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ALABAMA STATE BOARD OF PHARMACY

BUSINESS MEETING

Wednesday, March 25, 2015

9:20 a.m.

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

REPORTER: Sheri G. Connelly, RPR

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ATTENDEES

BOARD MEMBERS:

- Dan McConaghy, President
- Tim Martin, Vice President
- Buddy Bunch, Treasurer
- David Darby, Member
- Donna Yeatman, Member

ALSO PRESENT:

- Susan Alverson, Executive Secretary
- Eddie Braden, Chief Inspector
- Cristal Anderson, Director of Compliance
- Mark Delk, Board of Pharmacy
- Scott Daniel, Board of Pharmacy
- Richard Lambruschi, Board of Pharmacy
- Mitzi Ellenburg, Board of Pharmacy
- Rhonda Coker, Board of Pharmacy
- Cara Leos
- Gary Mount
- Gokul Rajaram
- Billy Lawley
- Rick Stephens

1	Lynn Connor
2	Scott Kruse
3	Carrie Krups
4	Ashley Core
5	Jim Easter
6	Melanie Smith
7	Louise Jones
8	Nancy Bishop
9	Jack Adams
10	Roger Bates
11	Chris Burgess
12	Ronda Lacey
13	Bruce Harris
14	Sharon Hester
15	Bill Maguire
16	Julie Hunter
17	Tommy Kliner
18	Carter English
19	Bart Bamberg
20	Eddie Vanderver
21	Scott Chapman
22	Dan Yarborough
23	

1 MR. MCCONAGHY: We'll call the March
2 25, 2015, Alabama State Board of Pharmacy
3 business meeting to order. We have a quorum
4 with all members present.

5 MR. DARBY: I'd like to make a motion
6 we adopt the agenda.

7 MR. BUNCH: Second.

8 MR. MCCONAGHY: We have a motion and a
9 second. All in favor?

10 DR. MARTIN: Aye.

11 MR. DARBY: Aye.

12 MS. YEATMAN: Aye.

13 MR. BUNCH: Aye.

14 MR. MCCONAGHY: All opposed?

15 (No response.)

16 MR. MCCONAGHY: The agenda is adopted.
17 I'd like to start with anybody that's
18 new here. We'll start with Rhonda since she's
19 not new. Everybody stand and tell us who you
20 are and who you represent, please.

21 MS. COKER: Rhonda Coker, Board of
22 Pharmacy.

23 MS. ELLENBURG: Mitzi Ellenburg, Board

1 of Pharmacy.

2 MS. LEOS: Cara Leos with ALSHP.

3 MR. MOUNT: Gary Mount, director of
4 pharmacy, Baptist South Montgomery.

5 MR. RAJARAM: Gokul Rajaram from
6 Cyberbest Technology, Inc.

7 MR. LAWLEY: Billy Lawley, Wal-Mart,
8 Inc.

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

11 MS. CONNOR: Lynn Connor, Senior Care
12 Pharmacy.

13 MR. KRUSE: Good morning, Scott Kruse
14 with Cubex.

15 MS. KRUPS: Carrie Krups, Senior Care
16 Pharmacy.

17 MS. CORE: Ashley Core, Samford
18 University.

19 MR. EASTER: Jim Easter, Baptist
20 Medical Center.

21 MS. SMITH: Melanie Smith,
22 BuzzeoPDMA.

23 MS. JONES: Louise Jones, Alabama

1 Pharmacy Association.

2 MS. BISHOP: Nancy Bishop, Department
3 of Public Health.

4 MR. ADAMS: Jack Adams, Huntsville
5 Hospital.

6 MR. BATES: Roger Bates, Alabama
7 Pharmacy Association.

8 MR. BURGESS: Chris Burgess, Heritage
9 Compounding Pharmacy.

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

12 MR. HARRIS: Bruce Harris, APCI.

13 MS. HESTER: Sharon Hester,
14 Transdermal Therapeutics.

15 MR. MAGUIRE: Bill Maguire, Omnicell.

16 MS. HUNTER: Julie Hunter, Omnicare.

17 MR. KLINNER: Tommy Klinner, Alabama
18 Department of Mental Health.

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

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

23 MR. VANDERVER: Eddie Vanderver, CAPS,

1 Incorporated.

2 MR. CHAPMAN: Scott Chapman,
3 Roadrunner Pharmacy.

4 MR. DELK: Mark Delk, State Board of
5 Pharmacy.

6 MR. DANIEL: Scott Daniel, State Board
7 of Pharmacy.

8 MR. LAMBRUSCHI: Richard Lambruschi,
9 State Board of Pharmacy.

10 MR. MCCONAGHY: Thank y'all. We're
11 going to move right into the presentations and
12 Cyberbest is up front. Does anybody want to
13 introduce them?

14 DR. ALVERSON: I would. For all of
15 you who have had to listen to me whine and moan
16 for two years about I can't get that information
17 for you because our data system won't allow us
18 to do that, Gokul is my answer. So we have
19 decided to contract with Cyberbest. We've been
20 looking at them. They have been working with
21 the Board of Nursing now for five years and so
22 we looked at the Board of Nursing's data
23 management system and were very impressed.

1 They've also done work, and I may get this mixed
2 up, with the University of Alabama in developing
3 data management systems for police within the
4 State, so it's their fault if you get pulled
5 over and in five seconds they know everything
6 about you.

7 So within the office we've had a
8 chance to speak to people at Cyberbest but the
9 Board has not and you know, we most certainly
10 need to have -- give the Board a chance to ask
11 questions that need to be asked, so let me
12 introduce you to Gokul and he's going to do a
13 presentation about Cyberbest, what they do, and
14 they've loaded some of our data already so we
15 can see what it looks like. So Joyce, come next
16 fall, I'll be going yes, Joyce, I got it. I
17 hope.

18 MR. RAJARAM: All right, thanks. Good
19 morning everybody, and like Susan said, I am
20 with Cyberbest Technology, Inc., and I've been
21 working with them for six years now and pretty
22 much the entire six-year duration has been spent
23 with boards like the Pharmacy Board and the

1 Nursing Board where my specialization is
2 understanding your business processes and
3 tweaking the products and services that we've
4 got to meet the requirements for each and every
5 board that we go to.

6 I'm sorry about not being here the
7 last time. I don't know who was here and who
8 wasn't. It was snowing pretty bad and Susan
9 said take the day off and I was too glad to do
10 it, so I'll get started right away.

