15:4, 9 18:6 ePrescribe 36:4 e-prescribing 52:12 e-prescription 93:22 equipment 75:19 erroneous 46:6 error 10:12 escape 86:6 e-scribe 91:10 102:19 103:20 e-scribing 104:5 especially 25:20 58:20 establish 96:2 established 37:11 42:6 64:22 evaluated 10:22 evaluation 11:20 33:14 evening 17:3 everybody 32:18 36:6, 19 48:19 62:5 81:13 88:15 evidence 38:1 88:10 114:11
---	--	---	--

<p>evidence-based 35:14 37:14 39:1 45:20 Exactly 77:3 exam 107:1 examination 31:8 43:8 examine 45:7 examined 50:12 Examiners 28:20 30:11, 15, 23 31:4, 5 32:1 39:10, 23 43:4 46:15 63:23 64:13 90:1 115:11 example 38:10 96:1 98:18, 19 exception 40:14 48:22 62:9 65:4, 4, 5, 6 exceptions 31:9 executive 28:10 88:22 91:1 112:18 113:1, 14 exemptions 39:16 exist 40:22 existed 96:4 existing 16:9 51:12, 19 exists 66:7 expand 16:10 expect 83:15 94:7 96:18 expectation 31:7 expenses 72:23 73:3, 14, 22 experience 66:11 experienced 32:19 Expires 118:22 Express 69:8 extend 16:6 extended 20:5 extending 20:8 extent 96:19, 21</p> <p>< F > face 35:8, 8 47:9, 9 face-to-face 30:7 31:14 32:6 33:21 38:22 41:16 43:7</p>	<p>facilities 13:15, 23 16:11 87:4 facility 13:18 14:12 15:12 88:9, 11 facility-driven 12:2 fact 29:12 96:3 factor 22:13 91:21 faculty 48:13 failure 38:9 fairly 21:12 72:21 fall 39:17 84:19, 21, 22, 23 falls 39:22 Family 58:11 far 39:2 44:7 64:10 66:10 81:21 favor 21:1 26:15 74:22 75:8 111:20 114:3, 14 115:5, 15 116:4, 16 117:1 FDA 66:10 67:16, 21 68:1, 1 88:7 February 39:14 federal 66:13 feedback 66:19 80:1 84:2 feel 28:8 31:23 32:5 38:20 43:9 63:4 78:2 95:8 feeling 42:3 feels 97:3 104:14 felt 28:14 78:5 fide 96:16 figure 49:9 file 50:23 filed 34:22 50:21 fill 47:6 50:18 69:11 91:7 93:10, 20 95:6, 6 97:1, 7, 18 98:1 99:8, 10, 11, 12 100:4 101:18, 21 102:11 filled 97:21 filling 44:3 52:7 53:23 91:18 96:4 97:9 final 78:2</p>	<p>find 53:2 58:10 63:22 64:1 67:16 70:23 74:17 fine 12:15 46:12 48:3 62:16 first 9:13 13:7 27:23 31:22 44:21 51:2 89:2 100:6 five 13:20 103:1 fixing 91:6 flag 33:19 38:19 flags 34:6 35:23 36:14 38:10 flip 65:7 floor 14:18 fluids 34:19 36:21 folks 68:23 73:18 follow 33:12 55:17 58:4 following 11:4 follow-up 55:19 foot 65:3 82:21 footage 79:11 forced 37:12 forcing 34:3 forego 80:18 foregoing 118:8, 12 forth 16:12 61:12 82:4 forward 11:5 108:20, 22 found 71:19 75:21 four 20:3 21:17 99:22 110:14 fourth 92:9, 13 frame 65:2 106:1 Freeze 3:2 5:13, 13 front 70:11 99:18 fully 36:10 function 79:14, 15 further 22:16 76:6 118:14 future 62:1 90:22</p> <p>< G > Garver 2:15 5:7, 7 9:20, 22 11:13 12:9 13:5 Gary 3:11 6:8</p>	<p>General 13:17, 22 14:11 17:7, 18 27:10 77:1 Generally 18:21 genesis 63:3 gentlemen 9:22 geography 103:2 getting 9:13 12:23 37:16 55:7 61:19 72:21 86:14, 15 93:18 96:6 girl 98:12 give 9:20 26:5 28:17 30:21 32:12 35:9 46:6 48:15 49:19 73:16 77:11 97:14 102:8, 18 given 78:10 giving 38:1 66:19 GL 85:8, 12, 21 glad 70:2 77:11 Glenn 2:18 7:1 82:20 GLS 84:3 86:1 go 9:18 12:3 13:7 17:13 22:5, 15 29:9 32:11 34:5 35:4 52:2 55:2 57:8 58:10, 13 59:3 64:8 71:14, 16 77:13 81:9 82:20 83:16, 19 86:9 92:19 96:19, 21 97:22 98:12 99:12 104:14 108:20, 22 112:7, 12, 17 goal 57:6 60:7 goals 37:2 goes 34:11 36:9 79:5 97:17 100:20 going 5:1 9:18 16:22 18:1 20:12 22:12 23:14, 17 24:6 27:22 32:9 33:10 35:2 37:15 39:13 46:5 48:18, 18, 22 50:17, 23 51:10 54:17 55:14 56:21 58:13 60:1</p>
---	--	--	---

62:18 65:18 67:16,
18 68:23 69:12, 18
72:20 81:5, 21
82:18 83:5 84:11,
19 85:19 86:23
89:10 90:21 91:1,
8, 9, 17 92:1 93:2
94:9 95:6, 10, 12,
15 97:7, 14 99:14,
15 100:9 101:15
107:22 109:4
111:1, 4, 5, 15
Good 13:4, 11
21:9 24:13 27:3
28:15 37:22 38:3
45:9 59:2 61:15
65:9 73:11, 13
84:2 86:10 90:4
98:13 112:9
gotten 30:12 35:21
84:1
graduates 53:14
granting 64:20
gray 95:18 96:9,
12 97:20 101:6, 11
102:21 104:19
great 40:5 48:2
62:6 76:11
greater 45:15, 17
greatly 41:4
grew 77:1
grounded 45:20
group 48:17
groups 49:9 65:1
grows 44:14
guarantee 46:21
guess 17:12 45:22
47:17 50:14 56:16
57:12 61:18, 19
63:18 89:7 91:4
94:13
guidelines 37:15
38:2 39:2 45:20
77:9
guys 13:3 21:13
32:19 69:17
101:20 102:8