11 Just a brief history about the company
12 and you can stop me in the middle or perhaps at
13 the end if you have any questions. The company
14 was established in 1998 in Mobile, Alabama, by
15 my company's president. He graduated from the
16 University of Mobile, I guess South Mobile or
17 something like that, so he started with the aim
18 of providing services to state and county
19 agencies in Alabama and that's basically what we
20 have been doing for close to 16, 17 years now.

21 And as we grew, we started having a
22 presence in states and agencies outside of
23 Alabama but I would say 80 to 90 percent of our

1 revenue comes from state agencies in Alabama and
2 we've got multiple models that we use to carry
3 out engagements depending on the type of
4 engagement. For example, the way that we did
5 the engagement at the Nursing Board since we
6 just got started with the licensing business, we
7 had pretty much my entire teams, the Board of
8 Nursing for three to four years to understand
9 the process and spend a lot of time at the
10 agency to understand how the licensing business
11 works.

12 But now we are at a stage where we
13 really do not need to have too many people
14 showing up at the site, so right from the
15 beginning, Susan, Eddie, and team, they just met
16 me and the company's president and we have
17 offshore team, off-site team rather, in back
18 office locations in Lake Mary, Marietta, that's
19 in Atlanta, doing the programming work. And the
20 products and services that we offer, we got a
21 standard licensing product, which is something
22 that I'm going to do a quick demonstration of
23 and we also do offer customized solutions that

1 are dedicated to your needs in specific.

2 Now, some of -- not throwing anyone
3 under the bus but some of the problems that
4 boards like pharmacy has like the other places
5 that I've been to have a -- when you have a
6 standard product that's basically retrieved from
7 the shelf, you have to adapt your processes and
8 the way that you do business around the product
9 and we believe that's really not the way to go
10 and that's not going to be good for you at the
11 end of the day. It might be a good business
12 strategy for us to just take it off the shelf
13 and charge X number of dollars but that's
14 probably not going to do every single thing that
15 you want it to do at the end of the day.

16 So the model that we propose and have
17 been following with -- thankfully with some
18 success is we do have 70 to 80 percent of what
19 we call as the base product because any board
20 that we go to, you're going to start with the
21 applications. You're going to start with
22 licensing. You're going to collect money from
23 the licensees. You're going to discipline them.

1 You take them to the Board. The attorney is
2 going to draft some letters and so on. So we
3 have 70 to 80 percent common framework and the
4 solution that we offered to Susan and even when
5 we came down here is, all right, we've got this
6 base product but what I'm going to do is spend
7 time with you all to understand where we have to
8 make tweaks to fit to your needs 100 percent and
9 that's what we are doing right now.

10 We also offer consulting services.
11 Let's say the company, the engagement service
12 end, Susan decides and the Board agrees that you
13 might need continuity of support for the product
14 to make it work better in the future, we offer
15 consulting services as well and coming to an
16 experience products, Susan said Nursing Board,
17 she met me, I think Rhonda was with Susan the
18 other day and that's how I came to know them and
19 a couple of months before we signed on the
20 contract with the Pharmacy Board, we signed a
21 contract with the Plumbers and Gas Fitters Board
22 in Birmingham, so we've started doing business
23 with them and a lot of county and other

1 agencies. I'll just leave it at that. I don't
2 know the details but my boss says we're doing
3 like extensive state work and Eddie and his team
4 being inspectors, they have actually used the
5 police system that Susan was talking about. So
6 that's the brief introduction about the company
7 and I'll just get into the details of the
8 system.

9 We call the system as licensing and
10 enforcement management system. We typically
11 call it licensing management system because not
12 a lot of boards have enforcement but since
13 Pharmacy Board is extremely heavy when it comes
14 to the work done on the enforcement side, here
15 we are calling it as licensing and enforcement
16 management system. It's basically a one-stop
17 shop where a board like this could do everything
18 that they want to do with respect to
19 licensing.

20 So when someone applies, you process
21 the license, you issue them a license, you
22 discipline them, you tag the complaints, you
23 close the complaints, you discipline them, you

1 remove them. The whole, what do you call it,
2 nine yards, 12 yards, whatever. So that's what
3 the system is and it's flexible but at the same
4 time it's guarded by a lot of security features
5 to maintain the system integrity because you've
6 got secret information floating all over.
7 You've got socials. You've got date of birth
8 and you've got in some places, for example, at
9 the Nursing Board, they have a program where the
10 nurse might come in and say, I have a drug
11 problem, please help me out. That information
12 is confidential only to the two people who
13 handle that division. Even the executive
14 director of the Board wouldn't know the internal
15 specifics of that.

16 So the system is capable of handling
17 role-based integrity as well as how to -- like
18 business situation based integrity. You might
19 have something real specific that only two
20 people might handle, so the system can be
21 programmed to handle all of that. And just
22 again based on experience, we've prepackaged the
23 system with a lot of standard reports for

1 licensing and the legal/enforcement side and
2 since we customize the system, we can also offer
3 to integrate it with any other products that you
4 might have. You might have your testing
5 agencies. You might have your labs that send in
6 your test results. You might have your document
7 system. The customization that we do is going
8 to make sure that the internal system interacts
9 with every other component that it needs to so
10 that you don't have just a system sitting out
11 there that doesn't interact with anybody else
12 and just real -- and that's basically
13 the explanation of what -- I'm going to show you
14 a summary of everything that we've talked about.

15 The divisions are licensing, finance,
16 legal, operations, administration, and general
17 features, which we talked about just a little
18 bit, and we could have other components that
19 need to be customized into the system like
20 interactions with testing vendors and the labs.

21 The licensing part of it is basically
22 going to let the licensing division, Rhonda and
23 her team, take applications, process them, keep

1 track of all pending applications, see who is
2 pending with what, what is it that they need to
3 send in, and processing and issuance of licenses
4 for businesses as well as individuals.

5 And the finance section is one of the
6 most robust features of the system. Blake isn't
7 here today I guess but the things that he and I
8 talked about where what he needed is pretty much
9 already there in the system right now. The
10 system is not going to let anybody edit a
11 financial transaction that's already been made.
12 We've got a lot of steps that even system
13 administrators, somebody like Terry will have to
14 follow to undo a financial transaction so that
15 once a dollar comes in, it's tracked all the way
16 to the service that is actually provided to the
17 licensee and we've got features to wire the
18 payment or refund them if we need to.

19 Legal/complaints/complaints/enforce-
20 ment, that's one of the most critical aspects of
21 any of these regulated boards. The system
22 allows you to initiate a complaint, to track the
23 complaint's status because the complaint is

1 usually tied to a particular person in the legal
2 division with regard to reports and dashboard
3 screens that tells system administrators who's
4 holding on to a complaint, how many days it's
5 been open, who's -- rather than who, what's been
6 the bottleneck and so on.

7 If you have a particular category of
8 complaint that stays open for a thousand days,
9 the system tells you all the data information
10 right there on the screen but it says, okay,
11 you've got all these cases and you'd be able to
12 group them by the source -- let's say
13 drug-related cases take the longest. The system
14 would let you see that on the screen. So
15 somebody like Susan could make a decision on
16 what is it that needs to be done to push the
17 process faster.

18 And the other part of it is the
19 enforcement forms that the field inspectors are
20 going to use. I'll do a quick demonstration of
21 that towards the end.

22 Just some utility tools in the system
23 where you might have a lot of logs or paper

1 documents made that's coming into the agency,
2 you've got a provision for -- to be able to keep
3 up with the data and track a particular document
4 if somebody may need something, you can record
5 that in the system and track the fact that let's
6 say you've got a mail and it's being delivered
7 to licensing and licensing has sent that to the
8 legal division, for example.

9 Administration, it's basically
10 inputting the users the way I put it because a
11 lot of administration work used to be done
12 behind the scenes by technical people. I don't
13 know if it's going to be hard for you to believe
14 but I'm not a technical guy myself. If you ask
15 me to program, I'm not going to be able to do
16 it. I have my team that does that for me but I
17 would say even five years ago, a lot of this
18 administration work needed someone to log in
19 behind the scenes to the actual technical tools
20 program to maintain the system.

21 Let's say the systems -- let's say the
22 Board moves from one place to the other. You
23 need to change the Board's address in all the

1 letterheads by programming it into the system.
2 You've got features that you can actually do all
3 of those things easily from the screen. That's
4 going to be accessible only to who the Board
5 decides are going to be the system
6 administrators and they could easily maintain
7 the system even after we are gone by not really
8 programming but by just using point and click
9 interface that are going to be easy to handle
10 and maintain in the future. I'm not saying that
11 you don't have to hire me but you don't need to.

12 We've got -- like I said, we've got
13 some prepackaged reports into the system but in
14 addition to that, just a good example that Terry
15 brought up the first time that I was here, he
16 has had to change the -- he's been trying to get
17 the system's letterheads changed when the Board
18 moved from one place to the other. Some of the
19 letters had someone else's name instead of --
20 anyone else's name, for example, I don't
21 remember the actual names but anyway. So all of
22 those things would be allowed through this
23 customizable report screen that we build into

1 the product. It's actually a proprietary tool
2 that my development person did for our product
3 and that's going to help us -- the system
4 administrators take a look at the prepackaged
5 reports, prepackaged address, and make minor
6 modifications to it. They don't have to go to
7 the programming level, so that's what this
8 report tool and similarly we have like you can
9 see that's like -- you have the option to select
10 which letter in the system that you want to make
11 changes to.

12 Let's say you have an administrator
13 complaint template. You prepopulate that into
14 the system and we deliver it to you but excuse
15 me for saying this but the Board changes the
16 legal terminologies in the letters, you might
17 have a new rule being added. You might have
18 something that frequently needs to be changed,
19 especially when it comes to the discipline
20 letters that need to be sent out. All of those
21 things can actually be maintained by the
22 administrators behind the scenes without having
23 to program it into the system.

1 And I showed you already software
2 solutions and the products that they thought
3 would work. We also offer hosting solution and
4 we have agreed to do that with the Pharmacy
5 Board as well as part of this contract. We'll
6 be hosting your solution at our data farms and
7 our data servers. It's going to be a secure
8 location. It could be a Cloud-based solution or
9 it could be a physical server-based solution.
10 We haven't decided that as we get into the
11 engagement but we do offer hosting services that
12 Susan and I have already talked about and
13 eventually I think the long-term plan is for us
14 to keep hosting it and to maintain it and make
15 it pretty much up to date and keep making
16 changes to it.

17 In addition to all those things that
18 are comparable, this slide is really not
19 accurate because I am not here on a sales pitch
20 but let me just cover it. The difference that
21 we bring to the table is not too many companies
22 offer you the source code like we are going to
23 do as part of this engagement. When you get

1 into an engagement with a typical vendor, they
2 are going to charge you on a monthly basis, are
3 they going to charge you a flat fee to use
4 their product for the lifetime but they don't
5 give anything back to you the moment you've got
6 the contract and say you're out.

7 But the way that we look at your
8 engagement is it's your source code. I am
9 making the tweaks to the system to fit your
10 needs. What am I going to do with it?
11 Absolutely nothing. So we'll drop off the
12 source code at your agency and say, you're free
13 to hire anybody else for you to maintain it but
14 I welcome the chance to maintain the system for
15 you. So we do so say we offer you a license for
16 the base product, we drop off the source code at
17 your agency because that's your customized
18 source code that we did for the money that we
19 got from you and absolutely notice our prices.
20 The dollar that you will be paying is what you
21 signed on and we've got multiple pricing models
22 and the way that we start your engagement is you
23 go to multiple other boards, let's say even

1 Nursing Board or the Plumbers and Gasfitters
2 Board. You would see that the pricing plan is
3 like all over the place and the reason that we
4 do that is we look at what is it that we could
5 get out of this particular engagement. It's
6 much more than the dollars. It's about the
7 references. It's our continuous business, so we
8 do have multiple pricing models that you could
9 choose from for more services and Susan and I
10 have already started talking about some other
11 future things that we could do and I don't want
12 to talk too much about it right now. Let's just
13 work on the things that we've got, deliver it to
14 the best of our abilities, and then I'm hoping
15 that there are going to be more engagements that
16 we're doing in the future.

17 Any questions on the standard company
18 and product presentation so far before I show
19 you some screens that we have done?

20 DR. MARTIN: I have a couple.

21 MR. RAJARAM: Sure.

22 DR. MARTIN: So where -- if you're
23 hosting, tell us a little bit about your

1 security and our comfort level that you're
2 not -- not going to be compromised.

3 MR. RAJARAM: Okay. The data farms
4 that we have, we're going to have something that
5 we call a security redundancy to begin with
6 where your data and the source code are going to
7 be on multiple servers and multiple locations
8 that we have. So point number one is that's
9 going to prevent you from losing any of your
10 data and when it comes to security, what we have
11 is we do have -- I don't know the actual
12 specifics on what they do but all they know is
13 we do have two full-time server/network
14 administrators who actually monitor the servers
15 and what we have behind the scenes is like they
16 have all these patches running on the server
17 that track all the spams or any sort of virus or
18 bug that comes into the server and I don't know
19 the way that they limit it but at my level, what
20 I get is like if I find some sort of an unusual
21 activity that's going on in the server, I get an
22 email and my boss gets copied on the email so we
23 have all these alert mechanisms that alert us

1 saying you have an unusual activity.