< H >

half 72:18
hammered 91:6
hand 92:9, 13 97:4
handed 13:2
handle 14:15 87:2
92:12
hang 64:14
hanged 96:6
happen 22:20 62:6,
16 91:2 99:13
happened 55:2
happens 63:15
harassment 77:17
hard 45:9 52:1
98:20
hardest 62:4
Harris 3:22 7:13,
13
Harrison 6:16
hat 64:14
head 59:23
Health 6:8 7:4, 19,
22 8:19, 21 9:4, 8,
10 10:9 24:13
25:7 27:10, 20, 21
28:21 54:23 55:9
56:12 78:1, 3 80:3
Health-System 7:6
healthy 59:17
hear 5:3 74:2, 2
94:22 98:21
heard 10:14 37:5
49:18 78:3 80:14
92:9, 13
hearing 51:22
118:8, 13
heart 38:9
heat 82:9
held 10:20
help 13:9 20:3
60:16 87:3 104:18
109:21
helpful 32:11
heretofore 96:16
Heritage 6:14
102:14
Hester 3:23 7:14,
14
hire 54:6

hired 86:19
historically 31:7
history 63:2
hold 73:21 89:1
holder 24:6, 7
holders 112:20
hole 24:19
home 22:2, 12
25:2, 7 78:8 79:2
homeless 22:11
honestly 64:4
honor 46:10
hoopla 82:3
Hoover 1:20
hope 44:8 82:19
hoping 60:9
Hospital 9:2 12:20
13:7, 13 14:1, 7
15:12, 16
hour 34:13 83:10
110:3
hours 15:7 16:9,
19 17:22 18:23
20:3, 4, 8, 8 105:2,
4 107:14 108:1, 15
109:18 110:2, 8
house 18:2, 4
Huh-uh 90:8
humanitarian 59:21
Humulin 70:14
Hunter 3:20 7:9, 9
Hurst 3:16 6:18,
18
< I >
idea 44:6 47:10
49:4
ideal 24:16
illegal 69:10 70:18
92:18 93:10
illness 38:8 59:19
implement 19:19
83:4 84:16
implemented 83:11
implications 66:4, 5
important 65:20
73:13
impose 77:13
impossible 57:3
impression 81:10

impressive 73:15,
23
include 10:9
includes 10:7
including 28:2
independent 70:8
indicated 38:2
indistinguishable
94:10
individual 61:6
83:11, 13
individuals 10:7
11:19 12:1
infection 97:22
infections 37:17
infinitely 45:15, 17
infirmary 27:13
influx 72:20
information 28:4,
16 33:16 45:13
46:6, 23 55:4
61:11, 15 70:10, 10
72:6 113:20
116:11
infusion 14:9 20:4
in-house 78:10
initially 86:23
inpatient 10:12
14:16, 23
inpatients 14:10
20:5
in-person 31:8
input 85:23
inspect 104:1
inspecting 81:22
87:3
inspection 88:7
inspections 88:2
Inspector 2:13
96:1
inspectors 81:15,
22 82:5, 19 91:5
100:9
inspector's 9:23
11:5
instance 56:14
69:17 78:15
instances 31:13
32:5

instructions 35:9
insulin 70:14
insurance 34:22
 113:21 116:12
insure 51:14
insured 58:23
intend 79:20
intent 24:4
interact 55:8
interacted 54:23
interaction 28:12
 56:12
interactions 38:18
interested 118:16
interim 30:9
internally 53:6
Internet 29:7, 11
 30:2 48:1, 8 63:4,
 7, 13, 16 66:12, 14,
 21 67:1, 2, 6, 17
 68:20 98:8, 9
 101:20
Internet-based
 52:10, 23 99:22, 23
interpret 41:8, 12,
 17, 18 47:8 78:5
 111:12
interpretation 23:4,
 12, 13 30:3 108:21
 111:6, 15
interpreted 109:18
interpreting 41:3
 111:8
interview 35:13
 45:12 75:5
introduce 27:3
introductions 32:15
inventory 78:22
 81:17, 18, 22
Inverness 52:15
investigated 10:22
involved 49:5
 66:19 82:2
involving 30:2
issue 30:4 40:7
 44:22 49:14 69:5,
 12, 16 96:7
issues 14:13 28:6
 33:7 35:15 37:7, 7

42:2 62:21 65:19
issuing 41:13
item 59:22
items 25:7, 9, 10
its 43:5, 5 78:6
 101:13
IVs 19:16, 17

 < J >
James 3:8 6:3, 3
January 13:23
 51:10 85:6
Jeanna 4:14 9:1
 13:12
Jeff 3:2 5:13
Jefferson 103:1, 2
jeopardy 47:13
Jim 2:14 3:18 7:3
 111:2 112:12, 13
job 38:3 82:16
Joe 63:15
Joint 19:7
Jones 3:9 6:4, 4
 93:18 94:4 98:23
 99:16 100:6
 101:14
Jubach 4:6 8:2, 2
judgment 54:3
 102:6
Julie 3:20 7:9
July 29:2 51:3
jumping 98:21
June 51:4
jurisdiction 28:19
 46:14 68:3

 < K >
keep 17:22 18:5
 19:2 60:16 85:12
keeping 87:2
Kelli 3:17 6:20
 92:2
key 78:16
kicked 35:22
kid 43:23 92:23
 103:12
kidney 38:10
kin 118:15
kind 17:1 20:11
 29:9 64:9 66:14,

15, 22 73:7 84:9
 94:11 95:7, 23
 102:1
Kirklin 34:8 52:15
Klinner 4:18 9:9, 9
know 12:11 13:3
 21:22 22:12 32:23
 39:8, 12, 20 40:16
 43:20 44:5, 6, 12,
 14, 19 47:13, 17
 48:4, 8, 17, 19 49:8
 52:3, 6, 11, 14, 18
 53:6 55:9, 10, 11,
 15 56:14 58:21
 59:8, 10 60:5
 62:11 63:5, 9, 20
 65:5, 12 66:7
 67:20 68:23 70:6,
 15 73:19 75:18
 77:11 81:21 82:3,
 8, 9, 11, 12, 17, 17
 83:9 84:10 85:16
 89:6, 14 91:1, 9, 12,
 12, 15, 23 92:1, 19
 93:3, 5, 21 94:14,
 17, 21 95:6, 22
 96:21 97:4 98:13
 99:8 100:21, 23
 101:2, 3, 6 102:6, 7
 103:1, 4 111:13
knowing 101:22, 23
known 99:19
 100:21 101:3, 5, 10
 102:9, 12, 12
knows 11:9 99:19
Koelz 3:5 5:20, 20

< L >
label 70:16
labeled 79:16
labor 14:17
Lacey 2:22 5:5, 5
 95:12 97:16 98:15,
 22 106:16, 20
 107:3 112:4, 9
Lantus 70:14
large 38:16 88:9
largest 9:12
lasted 88:8

late 17:3 30:10
 75:17
laughing 70:3
Laughter 69:22
launch 29:1, 2
law 69:3 70:9
 79:17 92:18 93:9,
 9 95:13 100:13
 107:1 112:8
Lawrence 2:21
 8:4, 4
lawyer 40:4, 12
 90:9
lawyers 40:16
 77:21 90:4
lead 66:18
learned 89:16
leave 24:16
left 75:18 79:7
legal 23:4 50:17,
 20 62:21 65:23
 68:22 69:4, 12
legally 61:16 62:4,
 10 100:11
legal's 23:12
Leon 3:15 6:16, 16
Leos 7:4
Leslie 4:8 8:12
letter 30:12 39:10,
 21 75:16 83:7
 90:6, 12 113:19
 114:22 115:10, 21
 116:10
letting 12:10 62:7
level 16:11 46:8
 66:13
liable 100:11
license 10:14, 17
 11:21 67:23 72:20
licensed 14:6 21:20
licenses 11:22 47:4
lie 45:21 46:1, 6
life 98:18
lifestyle 36:1
limited 21:13, 18
 24:22 51:17 65:1
 104:5
Lindsay 3:15 6:16
line 52:20 55:8