2 For example, we track the location
3 that a particular software is being used from
4 and I know all my typical users from the
5 Pharmacy Board are going to be in Birmingham,
6 Alabama, or you might be traveling to a
7 different location like Eddie once told me
8 about, so we track all of that information to
9 see who's accessing it from where and the moment
10 that it -- just like how the credit card
11 companies do. There was a day when I drove from
12 Alabama to Georgia to I think Mississippi. I
13 used my card in three different states on a
14 single day. They locked my card saying we found
15 unusual activity, so we have got all those on
16 guard behind the scenes to see which user is
17 accessing from outside.

18 For example, typically we would expect
19 the inspectors to access it from the fields in
20 the other places but none of the other users.
21 Everybody in the system, they have their own
22 user name and password to get into the system
23 and we have all these guidelines which alert me

1 and the company president about every single
2 thing, not just for the Pharmacy Board but we
3 have that running for every single client and we
4 give everyone dedicated walls, so that if --
5 let's say client A gets hacked, you are going to
6 be safe because you have your own walls and you
7 have your own pad, so we keep each client in
8 their own pad. So that way if we have all this
9 software running and the alert thinks that it's
10 an activity, that's not unusual.

11 DR. MARTIN: Okay. Have you had any
12 intrusions?

13 MR. RAJARAM: Not at all. With the
14 Nursing Board, we hosted it internally for them
15 and they -- the only time that I have come
16 across any problem was when the State system was
17 hacked from outside, not their own -- not the
18 actual thing that we ended up posting for them
19 but the State system was hacked but nothing was
20 compromised, no data or anything. To act on
21 that point with data security, we don't store
22 social security number, date of birth, or credit
23 card information or anything to the database

1 because what happens is when you process a
2 payment, the credit card number is actually sent
3 on the fly to the processing agency to send back
4 saying yes, it's valid or it's not valid. We
5 don't store the credit card information
6 anywhere. It's done on the fly and the social
7 and date of birth, yes, need to store it for
8 reporting our data on those purposes but the way
9 that it is stored is encrypted and the system
10 knows to decrypt and give it back to the users
11 on the screen but we have some logic that I'm
12 not going to give out where the format of the
13 social security number is not going to be the
14 typical nine-digit number that you'd expect.
15 It's going to be like a 135-digit number and we
16 know the programming logic that we need to look
17 for to bring that out of the screen. The same
18 applies for data or any other sensitive
19 information.

20 DR. MARTIN: I was going ask you about
21 redundancy. I think you already answered that
22 when you were talking about the multiservers.

23 MR. RAJARAM: Yeah, we've got -- we've

1 got multiple players pretty much. So let's say
2 one -- it's as simple as one box sitting over
3 there with multiple copies of the data and the
4 code and a similar box sitting at a different
5 office location where this one goes out, we will
6 be able to turn you back to this one.

7 DR. MARTIN: Did you say you have
8 backup at a different physical location?

9 MR. RAJARAM: Yes, my boss has -- the
10 company has physical servers in locations in
11 Lake Mary and he has us hosting services with a
12 different company I guess called Go Daddy, which
13 also has a location in Atlanta, Lake Mary,
14 around that area, so we've got two different
15 copies and what happens is your data is actually
16 going to reside in one of those two places but
17 the code, since we own the code and we hand it
18 over to you, we got developers their own backup
19 and security mechanism.

20 DR. MARTIN: So if you had a crisis at
21 one site, our business continuity wouldn't be an
22 issue?

23 MR. RAJARAM: It wouldn't be an issue,

1 I mean, unless like two different locations have
2 the same type of problem going on at the same
3 time, and even if it's one location, the chances
4 are that it's going to be box specific.

5 DR. MARTIN: Sure.

6 MR. RAJARAM: Not when you have two
7 different rooms and two different boxes are
8 staying over there unless it's something massive
9 like a fire.

10 DR. MARTIN: Yeah.

11 MR. RAJARAM: I wouldn't expect -- and
12 even in terms of fire, we have the code and all
13 of those things sitting in a separate room so
14 extremely unlikely. Nursing, like I said, we
15 didn't offer them the full flesh hosting that
16 we're going to do here but he has been doing it
17 for county agencies in Mobile and in Baldwin,
18 Jefferson. I haven't had any sort of breach so
19 far.

20 DR. MARTIN: If the system is
21 compromised in some way and there's claimed
22 damage, do you experience any of the liability
23 or is that ours?

1 MR. RAJARAM: He's got the insurance
2 to cover, you know, for those things like the
3 standard contract insurance to offer. I don't
4 have the details on me yet right now but yes, we
5 do have other solutions where the liability is
6 actually covered as part of the insurance.

7 DR. MARTIN: Thank you.

8 MR. RAJARAM: Anything?

9 MR. WARD: How about changing forms,
10 is that going to be a big deal?

11 DR. ALVERSON: What, to come up with a
12 different form?

13 MR. WARD: We've been talking about
14 adding stuff to our forms.

15 DR. ALVERSON: Right.

16 MR. WARD: Is that going to be an
17 ordeal with any of these people like it is with
18 most of the others?

19 DR. ALVERSON: No. We are, and
20 correct me if I misspeak here, Gokul, but right
21 now we are putting in what we have rather than
22 trying to redo every form before they put it in
23 and then we will have a year for free to make

1 minor adaptations. If we decide to do a major
2 rewrite, then we would have to contract for
3 that.

4 MR. WARD: Well, so if we decide to
5 add, for example, in a year and a half list
6 sterile compounding -- list drugs you sterile
7 compound.