84:14 102:9 lines 33:11 link 35:10 list 21:13 55:5 69:6 83:15, 17 99:21 102:18 103:13, 17 listed 10:9 11:4, 18 75:20 literally 79:20 little 12:12 15:1 19:17 28:17, 23 30:21 32:8 36:10, 12, 23 99:21 live 83:16 107:14, 21 109:20 110:3, 4, 9, 11, 12, 12, 14, 15, 20 lived 102:2 loaded 19:2 local 29:17 located 21:18 22:9 LOCATION 1:18 18:13 locations 33:22 lockable 79:21, 23 logic 33:7, 12 35:14, 23 login 33:8 long 75:23 83:17 87:12 104:2, 13 108:5 longer 11:16 look 16:20 23:10 32:3 34:15 35:6 37:20 43:1 59:21 64:23 65:12 77:17 83:6 87:23 90:15 102:3, 4 looked 32:1 43:10 91:22 looking 14:22 15:6 43:2 53:17 54:1 103:12 loss 26:6 lost 58:12 78:23 lot 22:20 25:18, 21 35:3 43:16 59:1 61:17 72:17 81:16	82:3, 9 86:3, 3 89:8, 15 97:15 loud 5:2 Louise 3:9 6:4 93:16 98:20 Louisiana 103:11 loves 62:5 low 33:7 34:21 35:1, 14 36:2 37:6 60:11 lower 34:21 73:8 92:6 lowering 60:15 lowest 85:23 < M > ma'am 25:10 27:8 80:11 machine 76:15 machines 15:11 17:23 18:2 mad 82:13, 14 mail 48:8 main 19:13 20:16 major 64:21 majority 61:1 making 19:1 54:2 57:19 65:4 man 97:18 manage 60:12 managed 35:18 44:18 Management 12:17 33:14 Mancini 4:17 9:7, 7 27:20 manpower 53:21 Mark 2:4, 19 6:22 81:8 89:6 104:23 112:10 marketed 53:4, 6 marketing 53:7 101:8 Marlin 4:4 7:21, 21 Martin 2:5 9:15 15:15, 20, 23 16:5, 8, 14 17:5, 12, 19 18:11, 20 19:5, 14, 20 20:20 21:3	26:4, 12, 18 39:8 49:3, 17, 22 50:3 61:5, 8 65:15 74:3, 11, 17 75:1, 10 84:13 85:1, 4 86:5, 10 87:6, 9, 17, 20 90:7, 9 94:3, 6 95:17, 21 96:11 97:2 99:3 100:5 103:3, 16 104:3, 9 105:12, 18 106:8, 13 107:10, 16 108:7, 13, 16, 19 109:7, 11, 16 110:5, 17, 22 111:18, 23 112:11, 15 113:3, 8, 9, 23 114:5, 13, 17 115:4, 7, 14, 16 116:6, 17 117:3, 8, 11 materials 68:2 math 12:13 matter 52:14 81:3 86:8 Matthew 3:6 5:22 McClain 77:2 McConaghy 2:6 20:11, 19 21:2 24:12 26:16 50:14 51:14 52:8, 19, 22 66:9 67:15 68:21 72:9, 10 74:9, 23 75:9 79:19 80:4 81:8 86:12 89:6, 17 91:4 95:3 96:8, 20 97:12 106:23 107:12, 23 109:3, 9 111:21 113:4, 5 114:4, 16 115:6, 18 116:5, 18 117:2 McWhorter 5:5, 17 7:11, 23 8:2 mean 43:21 44:6, 7, 16 45:5, 9 46:18 47:7, 8, 9, 10 51:19 52:2 54:1, 12 60:7 63:20 64:8, 8, 14 68:17 79:20 89:19 91:10 94:16 95:7 98:11, 17, 18, 20	99:6 102:5 108:8 111:9 meaning 52:2 means 11:21 37:23 111:9 118:10 meant 67:16 med 55:5 Medicaid 6:19, 21 24:17 50:22 69:1 70:22 92:3, 5, 14 93:3, 4 94:21 Medicaid's 94:16 Medical 14:6 27:14 28:20 30:11, 15, 22 31:3, 5 32:1 33:6 35:18 38:8, 20 39:9, 23 40:16 43:4 46:14 47:19 55:3 62:19 63:23 64:13, 22 89:23 114:21 115:11 Medicare 15:18 33:17 medication 19:2 25:19 31:21 34:18 38:1 67:4, 6 78:8, 9, 13, 17, 20 79:2 medications 26:10 38:17 78:23 79:16 Medicine 7:8 9:6 44:2, 15 45:10 46:16 48:13 64:19 MEDITECH 15:10 meds 18:9 meet 29:8 MEETING 1:8 4:23 10:18 64:17 74:19 75:6 89:14 117:13 meetings 12:3 meets 78:4 Melanie 4:2 7:18 Melissa 4:17 9:7 27:20 Member 2:7, 8 MEMBERS 2:3 28:14 29:8 63:11 membership 41:9 memory 26:6
---	--	---	---

Mental 9:4, 10 78:1, 3 80:3 115:1, 1	57:9 monitored 30:16 monitoring 10:8 Montgomery 6:9 83:5 month 12:6 22:23 36:10 44:19 62:6, 17 70:16 74:16 88:1, 14 months 11:6 39:13 51:5 54:15 76:9 82:4 84:16 88:6 Morgan 9:2 13:7, 7, 13 14:1, 7 morning 13:11 21:9 27:3, 22 28:1 mother 12:12, 16, 20 13:2 mother-in-law 12:19 mothership 16:1 motion 9:14 26:7, 8 74:3, 16 109:5 114:9, 11, 20 115:12 116:1, 13, 22 117:7, 9 Mount 3:11 6:8, 8 move 9:15 14:10, 14 20:20 39:10 74:4, 18 75:4 108:8 109:16 113:23 117:11 moving 14:17 20:15 MPJE 112:6 MSA 48:20 102:23 104:5, 11 Muscato 3:6 5:22, 22	65:19 66:7 74:3, 14 83:16, 18 85:7 89:10 91:2, 20 95:8 104:14 106:14 107:10 108:8 113:1 needed 18:12 49:11 needs 11:17 14:16 17:21 26:4 35:7 65:16 90:23 91:21, 22 negative 73:4 neither 92:11 118:14 never 42:1 43:19, 21 47:9 52:18 54:23 82:21 106:11 new 31:21 51:20 60:13 83:4 84:17 86:19 89:1, 3, 7 Newman 3:17 6:20, 20 92:5 93:1, 7, 14 94:18, 21 103:7 newsletter 106:19 newspaper 53:11 nice 34:11 night 107:18 nongray 100:8 nonlive 110:13 nonresident 21:19 normal 34:8 67:9 73:6 normally 69:19 note 33:14, 15, 18 34:11, 11, 16 35:7 70:3 notes 7:5 November 13:4 106:22 no-win 94:5 NPI 92:16 number 10:7 15:17, 19 36:7 38:16 52:17 83:23 88:5, 10 113:17 114:10, 19 115:9, 20 116:9	numbers 20:12 109:21 116:21 nuns 76:17 nurse 18:15, 22 25:7 60:20, 23 nurses 18:3, 8, 18, 22 79:12 Nursing 61:4 83:7 < O > obtain 61:11 obtained 45:18 obtains 45:14 obvious 22:14 101:16 obviously 28:6 32:9 98:15 occurs 57:10 61:2 October 1:10 4:22 offer 23:2 34:23 offering 34:4, 14 51:10 office 25:12, 19 26:1 33:15 34:8 46:1 75:16 88:11, 13 oftentimes 37:8 Oh 20:19 85:10 86:19 Okay 9:18 13:11 16:8 18:17 20:19 25:4 27:9 40:7, 19 47:18 62:19, 20 68:21 69:11 80:4 87:20 96:20 98:1 100:5 101:14 106:20 107:17 108:4 109:7 110:6, 17 111:7, 13, 16, 20 112:3, 12 old 89:2, 3 104:15 Omnicare 7:10 on-call 19:12, 19 once 83:10, 16 85:18 ones 15:23 57:1, 1 58:4 66:12 81:11 online 35:13 37:15 45:1 67:10
---	--	---	---

open 36:10, 10	7 17:9, 9, 12, 14	60:14 65:16, 20	perspective 37:1, 5
operates 14:8 28:9	18:13 19:18, 23	102:21 103:19	38:20 39:4 42:23
operating 79:13	20:1, 16	patient's 18:9 22:2	64:17 65:8 100:16
operation 60:8	part 54:19 56:11	25:1 31:22 68:15	pharmaceuticals
operationally 49:11	57:10 62:3 66:12	Paul 3:7 6:1	67:14
operations 15:6	68:22 73:13 79:8,	pay 50:23 69:2	pharmacies 21:16,
27:12 32:15 35:12	9 87:5 99:5	91:19 92:6, 8, 22,	17, 20 29:7, 17
49:8 73:17 81:14	104:16, 16	22 103:23	30:2 63:4 69:4, 11
opinion 43:4 81:23	participate 80:19	payer 69:18	94:23
opportunity 28:15	participation 19:8	payers 51:9 69:15	pharmacist 10:13
86:6 108:22	particular 10:20	103:22	16:23 20:2 22:17
optimal 85:2	29:1	paying 68:6 86:2,	66:17 68:5 78:16,
optimally 31:6	particularly 82:20	13	18, 21, 21 79:4
order 9:19 10:15,	parties 50:17	payment 35:4	86:19 89:11 91:12,
21 13:14, 16 15:4,	69:13 118:15	Payne 4:8 8:12, 12	17 94:7 96:4, 12,
8 18:6, 7	partner 31:16, 17	pays 59:4	18, 21 97:3, 6
orders 10:7 13:21	41:22, 23 42:19	PDMP 113:21	99:19 101:1, 23
78:10	party 70:7	116:12	102:15
organization 73:21	pass 88:15	PDMs 94:23	Pharmacists 7:6
100:10	password 33:9	pediatrics 38:15	10:11, 19 13:22
organizations 58:18	patient 18:13, 16	pending 112:20	40:19, 23 41:2
originally 28:21	21:21 22:3, 5	people 10:5 32:22	44:3 47:3, 5, 13
79:22 80:16	24:20 25:11, 14, 22	35:3 37:20, 21	48:16 52:5 61:21
outfit 77:7	26:11 30:8, 18	41:12, 21 42:20, 20	68:17 73:9 89:20
outlining 83:9	31:12, 22 33:8	56:22 59:6 61:22	93:12, 19 94:4
outpatient 11:14	34:16, 20, 23 35:7	62:15 71:10, 12, 13,	96:5 97:10 101:7,
14:9, 21 37:7 50:8	36:5 37:9 41:15	16 72:20 80:15	17 102:5, 22
outside 12:3 15:1	42:1, 6 43:17, 21	83:8 86:20 108:14	103:15, 20 104:19
25:14 102:16	44:10, 11 45:7	percent 13:21	105:4, 14 108:21
outstanding 88:4	46:9 47:10, 14	36:15, 18 37:21	109:17 112:20
overlays 33:6	50:11 51:15 56:3,	56:17 59:6 73:2	PHARMACY 1:2,
override 18:4, 10	13 59:8, 18 60:13	76:9	18 2:16, 17, 18, 19,
overrides 18:5	69:20, 21 91:13	period 48:10	20, 21 4:23 5:6, 10,
oversight 115:23	92:6 97:3, 17	55:21 56:7 109:19,	16, 18, 23 6:2, 5, 7,
overview 33:4	100:22 102:2	20 110:16, 18, 19	15, 17, 23 7:2, 12,
owe 73:23	103:21 104:18	permanent 11:8	15, 17 8:1, 3, 5, 7, 9
owner 102:15	patient-physician	116:23	13:13 14:5, 6, 16
ownership 24:9, 11	30:6 96:3, 16	permission 15:2	18:1 21:10 22:5, 9,
< P >	patient-practitioner	28:21	9, 18 23:21, 22
packets 30:12 31:3	30:17 94:1 100:3	permit 24:6, 7	24:5, 8, 8, 22 25:3
PACT 60:9	patients 14:14	112:20	26:10 28:13 29:11
paid 69:7 71:6, 7	16:21 19:17 20:16,	permits 24:2	30:1 34:7 36:3
73:18 99:14	17 23:2, 8 24:15	Permutt 6:13	49:12 63:7, 13
Pamela 4:6 8:2	29:17 31:1 37:11,	person 11:17	66:6, 14, 18, 22
paper 77:10	15 38:4, 7, 11, 12	31:18 55:13 83:14	67:1, 17, 19 68:11,
paragraph 40:8	44:20, 20 46:1	84:8	20 70:9, 12 75:20
parishes 103:12	50:2 51:12, 19	personally 9:21	78:15 79:6, 7, 10,
Parkway 14:2, 4, 6,	53:2 54:11, 11, 18	50:12 97:8	14, 17 82:8, 22
7, 11, 20 15:3 16:6,	56:15 57:4 59:13	personnel 54:7	96:2 98:8 100:15

104:14 115:2, 22, 23	point 33:18 35:1 46:11 57:6 59:6, 23 69:1 78:22 86:11 91:4 92:17 112:4	34:17 36:19 37:22 43:19 44:22 49:16 50:20 63:17 69:4, 10 70:12, 17, 19 91:7 92:4 94:14, 17 96:5, 13 97:7, 19, 23 99:9, 20	45:15 59:18
Pharmacy's 42:23	points 91:15	prescriptions 22:1, 23 29:12, 15 36:17 41:13 44:4 47:6 48:8, 12 52:9 63:10 68:6, 13, 18 70:15 91:18 92:16 93:10 102:3	procedural 50:15
PharMedCo 5:12, 14 8:17	policies 111:14	PRESENT 2:10 10:23 28:15 78:21 80:2 87:17 116:23	procedures 17:14
PharMerica 6:3	policy 24:14 106:17 111:2	presentation 10:23 32:12 80:17, 18 81:4	proceed 59:11
phone 12:17, 18, 21 37:9 44:21 45:16	population 33:3 44:14 59:13	presentations 13:6	process 10:21 39:2, 5, 15, 16 45:12, 13, 19 56:11 57:23 61:2 66:17 73:7 79:8
physical 31:8	position 24:16 64:10 93:13 100:11	presently 10:5 11:20	processes 18:19
physically 19:10 30:19 57:3	positive 102:16	President 2:4, 5 8:10 27:19 111:3	product 18:13
physician 15:8 37:5, 10 40:2, 10 50:11 54:9 68:6 92:4 93:8 97:5 113:20 115:12 116:11	possibility 38:17 45:23 99:4	pretty 22:10 40:13 62:8 81:12 95:9, 9 98:5 102:16	products 19:3
physician-patient 31:11 40:21	possible 18:6	previously 30:19 87:7	Professional 2:11 21:10 40:10
physicians 44:10, 17 60:19 68:12, 17	possibly 17:2 43:22 65:17	price 60:16	professionals 10:9
physician's 39:4	post 15:9 106:17	primary 27:15 32:16, 18 37:9 44:8, 17 45:10 46:15 60:8 86:22	profitable 59:22 60:18
pick 22:5, 15 25:8	Potawatomi 103:10	Prime 71:3, 4, 5, 20	program 5:8 9:20 10:6 28:12, 16, 18, 22, 23 29:1, 16 30:14, 16 32:2, 3 37:18, 23 38:12 45:1 46:22 53:8 54:19 58:22 62:19 64:21 68:3 78:4 79:3 83:6 89:18 90:16 92:15 93:5 102:18 104:2, 16, 17
picked 26:10	potentially 66:6	Primes 94:23	programs 77:10, 20 80:16
picks 69:5	PowerPoint 32:12	printed 111:14	progress 65:16
pickup 25:3	practical 91:16	prior 31:22 96:4	project 39:20 48:11, 17 63:21 72:2
pick-up 23:15	practice 42:7, 21 60:9 102:1	probably 11:6 22:22 24:13 29:22 50:19 60:23 81:12 85:19 100:9, 18	Projects 83:12 86:3
piece 66:20	practitioner 30:20	probation 47:4	promise 95:22 105:19
pieces 55:10	practitioners 60:20, 23	problem 40:3 47:2, 11, 15 48:3 51:20 54:12 61:19 89:20 92:1 93:21	prompted 108:11
pill 98:16	prayer 12:11	problems 37:6	proof 113:19 116:11
pills 98:11	preceding 105:5, 7		proposal 80:19 83:3, 8
pilot 28:18, 22 39:20 46:21 48:11, 17 49:5 50:16 51:3 62:18 63:21 64:21 89:18 90:16 104:5	predicament 43:9		propose 81:5
place 17:15 57:23 81:16 84:21	preexisting 30:5 31:14 32:6 41:14 94:1		proposed 9:16 77:9 79:18
placed 12:16	pre-existing 100:2		prosecute 41:12, 20 42:14 43:13 61:22
plan 17:14 25:23 83:7	prepared 49:6 55:7 78:20		
planned 80:16	prescribe 31:12 61:6		
plans 24:18 39:9 44:18, 18 58:23 86:2	prescribed 55:11, 15		
playing 64:5	prescriber 94:11		
please 59:11	prescribing 31:1 36:3 48:5, 14 50:2, 11 67:19		
Plus 94:22	prescription 21:21 22:1, 6 25:23 29:13, 14, 19, 20, 21		