8 DR. ALVERSON: Right.

9 MR. WARD: That's one line.

10 DR. ALVERSON: Right.

11 MR. WARD: Do you have to pay for
12 that?

13 DR. ALVERSON: No.

14 MR. RAJARAM: Are you talking about
15 adding a line to a letter, for example?

16 MR. WARD: No, we have applications
17 that have --

18 DR. ALVERSON: Do an application.

19 MR. WARD: -- renewal forms and
20 they're works in -- we're always -- we're
21 updating them making them better.

22 MR. RAJARAM: No, you don't have to --
23 you don't even have to call me to do that.

1 MR. WARD: We can do it here?

2 MR. RAJARAM: You can do it in house
3 by yourself because you'll get access to all of
4 that.

5 MR. WARD: Wonderful.

6 MR. RAJARAM: You were right, Susan,
7 there's little to correct or add to what she
8 said, the day that we release the data system,
9 from that day you get a one-year warranty where
10 you can add for any sort of bugs. I wouldn't
11 expect that because even before we go live on
12 the system, there's going to be like -- for
13 example, I've given Eddie and his team the
14 inspection forms already. They've got between
15 now and September to tell me whatever is wrong
16 with it, so I'm going to be doing that with all
17 the editions so you will have at least a couple
18 of months to play with everything that they're
19 going to use and tell me ahead of time what's
20 wrong and what's not going right but then nobody
21 is perfect. I'm not perfect. My programmer is
22 not and I never expect the users to pass
23 everything on the first instance either, which

1 is why we offer one year for you all to continue
2 to track any sort of bugs or minor changes, we
3 usually take all those things but I mean, the
4 example that he was talking about like making
5 a -- adding a line to a new form, all of those
6 things are going to be served under the -- you
7 just make the changes without even talking about
8 it and once the one-year period ends, the tools
9 and everything that are going to be available
10 for someone like Terry to make minor changes to,
11 but let's say that it's a brand new division
12 that you want to add to the system then yes,
13 that's going to be something that we have to
14 talk in terms of a maintenance contract or an
15 engagement where I just come in and say, okay,
16 here is the work that is going to entail for
17 this particular thing and here is the number of
18 hours, here's the dollar cost for it, let me
19 know what it is.

20 And Susan would -- I'm pretty sure
21 Susan remembers before we started the engagement
22 putting everything into writing, I spent quite a
23 bit of time even before we had the contract to

1 know what it is that you all want and then gave
2 the prices to her. So in other words, what I'm
3 saying is the analysis that I'm going to do to
4 find out how much it's going to take in terms of
5 dollar and time is going to be free of charge
6 for you. So you want me to do something, you're
7 going to come in and understand what is it that
8 I need to do with my team, we are not going to
9 charge for that effort.

10 Now, once I say here is how much it's
11 going to take and you say, yes, go ahead and do
12 it, that's when we bill. We charge by basically
13 what we call the options model. We give you the
14 options. We tell you what it's going to entail.
15 You get to decide.

16 MR. DARBY: This might be a better
17 question for Susan but how many people and who
18 will be trained to make these changes?

19 DR. ALVERSON: When it comes to
20 something that would be seen by multiple people,
21 I would like the director for each division to
22 be trained and everything would have to be
23 approved by the director of that division, just

1 so we don't have, you know, somebody thinking,
2 oh, it would be a great idea if we -- not
3 realizing it would affect everybody else so.

4 MR. DARBY: There will be multiple
5 people trained so.

6 DR. ALVERSON: Oh, definitely,
7 right.

8 MR. BUNCH: We can change the forms
9 after -- after you turn it over to us, we can go
10 in and change --

11 MR. RAJARAM: Change.

12 MR. BUNCH: -- all of them without
13 contacting you and all, just if we had to add
14 and you said something came about we had to add
15 a new division or something, then we would bring
16 you in to write that program.

17 MR. RAJARAM: Yeah, you are right.
18 Anything that's going to require -- it's hard
19 for me to categorize it right now but in my --
20 more like anything that's going to require
21 extensive work is going to be options, the cost
22 analysis that I told you about, but changing a
23 few things here and there or let's say Terry

1 picks it up and he's able to make changes to the
2 system, you all are free to do that because
3 you're going to own the source code and the data
4 but the examples that he was talking about
5 earlier were making minor changes that really
6 aren't doing programming. All you have to do is
7 like just locate the form that you're talking
8 about and make the changes to the form and save
9 it, as simple as a Word document, for example.

10 MR. BUNCH: Right, good.

11 MS. YEATMAN: So you said it will
12 integrate with other systems, so if we implement
13 background checks, that's not going to be an
14 issue to have that?

15 MR. RAJARAM: Perfect. I'm glad that
16 you brought it up. That's going to be part of
17 the post analysis effort because I wouldn't know
18 what that's going to entail so you have to tell
19 me which is the agency that you're going to
20 partner with for the background check. So I
21 need to get in touch with someone from that
22 agency and see, okay, any sort of software like
23 this one, if somebody wants data from our

1 system, we'll be able to give them the data.
2 The same thing has to come from them because
3 it's got to be by direction. So if you put me
4 up with the agency, then you talk with them and
5 figure out how is it that we prevent the systems
6 stop, then yes, that's going to be part of a
7 bigger effort that we talked about but yes, it's
8 doable but it's going to entail some analysis as
9 well and then come back and say, okay, here is
10 what it's going to cost you.

11 MS. YEATMAN: Okay. And you said
12 obviously the inspectors will be able to put in
13 their complaints and all of that. Will it be a
14 way for us to track particular individual
15 pharmacists and will it log -- if I wanted to
16 know how many complaints an individual had, will
17 it be able to search that information?

18 MR. RAJARAM: Yes, and it's going to
19 depend on whether you have access to the
20 internal system. I mean, yes, I --

21 MS. YEATMAN: Oh, I don't mean for me.
22 I mean for them.

23 MR. RAJARAM: Yes, they will be able

1 to do it, yes. Yeah, the answer is yes.

2 DR. ALVERSON: Could you comment about
3 reports because that was a big deal for us. We
4 wanted to know if an inspector were in a certain
5 county and wanted to say, how many hospitals are
6 in this county that I might want to inspect, so
7 would you comment on getting reports. We're
8 required to send a report annually to the
9 pharmacy association with certain information.

10 MR. RAJARAM: Yeah, for the reports,
11 the way that I usually like to do it is get a
12 list as much as possible before we get to the
13 engagement's end, so that's why I spent the time
14 here in talking with Eddie and Rhonda and their
15 team and I collected a list of forms and reports
16 and everything that they wanted here and I
17 consolidated all of those things here for my
18 team. So for example, you could see that here
19 are the certificates that the system needs to
20 send out, so all of these things are going to be
21 prepackaged in the system. So the reports and
22 letters, for example, this is the part that we
23 have now that we are comfortable with, the

1 enforcement only forms, they gave me the samples
2 of the enforcement forms that are right now in
3 the paper format and we take that and put that
4 into the system pretty much.

5 So all of those reports and everything
6 that she's talking about, I would like to
7 prepackage as much as possible into the existing
8 scope of work so that I can plan it and deliver
9 it and I could spend the time that they did give
10 me the samples and the type of reports that they
11 would want but anything that's not in this as
12 part of the prepackaged product could be done
13 using that report that I was talking about.