<p>prosecuting 47:3 52:4, 6 64:11 89:20 108:11</p> <p>prosecution 41:19</p> <p>protect 22:11</p> <p>protocol 33:7, 12, 20 34:6</p> <p>protocols 35:14 36:14</p> <p>provide 18:7 23:7 25:15 28:4 31:2 32:7, 17 39:14 114:21</p> <p>provided 21:14 33:23</p> <p>Providence 12:20</p> <p>provider 15:17, 19 25:16 30:8 37:1 45:14 47:22 52:13, 16 53:17 54:1 61:12</p> <p>provider-patient 40:2</p> <p>providers 25:18, 21 32:21 34:12 35:18 49:15</p> <p>providing 44:16 46:23</p> <p>psychiatric 13:18 16:4</p> <p>psychiatrist 114:23</p> <p>public 24:13 101:9</p> <p>publicized 45:1</p> <p>publish 106:22</p> <p>Publix 8:22</p> <p>Puerto 98:11, 13, 19</p> <p>pull 94:14</p> <p>purposely 34:20</p> <p>pursuant 41:13</p> <p>purview 39:23</p> <p>push 53:13</p> <p>pushing 101:9</p> <p>put 18:18 19:11 33:17 44:1 45:7 52:3, 19 61:11, 16 64:9 65:3 70:12, 16 77:8 79:2 97:4 101:7 106:18</p> <p>puts 24:19 93:12</p>	<p>putting 47:4, 12 65:1 96:12 100:11</p> <p>Pyxis 15:10, 11 17:23 19:2</p> <p>< Q ></p> <p>qualifications 88:14, 16</p> <p>quality 21:11 37:2 48:23 51:5 56:11 64:23</p> <p>quarterly 13:19 16:17</p> <p>question 14:15 17:13 33:19 35:21 42:15, 16, 22 45:21 46:13 51:2, 7 57:15 65:21 101:4 102:20 104:18, 23 105:2 107:2, 6 110:23</p> <p>questionnaire 40:9, 20 43:23 44:4 47:7, 14, 20 52:10 53:1 97:19, 21 99:23</p> <p>questions 12:6 15:14 17:17 19:21 20:10 22:16 29:5 32:9 33:13 39:7 47:21 50:13, 15 53:23 58:2 89:8 91:6 93:19 97:15 100:14 101:1 118:9</p> <p>queue 34:11</p> <p>quick 45:18 95:9</p> <p>quickly 29:7</p> <p>quicksand 62:11</p> <p>< R ></p> <p>racket 48:4</p> <p>radio 53:12</p> <p>raised 91:14</p> <p>Randall 4:12 8:20, 20 27:18</p> <p>range 13:20 21:22</p> <p>rate 36:15 37:19 51:11</p>	<p>reach 37:2 55:21 56:22 57:23</p> <p>reached 28:11</p> <p>reactivated 10:17</p> <p>read 10:3 40:7</p> <p>reads 91:11</p> <p>ready 10:22 27:6 86:9</p> <p>reaffirms 30:13</p> <p>real 45:7 64:10 73:11 98:18 101:16</p> <p>realistic 94:6</p> <p>realize 46:22</p> <p>really 28:5 32:22 34:4, 23 36:9 37:4 39:3, 17 58:4 59:4, 12, 13, 15, 17 63:8 73:12, 13, 15 84:2, 11 97:8 109:8</p> <p>reason 10:20 35:6 98:7</p> <p>reasonably 111:11</p> <p>reasons 22:14 93:4</p> <p>receive 74:4, 4</p> <p>received 75:15 88:2</p> <p>recess 113:13</p> <p>reciprocating 107:1</p> <p>reciprocity 10:16</p> <p>recognizable 93:11</p> <p>recognizes 31:5</p> <p>recommendation 34:19 59:11 113:19, 22 114:1, 10, 20 115:10, 13, 21 116:2, 10, 13, 14, 22</p> <p>recommendations 11:15 36:20</p> <p>reconcile 47:11 52:1, 6 61:20</p> <p>record 10:3 11:2 27:5, 17 33:6 55:3, 12 79:1 80:22 109:6</p> <p>records 104:15 114:22</p>	<p>recoup 69:9, 19 70:8, 13, 17, 19 103:23</p> <p>recoupable 92:20</p> <p>red 33:19 34:6 35:22 36:14 38:10, 19</p> <p>reduced 51:11</p> <p>reemphasize 29:15</p> <p>refer 39:22 115:10</p> <p>reference 114:22</p> <p>references 83:18, 22 84:1</p> <p>referred 38:11, 19</p> <p>refills 116:1</p> <p>reflected 37:18</p> <p>refund 35:8</p> <p>refused 11:15</p> <p>regard 115:23</p> <p>regarding 29:6 115:22</p> <p>regardless 90:16</p> <p>registering 84:18</p> <p>regulating 66:13</p> <p>regulation 29:6 30:1, 23 31:4 39:22 43:11, 13 63:2 80:7</p> <p>regulations 23:3 80:2</p> <p>regulatory 62:22</p> <p>reinforce 37:4</p> <p>relationship 16:9 30:6, 18 31:11, 14 32:6 37:11 40:2, 9, 20, 22 41:15, 15 42:6 43:18 68:16 94:1 96:3, 17 100:3</p> <p>relative 45:12</p> <p>relatively 45:15 59:17</p> <p>religious 76:22</p> <p>remember 72:1</p> <p>remote 13:14, 16 15:4 16:1 18:6</p> <p>renewal 105:9, 17 106:1, 9 109:19, 20 110:8</p>
---	---	---	---

Rengering 3:7 6:1, 1	78:7, 9	rule 39:10, 12 40:8 41:12, 16, 18 42:17 45:4 47:11 48:22 49:19 62:9 64:2 68:10 90:5, 12, 18 99:17, 18 107:8, 8, 20 111:8	Secretary 2:12 section 23:15 secure 35:10 see 13:4 23:10 31:20 35:7, 8, 10 36:5 44:19, 20 47:7 49:1, 13 50:16, 22 56:13 57:5, 9 60:13 63:18 64:18 65:3, 9 67:18 87:23 92:3 96:5 98:12 104:3 109:7 112:16
replaced 53:14, 17	responsive 33:3	run 25:22 28:18 51:4	seeing 22:22 23:1 45:9 46:3, 9
report 9:20, 23 11:5, 18 12:6 48:23 57:10 72:8, 11, 12 74:4, 5 75:14 112:13	rest 34:19 36:21 65:9	< S >	seek 35:2
REPORTER 1:23 80:10, 13 118:7	restrictive 51:17	safe 78:13, 14 79:19, 20 80:9	seen 25:17, 20 30:19 37:12 43:18, 22 68:2 77:22 78:1
reporting 51:5 72:12	result 96:15 99:21 118:17	safest 102:13	sees 78:6 91:11
reports 13:19 16:15 54:15	retail 82:7	safety 39:2	segment 59:13
represent 5:2 7:5 80:23	return 115:2	Saint 103:5	selected 38:21
representatives 77:20	revenues 72:13, 14	Sally 4:3 7:19	selecting 38:4
representing 6:10	reversed 113:20 116:12	satisfied 55:20 56:6 81:5, 6	self-select 33:9
represents 10:4 118:12	review 60:23 61:2, 12	saved 34:9	selling 67:4, 5, 13
request 15:2, 13 20:21 21:12 25:11 81:3	reviewed 47:22 68:1 112:23	saving 54:7	send 13:19 16:16 63:9
requested 25:2 29:19	reviewing 60:19	saw 81:14 97:5	sending 16:14 44:2 67:8
requests 22:4	Rhodes 4:5 7:23, 23	saying 42:22 43:8, 10 45:4 75:16 78:6 80:6 85:5 92:7	sends 29:12
require 25:6, 13	Rhonda 83:22	says 30:15 40:8 50:8, 10 62:16 71:20, 22 99:17, 18	Senior 5:9 27:18
required 16:15 32:7 114:21	rich 60:1	School 5:6, 18 6:17 7:12 8:1, 3 11:16	sense 32:12 64:16
requirement 23:7	Rick 2:23 5:9	Scott 2:20 8:8	sent 22:1 29:15, 16, 20, 21 36:17 63:17 83:8 97:19
requirements 78:4 80:3 109:17 110:7	Rico 98:11, 13, 19	Scotty 4:10 8:16	sentence 40:8
requires 33:17	Right 17:16 18:17, 20, 23 19:11, 12 22:21 26:14 32:16 35:3, 16 46:17 53:19 56:9, 20 58:14 59:6, 12 61:19 63:19, 19 64:11 67:7, 12 68:7, 14, 14 69:3 72:3, 10 77:6, 8 78:15 80:6 84:10 86:1, 16 93:6 97:2 100:20 102:4, 7, 7 104:4, 12 106:13 109:11, 13, 16 110:6 111:10	scrambling 84:22	separate 39:18 71:12
research 89:13	Rhonda 83:22	screening 10:6	separately 74:15
residents 60:6	rich 60:1	script 67:8 101:18	September 28:22 30:13 72:11 74:19 75:5 88:1
resolved 96:7	Rick 2:23 5:9	scripts 67:9 69:8	serious 65:20
respect 45:12 63:13	Rico 98:11, 13, 19	se 79:19	serve 22:14
respiratory 37:16 42:2	Right 17:16 18:17, 20, 23 19:11, 12 22:21 26:14 32:16 35:3, 16 46:17 53:19 56:9, 20 58:14 59:6, 12 61:19 63:19, 19 64:11 67:7, 12 68:7, 14, 14 69:3 72:3, 10 77:6, 8 78:15 80:6 84:10 86:1, 16 93:6 97:2 100:20 102:4, 7, 7 104:4, 12 106:13 109:11, 13, 16 110:6 111:10	Second 9:17 10:12 20:22, 23 26:12, 13 51:7 74:6, 7, 20, 21 75:7 110:21 111:17, 19 113:1, 3 114:2, 13 115:3, 4, 14 116:3, 15	service 23:1, 8 24:20 31:19 33:5 34:13 36:9 41:23
response 12:8 34:13	ripple 41:4		
responsibilities 86:23	risk 99:12		
responsibility 49:13 78:7	road 59:22		
responsible 18:23 19:1 32:15 69:21	roll 5:4		
	rolled 53:6		
	Ronda 2:22 5:5		
	roof 88:19		
	room 12:19 14:8		
	rooms 14:14		
	RPR 1:23 118:6, 21		

53:3, 5 58:8
serviced 54:18
Services 12:17
 32:18 86:13
servicing 22:10
session 88:22
 112:18 113:1, 14
set 34:20 47:21
setting 82:21
 95:23 115:2
seven 13:21 35:15
share 12:10
Sharp 103:8, 9
Shelby 103:2 118:4
She'll 86:21
Sheri 1:23 5:3
 118:6, 20, 21
Shield 71:3, 8
shift 16:23
ship 22:4 25:2
 26:9
shipped 23:18
 25:1, 19
shoot 88:18
shortening 20:8
Shortly 29:4
short-term 31:21
show 20:12 72:13
 73:3
showing 48:13
shutting 66:14
sick 92:23
sicker 60:13
side 49:8 60:8
 65:7 70:11, 13
Sidwell 4:7 8:10,
 10 80:7, 12, 12
SIG 52:20
sign 24:18 111:3
signed 10:6, 15
 11:11
significant 38:8
 59:18
signing 11:8
signs 45:8
simple 45:15
simply 33:5 34:18
 37:13 46:9 47:21
Sims 4:3 7:19, 19

single 101:17
 102:5
sinus 97:22
sir 16:17 23:16
 46:5 47:16 51:1
 87:22 88:17, 23
 89:5 93:14
Sirote 6:12
sit 13:9 107:18
site 63:16
sitting 52:4
situation 18:12
 94:5
situations 31:15
 41:20 42:18, 19
 45:2
six 11:2 39:13
 51:5 54:15 82:4
 107:14 108:1
 109:19 110:7, 19
skipped 112:11
slow 61:19
small 12:11 59:12
 69:18
smaller 65:1
Smith 4:2 7:18, 18
social 13:1
Society 7:6
software 33:5
 34:10
solid 95:9
SoloSTARS 70:14
somebody 19:9
 48:3 50:21 105:13
 109:21
somewhat 48:6
soon 62:8 74:17
sorry 54:13 62:12
 75:17, 22 86:20
 110:18
sort 39:21, 22
 64:20
sounds 103:22
special 25:6, 14
specialty 21:16, 17
 22:8, 18 23:20, 21
 26:9
specific 18:9 58:23
 106:15