14 So it gets back to your point of who's
15 going to be the user that would maintain it. So
16 once Susan identifies those users, I'm assuming
17 given what I know right now, the reporting tool
18 is something that Terry is probably going to be
19 doing behind the scenes because he can use those
20 tools and produce the reports that he wants
21 versus division specific anything that's got to
22 do with rules and got to be approved will
23 probably be going through Eddie and Rhonda but

1 anything that needs to be pulled from the
2 existing data could be done by Terry. All he
3 would have to do is just find out the source and
4 say, give me these data fields for the
5 reports.

6 DR. MARTIN: So I know that internally
7 we would have to have a discussion about who
8 would have what access and it would be someone
9 who would oversee the security levels but let's
10 say that perhaps the Board members were given
11 access to certain modules in the system, we
12 could do that through VPN or some other
13 connection.

14 MR. RAJARAM: Yeah, I mean, like it's
15 going to depend on how we end up hosting it
16 eventually.

17 DR. MARTIN: Yeah.

18 MR. RAJARAM: It might be a VPN
19 connection or it might just be a direct
20 connection that it have to pass through two
21 different servers.

22 DR. MARTIN: Sent directly to the
23 host?

1 MR. RAJARAM: Yeah, directly to the
2 host.

3 DR. MARTIN: Okay.

4 MR. RAJARAM: But in addition to the
5 system login page, we'd probably -- what we've
6 done is to adjust the system login page that
7 anybody could know the password and login. We
8 usually have this done even before this point,
9 the agency that you belong to, so it had to go
10 through -- if it's a data link, like what is
11 used in addition to this login page, we would
12 ask you credentials about the board that you are
13 from because we handle it for multiple boards
14 and multiple places.

15 DR. MARTIN: Okay.

16 MR. RAJARAM: So we would have to --
17 I'll put it this way: If Susan gives me the
18 list of all people that should have access to
19 the system and in the future, we're going to
20 load that into the system.

21 DR. MARTIN: Thank you.

22 DR. ALVERSON: There's a place in the
23 system too where we can list everybody who would

1 have access and then we can check certain
2 columns. This person, yes or no, can look at
3 complaints. This person, yes or no, can look at
4 controlled substances.

5 MR. RAJARAM: That's the screen that
6 she's talking about. This is just a sample.
7 These are different types of users in the
8 system.

9 DR. ALVERSON: Pardon? Electronic.

10 MR. RAJARAM: I'm sorry?

11 DR. MARTIN: Go ahead.

12 MR. RAJARAM: Yeah, so this is the
13 screen that Susan was talking about earlier
14 about these columns are going to be -- I mean,
15 the values that you find in this column, they
16 are going to be the user types, so you have a
17 licensing user, legal, board member, whatever
18 user type and this one decides what to have
19 access to. So all you would need to do is tell
20 me how you want to split it this way. Like you
21 said, you're going the right direction as to you
22 would have to decide what are the different
23 types and what is it that they need to have and

1 all you need to do is basically just give me the
2 metrics and we can change that at any point in
3 the future by just clicking the editor.

4 DR. ALVERSON: Jim was mentioning
5 electronic signatures.

6 MR. RAJARAM: Yeah, we thought of that
7 already.

8 MR. WARD: It's on there?

9 MR. RAJARAM: Yeah. All right. I
10 don't know how much time I still have left but
11 I'll just quickly run through the inspection
12 forms that we completed development of and I did
13 the demonstration for Eddie and his team
14 yesterday. We have the links for them to use
15 for the next, what, April, May, June, July,
16 August, five months. So the forms -- the first
17 thing that we did was since we didn't -- I
18 personally didn't know too much about what was
19 being collected on the form.

20 The first thing that I asked my people
21 to do was, okay, just give me an electronic form
22 of the existing document. Don't think anything
23 about making it better, just give me what is

1 there in the Word document, so they did that and
2 then they gave me several different links to
3 new -- for some of the inspection forms and then
4 I had a quick talk with Eddie and I did an
5 online demo to them and said, here's what we've
6 got, now my intention is not to just reproduce
7 what you've got. The goal here is to make
8 everything better, to make everything electronic
9 and more efficient.

10 So we took out a lot of things that
11 are not going to required for the investigators
12 to type in every single time and even
13 these fields -- what's going to happen is once
14 we've created that internal system that we
15 talked about, the inspectors will just have to
16 type in the license number of the pharmacy.
17 Everything else is going to be preordered from
18 the system based on information that we've got.
19 So that's going to save them a lot of time but
20 to begin with, I'm just asking them to type in
21 as much information as possible because we need
22 to collect the data first.

23 So I'm in -- we might not know who's

1 the pharmacist but once we build the data, we'll
2 pull everything from the system but to begin
3 with, they might have to type in a few more than
4 in the future.

5 And then every single section of the
6 Word document, we have divided that into
7 multiple tabs and if they want to skip a
8 section, they can just click on this and say,
9 okay, nothing is applicable or they can click on
10 this, they can type in some more comments about
11 the question and the way that this thing is
12 structured is it would let you move to the
13 previous step but it won't let you go to the
14 next step until you have done what it is that
15 you have to do in the particular section.

16 So right now I've answered -- the
17 green mark is basically telling me I've
18 completed it so it's -- in terms of the
19 interface, you get used to one form, they could
20 use all the other seven forms. Every single one
21 of them is going to be exactly like this and the
22 way that we try to keep using interfaces, we try
23 to give the same interface to the internal users

1 like the inspectors as the licensees who are
2 going to do something like renewal, so that when
3 somebody gets stuck and says, hey, I'm stuck in
4 this tab, I don't know how to move on, people
5 here have actually used those forms. All
6 they're going to say is just go and hit the
7 next, as simple as that.

8 So I mean, like most -- like, for
9 example, I tried to click the next year. It's
10 going to tell me to please answer all the
11 questions. It's not going to let me move on
12 until I answer this question and then I can just
13 forward through that and they -- the inspectors,
14 they had the option to view what is it that they
15 have done, just like a review before they submit
16 it and the design is going to be the same for
17 license renewals, initial application, and
18 everything.

19 We give the user the chance to see
20 what they have done, correct any sort of errors
21 that they might have before they submit it. And
22 once you click on the next, you get the option
23 to type any comments from inspectors and what's

1 going to happen behind the scenes with this is
2 right now I think Patti has to do some sort of
3 scanning work I think and she has to do
4 something with a Word document. This interface
5 is going to replace all of that. This is going
6 to be used by the inspectors outside if they
7 need to refer to something as for the people
8 inside the agency to take a look at what
9 inspection form has been done on what particular
10 date or range.

11 So for example, I test form on this
12 date for 795 and that's going to tell you what's
13 the pharmacy and for whom the inspection has
14 already been done. You'll be able to print that
15 and that's going to give you a PDF that you can
16 print on email or whatever you want to do with
17 it. So that's -- and the data basically that
18 they do while they're in the field, which they
19 have to log in to so that everybody doesn't do
20 the inspection report, you're going to set them
21 up each with a user name and password that they
22 can share with the other inspectors if they need
23 to but the system is going to give them their

1 own user name and password that they can submit
2 the reports and then that gets transferred to
3 the agency right away. There is no need to
4 transfer any work.

5 You type the inspection form once and
6 then it gives them the PDF, they can email that
7 to the pharmacist or the pharmacy, anybody who
8 is out there, have them sign it if they need to
9 and so on but as electronic as possible, the
10 information gets loaded to the system via that.

11 So that's -- and every single form,
12 every other inspection form has been the same
13 way and once I leave the room, you can probably
14 ask Eddie how it is, so.

15 DR. MARTIN: Do you anticipate that
16 any changes we would be making we'd be making in
17 the live system? Do we need a test system? Do
18 you have the test system?

19 MR. RAJARAM: Yeah, that's what --
20 like I said, this is sitting on the test server
21 right now, not your data is sitting out there so
22 you all are free to test this as much as you
23 want and they have the links to do the same

1 thing. Once we bring the data, for example,
2 from GL for licensing division, what you're
3 going to do is take the sample data and then
4 look at the structure but not load the actual
5 data on the test server. We don't want to
6 expose the data on the test server but we look
7 at the structure --

8 DR. MARTIN: Yeah.

9 MR. RAJARAM: -- and lured our proper
10 test data for the users in this link. They all
11 can actually start using the internal licensing
12 system just the same way that Eddie and his team
13 are going to start using the inspection form
14 ahead of time. So the goal is to give at least
15 every division like two months to get used to
16 the system and the reason that we not go to
17 inspectors first is two-fold.

18 One is Susan was extremely concerned
19 with the inspectors, so that was my first place
20 to get started with them and say, yes, we could
21 do it. So we did that and the other reason that
22 I chose to do the inspection form first before
23 the licensing and the internal complaints and

1 all of those things is we didn't have the data
2 to begin with and Susan had to work with them to
3 get the data and then the time that we had the
4 data, my people are already halfway through
5 this, so I said, let's go ahead and lock this up
6 and then try to move the data internally to see
7 how that's going to come in.

8 So what's going to happen just to give
9 a road map, since we are at the end of March
10 right, I know this, April is the month that I
11 expect to bring most of the data that's in the
12 current system to our database in terms of
13 structure, not the actual data, and then that's
14 the time that probably I guess it's got to be
15 Susan, me, and Rhonda where I have to present
16 them a few things about how the data is, what is
17 it that can be brought in, what is it that
18 cannot be brought in, if it's badly maintained
19 data, for example, or if something that they had
20 is not in our system, then I'm going to go back
21 and add those into our system. So that's
22 basically the process where we make sure that
23 anything that you've got right now is going to

1 be transferred into the new system, so that's
2 the plan for April. And then the month of May
3 you're going to be putting all the letters and
4 the forms and setting up the users and all of
5 those things. So June -- middle of June, July,
6 August, everybody will have the entire system to
7 hammer pretty much.

8 DR. MARTIN: What happens if somebody
9 comes along and thinks that Cyberbest is an
10 incredibly good system, they offer you a small
11 fortune to buy you and all of a sudden we're not
12 working with Cyberbest and we're working with
13 someone else?

14 MR. RAJARAM: I don't get you, I'm
15 sorry.

16 DR. MARTIN: You're bought out.

17 MR. RAJARAM: The company?

18 DR. MARTIN: Yeah, and you get to
19 retire because you made so much money.

20 MR. RAJARAM: I don't know. That was
21 one of the repeated questions from Susan I
22 think, what if -- what if I leave the company
23 because I'm the point of contact and I'm still

1 here after six years so I don't think my boss
2 has any intention of selling the company because
3 more -- more than -- like I said, more than the
4 money factor is the relationship that he has
5 built toward the State with all the different
6 state agencies and everything.

7 DR. MARTIN: Yeah.

8 MR. RAJARAM: I don't ever see it as
9 being a -- like stepping out of what we are
10 doing, which is working with the state and
11 county offices.

12 DR. MARTIN: The last time somebody
13 told me that, they were sold within two weeks.

14 MR. RAJARAM: Seventeen years, 17
15 years, I mean, I would bet it's not going to be
16 sold. So I mean, history -- history is the
17 reference for me there.

18 MR. WARD: Did you ever hear the
19 expression everything is for sale?

20 MR. RAJARAM: But that's a good thing
21 for me to actually talk with my boss about on my
22 way back home and say, hey, what if you get
23 bought out and he's going to be like, what are

1 you, out of your mind? No, that came from the
2 Board.

3 DR. MARTIN: That may not be part of
4 your continuity plan but that happened to be
5 part of our continuity plan.

6 MR. RAJARAM: Yeah, I agree, and I
7 mean, that's the way the return contract or
8 anything at least in the employee level, I
9 haven't signed anything. It's the company that
10 has signed it so the personnel you don't have to
11 worry about it but at the company level, I don't
12 think I have the answer to that question, what
13 if my boss decides to bail out tomorrow, then my
14 honest answer is then I'm going to be having to
15 be -- I'm trying to answer you.

16 DR. MARTIN: We just needed it to be
17 on the record.

18 MR. RAJARAM: Yeah, then I would be
19 like, well, my hair is on fire to answer, wait.
20 Anything else?

21 MR. MCCONAGHY: I think what Susan and
22 Tim were probably both trying to get around to
23 is we need an exit strategy because so far we're

1 0 for two on databases --

2 MR. RAJARAM: Yeah.

3 MR. MCCONAGHY: -- and you will be the
4 third and what we need to know is for some
5 reason it doesn't work out, are you going to be
6 able to give us a memory stick that we can take
7 to somebody else --

8 MR. RAJARAM: Yeah, that's part --

9 MR. MCCONAGHY: -- to convert that
10 system over to that?

11 MR. RAJARAM: Yeah, that's part of the
12 contract. That's why I said you own the source
13 code so we give you everything that we have done
14 and the expression that I like to use to all my
15 clients who ask for this in writing is you have
16 the option but not the obligation to retain us.
17 So once we complete the engagement, you don't
18 like me or you don't like anyone else, go ahead,
19 you're free to -- and that's -- in my opinion,
20 that's the value that you get for the dollars
21 that you're paying me already. Like I said, I'm
22 going to do absolutely nothing with the source
23 code that I'm customizing for you. What am I

1 going to do with the enforcement forms.