specifically 25:1
spending 60:10
SPI 36:6 52:12
SPIs 48:12
spoken 77:21
spot 22:14 52:4
Sprayberry 4:9
 8:14, 14
spread 48:18
square 79:11
staff 9:23 15:5
 17:17 28:14 29:9
 35:19 42:16 54:5
 115:23
staffing 16:21
 19:23
stance 92:3
Stand 5:1 82:17
standard 19:6
 62:10
standards 63:22
 64:1
standpoint 66:1
start 5:1 9:13
 27:22 28:22 51:10
 81:18
started 53:5
starting 77:16
 86:22
starts 51:3 91:17
STATE 1:2, 18
 6:22 7:1 8:7, 9
 23:5 34:22 39:4
 40:23 48:19 49:1
 57:11 61:4 66:6
 75:16 81:14 101:8
 102:22 104:20
 118:3
statement 30:14
 40:13 92:14
 106:17
statements 43:5
 118:10
states 22:3, 21
 58:17 69:3
station 23:15
stats 36:11
statute 23:9 43:11
 107:6, 7

stays 73:20
stereotype 118:9
Stephens 2:23 5:9,
 9 107:13, 17
stereotypical 93:2
sterile 18:12
Steve 3:13 6:12
sticker 70:13
stocked 17:23
stored 78:13
straightforward
 13:8 21:12
strategy 27:19, 21
Street 1:19 14:3
 58:11
stretch 32:21, 21
strictly 40:9 41:17,
 18
struggle 44:15
Stuart 4:16 9:5
 27:14
student 11:14
students 112:5, 19
study 50:16 54:19
stuff 45:22 60:10,
 12 107:19
subcontractors
 71:15
submitted 9:23
 74:5
Subsequent 92:15
subsequently 56:13
substances 36:2
success 36:15
 37:19
successful 54:5
 55:16
successfully 34:5
 37:21
sudden 41:3
suggest 33:22
 41:10 43:1, 3
 46:13 109:1
suggested 36:16
 55:18 78:12
suggesting 42:11, 12
suitable 50:12
Suites 85:9, 12, 21
super 55:1

Supermarkets 8:23	taken 10:17 17:21	ten 17:8 84:16	97:2 100:6, 20
supervise 32:3	41:1 82:9 113:13	tenet 46:4	101:2 102:6
supervising 78:9	118:8	Terry 2:21 8:4	106:13 107:16
supervision 28:19	takes 53:20 63:6	13:9 76:7	108:7 109:10
46:19 78:18	talk 15:11 22:16	test 65:8	110:23 111:18
supervisor 115:22	36:23 40:15 58:12	testing 38:23 59:3	thinking 107:19
supervisors 18:4	83:19 84:5 90:20	Thalia 3:19 7:7	third 50:17 69:13
support 83:10	102:10	27:12 32:11 37:3	70:7
supportive 51:13	talked 44:16 66:3	Thank 9:11, 22	third-party 22:7
supposed 70:11	69:14 91:13	11:13 12:9 13:5	Thirty 106:2
93:20 100:18	talking 23:15 40:4	21:6, 7 26:21, 22	Thomas 4:1 7:16
sure 32:19 45:22	60:15 84:8, 14	32:13 37:3 66:8	thorough 45:19
58:1 59:3 61:16	97:12, 13	72:7, 9 80:13 81:7	thought 72:17
76:12 78:23 81:15,	talks 41:17 87:13	82:23 87:20	76:5 81:12 90:23
17 84:20 90:3, 5	Tammie 3:5 5:20	104:21 106:20	104:7
95:12 104:16	Target 86:21 87:8,	112:9 113:11	thoughtfully 49:9
surprised 96:1	9	the-counter 34:18	threatened 59:16
97:8	team 34:12	themselves 25:15	three 13:6, 23
surrender 116:23	teams 66:15	thereto 118:10	15:12, 16, 20, 22
surrendered 11:23	tech 109:21	thing 12:11, 12	55:19 56:2 92:22
surrenders 11:8	technical 68:22	29:10 37:23 40:5	94:22 99:22 102:4
survey 67:10	technician 20:2	48:7, 9 52:5 56:7	108:2, 3 109:21
Susan 2:11 4:7	114:21	58:18 59:21 63:14	110:2, 4, 6, 18
8:10 54:13, 21	technicians 73:9	73:11 89:21 95:7	three-day 55:17
80:12 81:2 82:23	79:13 84:19 108:9,	98:19 99:7 101:19	throw 97:16 99:5
89:11 91:5 100:15	12, 23 110:7	things 19:4 31:9,	109:11
Susan's 96:22	technician's 114:23	23 63:6 64:18	Tim 2:5 97:13
suspect 16:22	technique 18:19	67:17 72:20 83:9,	109:5
suspended 10:14	technology 13:10	10, 15 89:15 90:23	time 10:23 14:4
swear 97:5	techs 11:1, 2, 7	99:22 101:7	17:1 28:1 29:1
sweet 97:18	teledoc 58:22	102:11	30:10 32:10 45:9
switch 85:14	telehealth 39:15	think 12:20 13:8	49:20 54:7 60:10,
syrup 92:23	49:18 61:18	15:1 19:6 21:12	12 65:2 79:1
System 7:4, 20, 22	telemedicine 27:2	23:3, 3 24:4, 13, 17	84:14 85:9 87:19
8:19, 21 9:8 15:10	72:1	26:4, 5 29:10	93:9 106:1 109:8,
19:12, 19 27:11, 20,	telepharmacy 61:18	32:10 33:10 37:18,	12, 14
21 28:21 38:6	telephone 60:11	22 38:3 39:3 40:6	times 25:18 43:6,
55:1, 9 56:12 58:9,	telephonic 41:14	44:14 45:2, 2 48:6	16
16 83:5, 14 84:17	100:1	49:3 51:2 57:21	tiny 73:1
systems 15:16 87:1	television 53:9	59:2, 15, 23 61:14	today 13:6 15:13
< T >	tell 5:2 12:21	63:2, 10, 20, 21, 21	27:17 28:3, 4, 16
table 91:2	29:19 41:8 42:8	64:7, 12, 19 65:2,	29:10 30:10 32:22
take 7:5 32:9	49:7 58:6 61:21	13 66:20, 20 68:9	71:1 77:23 78:2
42:20 49:12 50:20	70:4, 6 72:15	70:18, 20 72:18	80:17 87:10, 17
66:4 76:19 78:7	75:23 89:11 98:2,	73:18 83:16, 23	89:15, 16, 21 92:18
81:18 84:16 85:22	4	85:22 89:12, 15, 21	94:18 95:16
take-home 78:12,	telling 25:22 42:11	90:1, 14, 17, 19	Todd 2:17 8:6
17, 19 79:15	69:11	91:2, 20 92:12, 21	88:20
	temperature 22:13	94:3 95:3, 15, 17,	
		18 96:9, 9, 11, 17	

told 40:23 42:7, 7,
8 81:13 82:10
94:19
Tommy 4:18 9:9
Tony 75:18
total 79:9 105:14
110:2, 4, 17, 19
totally 65:15 83:4
touch 12:23 58:9
touched 57:5
tour 81:9
track 54:18 58:15
87:2
tracking 49:15
67:18, 19
tract 37:17
Tracy 3:10 6:6
training 44:9
transcribed 118:10
transcript 118:13
transcription
118:11
transported 88:12
Treasurer 2:6 74:5
Treasurer's 72:8
treat 34:16 35:23
57:7 60:11 62:14,
15 78:14
treated 38:5, 5
55:12 59:7, 10, 14
treating 55:11
Treatment 8:13, 15
10:12, 21 11:1, 15,
19 12:4 61:13
114:22
tried 49:9 76:14
78:5 96:2
truck 76:15
true 57:17 70:5
118:12
trust 46:8
try 17:22 25:18
32:21 48:23 57:2
59:9 60:16 62:23
96:19
trying 12:15 21:15
32:20 33:2 37:2
47:11 57:9 58:22
60:11 61:20 63:8,

9, 22, 22
Tuesday 105:11
Turenne 5:12, 13
8:17
turn 36:22
two 10:11 11:7
22:22 24:2 25:10
38:3 51:9 57:8
76:3 81:11, 11
105:15 106:2
107:14 108:6
109:12, 23 110:1, 8,
12, 13, 14, 15, 19
two-year 105:9
106:1 109:19
110:8, 16, 18, 19
two-years 107:13
type 19:3 36:3
37:7 48:7, 9 50:15
58:8, 18
typically 31:6
45:18
typing 44:7

< U >

U.S 21:19 58:20
UAB 7:7 8:18, 20
9:5, 7 12:4 27:1,
10, 15, 19, 21 28:3,
6, 21 29:11 30:19
32:13 33:6 34:1
35:19 43:22 44:9
48:2, 13 54:23
59:21 62:8 64:21
71:11 89:8 91:10,
15 94:11 98:20
99:10 101:9
102:19 104:5
Uh-huh 54:16
107:12
ultimate 84:7
uncomfortable
97:11
undecided 11:20
understand 24:21
43:9 47:1, 16
49:10, 17 62:12
63:1, 3 64:4 65:18,
22 71:1 93:8
97:10 100:19

understanding
99:17 105:19
understood 64:1
underway 72:2
unfair 102:8
unfortunately 44:13
unique 33:8
unreasonable 96:18
unrecognizable
92:17
upcoming 83:6
upper 37:16 42:2
urgent 34:1, 4
35:11 36:17 37:12
45:18 60:17
use 36:7 38:22, 23
42:12 60:12 87:3
93:5
user 84:8
uses 36:6
usually 5:1 35:13
102:2, 7
UTI 33:11 55:16
utilization 36:8

< V >

vacuum 90:15
valid 30:5, 17
40:21 49:4 93:23
100:2
validation 18:19
various 77:19 79:1
93:4
venture 60:14
verification 18:7, 8
verify 104:15
Viagras 48:7
Vice 2:5 27:18
view 66:21, 23
Village 1:19
violation 114:11
viral 37:16
visit 30:16 33:16,
17, 21 34:8, 10
36:13 38:23 45:19
54:22 55:4, 12, 18
visits 13:1 35:1
36:12, 19 56:8, 8
57:22 61:1

vital 45:8
Viva 51:8, 13
voice 113:2
voluntarily 11:22
100:22
vote 26:2, 4 113:2

< W >
Wahlheim 4:11
8:18, 18 27:6, 9, 10,
16 39:6, 11 41:7
42:10 44:13 46:11,
18 50:1, 6, 10 53:4,
11, 16, 20 54:16
57:21 63:1, 19
67:5, 8, 13, 22 68:7,
14 70:21
wait 91:2
waiting 97:23
waived 23:10
waiver 23:6
Walgreens 5:19, 21,
23 6:2 21:8, 11, 15
23:20, 23 24:1
25:3 26:9, 10 95:4
walk 76:13
Walker 103:7, 7
want 12:10 16:6
22:19 23:1 27:23
29:10, 20, 21 32:22
33:1, 1, 1, 2 36:22
56:14 57:6 64:19,
20 65:10 70:7, 13
72:14, 15 77:10
82:12 84:17, 20
86:2, 12 93:2
108:22 109:8
wanted 39:4 75:17
86:7
wants 62:17
Ward 2:14 11:8,
11 23:9, 14, 17, 22
24:1, 4, 10, 21 25:4
40:3 42:4 50:5, 7
61:23 62:4, 14
67:11 90:3, 11, 14,
21 91:14 92:17
95:20 98:2, 4 99:1,
11 101:12, 15
107:18 108:5

110:1, 10, 12 111:6, 8, 11
warning 113:19 116:10
warnings 59:10
water 65:3
wax 51:20
way 34:23 36:4 46:7 47:8 48:15, 15, 21 52:8 54:18 56:5 60:18 62:20 65:2 76:20 77:13 79:4, 11 81:13 82:7 87:1 92:12 94:2 97:17 103:19 104:13
ways 14:22 41:4 79:1 81:11
wearing 76:22
website 103:14
Wednesday 1:10 105:11
week 17:2 20:4 21:14 83:6 88:8
weekend 17:2, 4 41:23
Welcome 4:22 82:20
Well 12:9 24:19, 21 29:23 37:18, 20 40:17 42:3, 16 44:13 45:11 49:3 53:16 54:9 55:17 60:7 62:7, 18 63:19 64:3 71:23 85:11, 20 92:5 94:9 96:11 98:13 100:18 101:19 103:11 107:14 108:19 112:11
Wellness 2:15 5:8 9:20
Wells 2:18 7:1, 1
Wendy 4:9 8:14
went 39:19 69:7 79:2 81:10 96:1 106:19
We're 4:23 15:6, 9, 12 20:17 22:22, 23 28:3, 5 32:9, 20

33:2 34:3, 3, 4, 14 35:15 40:17 41:7 46:22 47:3 48:11, 18, 22 51:4 52:4 54:20 55:7 56:7, 10 57:8 59:3 60:15 61:18 63:8, 9, 9, 22 64:5 66:21, 22 67:3, 3, 5, 8, 13 68:4, 15, 15 69:10, 16 71:20 72:3, 10 73:4 79:10 84:19, 21 85:1, 19 86:13, 14 89:20 90:17 95:15 96:9, 11 100:8 104:4 107:22 117:8
West 13:17, 20 14:4 15:4 16:3, 5 17:9, 13 19:15, 16 61:18
western 58:20
we've 9:12 16:20 18:18 23:10 35:21 36:11 41:3 43:10 44:16 64:11 69:14 71:23 77:21 78:3 82:18 83:23 84:2 85:19, 21 86:19 87:12 89:12 91:5 101:6 103:9 104:23 112:18
white 76:23 77:5 96:10 98:6
wife 87:11
wife's 12:19
willing 46:20 50:23
window 85:2
Wisconsin 57:16 77:14 103:5
wise 24:13 55:12
wish 32:10 60:2 102:9
wonder 48:10, 14
wonderful 90:16
Word 98:22 100:14
work 10:4 12:15 16:10 48:3 63:23

71:9, 10, 11, 12, 20 81:15 86:4 115:2
worked 34:12
workers 13:1
working 52:14 79:3
workload 20:15
workplace 11:21
works 13:4 33:5 35:12 73:10
worried 82:21
worth 70:15
wound 14:22
wrestling 40:17 41:6
write 68:6, 12 83:7
writing 26:6
written 63:17
wrong 105:13
wrote 101:22 102:2

< Y >
y'all 27:3 29:6, 22 43:9 44:1, 5 47:5, 12 48:2 52:2, 3 64:7 72:9, 16 81:8 95:10 98:1 106:16 107:18 113:11, 21
y'alls 44:9
Yarbrough 3:1 5:11, 11 75:18
Yeah 11:13 19:5, 14 24:11, 12 47:2 50:5, 14 51:21, 22 53:11 67:11 71:18, 18 84:6, 12, 12 85:10, 13, 16 86:10 90:13, 19 94:15, 20 95:10 103:3 104:8 107:3 108:13 109:9
year 29:3 51:3 73:6, 7, 8, 9 91:19 94:19 105:4, 6, 8, 16 108:1 110:5
year-end 72:12
years 58:14 76:3, 17 105:15 106:2 107:15 108:6
year's 70:15

yesterday 10:1, 15 11:12, 18 98:12
yesterday's 10:18
young 59:17

< Z >
zeros 106:8
zip 33:22 51:16, 17 102:17, 18, 20 103:18