2 DR. MARTIN: Do you need a motion,
3 Susan, or is this just information?

4 MR. MCCONAGHY: I don't think we need
5 anything.

6 MR. WARD: We need to see the contract
7 then you move.

8 DR. ALVERSON: You guys did.

9 MR. WARD: Huh?

10 MS. YEATMAN: We already did.

11 DR. ALVERSON: You already did see the
12 contract but I'll be glad to get it for you
13 again.

14 MR. WARD: That's fine if they've seen
15 it. You need to do a motion to give Dan the
16 authority to bind.

17 I haven't seen it. Joe has been doing
18 it. Who's the signatory for the Board?

19 DR. ALVERSON: So far I'm the only one
20 who has signed an up-front agreement but
21 obviously I don't have the ability to sign and
22 commit us long term so.

23 MR. WARD: But that contract has been

1 sent -- the long-term, permanent contract?

2 DR. ALVERSON: Yes, we have a copy of
3 it.

4 MR. WARD: Who's the signatory on
5 that?

6 DR. ALVERSON: I don't know. Tell me
7 who it should be.

8 MR. WARD: I'm just going to say there
9 needs to be a motion to give the authority to
10 whoever is going to sign it to sign it, probably
11 Dan.

12 DR. ALVERSON: Mitzi knows more about
13 all of that than I do.

14 MS. ELLENBURG: It's usually the
15 president of the Board who has the most
16 authority.

17 MR. WARD: Somebody needs to make a
18 motion to authorize Dan as the president to sign
19 the contract.

20 MR. DARBY: I'll make a motion that
21 the president of the Board, Dan McConaghy, has
22 the authority to sign the contract with
23 Cyberbest.

1 MR. BUNCH: I second that.

2 MS. YEATMAN: Second.

3 MR. MCCONAGHY: All in favor?

4 DR. MARTIN: Aye.

5 MR. DARBY: Aye.

6 MS. YEATMAN: Aye.

7 MR. BUNCH: Aye.

8 MR. MCCONAGHY: All opposed?

9 (No response.)

10 MR. MCCONAGHY: Is that all you got?

11 MR. RAJARAM: I could keep talking if
12 you want me to but I don't want to -- I don't
13 want to scare them.

14 DR. ALVERSON: Rhonda asked if she
15 could make a comment and I said yes, most
16 certainly.

17 MS. COKER: I just want to say that so
18 far this company has done more in the few months
19 that they have been working with us than the
20 prior database did in two years. And you know,
21 when we say something like, can you change a
22 word, they're like, well of course, we can
23 change a word. But when we've been asking these

1 other companies, you know, they're like no,
2 we're going to put a task out there, you know,
3 to charge you if you want to change a word.

4 So I mean, personally I'm excited to
5 have somebody that actually looks like they know
6 what they're doing, you know, that they're
7 not -- so what we've seen so far has been very
8 positive and what we saw at the Nursing Board
9 was very positive and one thing, the Nursing
10 Board approached us. Cyberbest did not approach
11 us. The Nursing Board approached us and they
12 said, hey, look, this is what we've got, you
13 know, let -- we're excited, we want you to look
14 at it and see what we've got, so that's just my
15 own personal opinion for what it's worth.

16 MR. BUNCH: That means a lot because
17 y'all are in the trenches doing it, so that's
18 good information.

19 MR. MCCONAGHY: Yeah, we're never
20 going to look at the system so.

21 MS. COKER: Well, take it from
22 somebody that actually works in the office, you
23 know.

1 MR. MCCONAGHY: We're just going to
2 complain if it doesn't work right.

3 DR. ALVERSON: Yes, and I'm sure
4 you'll be glad to not have me complain every
5 board meeting.

6 MR. BRADEN: And as Gokul said, he
7 showed us some of the test models yesterday.
8 Some of the inspectors were able to look at it
9 and they were all excited about it. It's been
10 very tedious out in the field with this past
11 system and they're excited. I'm excited about a
12 keep-it-simple, end-user ease to use the
13 system.

14 MR. BUNCH: That's good.

15 DR. MARTIN: Thank you.

16 MR. DARBY: Thanks.

17 MR. RAJARAM: Thank you.

18 DR. ALVERSON: Thank you very much.
19 Have a good trip back.

20 MR. MCCONAGHY: We've got Rick
21 Stephens as the next presentation on there. I
22 hope he's not doing all of it so you brought
23 your team.

1 MR. STEPHENS: I'm going to bring
2 somebody with me here.

3 MR. MCCONAGHY: Okay.

4 MR. STEPHENS: I want to thank the
5 Board for the opportunity and the time on your
6 agenda for us to be here and also thank you for
7 the rule change that you had the hearing on and
8 that's kind of what brings us here is the rule
9 change that changed the limitations in long-term
10 care stat boxes and we are really doing what
11 y'all are doing right now. We're looking at
12 technology that can help us in doing some of the
13 things we've got to do.

14 A little bit of background, long-term
15 care, we all know people are being admitted to
16 nursing facilities with higher acuity. They're
17 there for rehab of some serious and extensive
18 surgeries, joint replacements, that kind of
19 thing, and they come in at all hours of the day
20 and night literally. They come in with
21 complicated medication regimens and most
22 long-term care pharmacies are at a distance from
23 the facility they serve, so there's a time lag

1 there in getting them set up.

2 And right now the way the system works
3 and is serviced, it's called a tackle box system
4 and -- or a stat box and it literally is a
5 tackle box. You can take the drugs out and put
6 your hooks in and go fishing if you wanted to,
7 so what we have looked at, and it wouldn't be
8 every facility necessarily that would need this
9 extended inventory of drugs but some facilities
10 do have need for more than the old rule allowed
11 us. But in doing that, we want to manage that
12 better. We want to have it secure. We want it
13 to be accountable and what we've found is that
14 technology can help us do that.

15 I want to say one word and then I'm
16 not going to say it again in that what we
17 consider our system, just as it says an
18 electronic e-kit, it's not an automated
19 dispensing system. I know the Board is looking
20 at that as another issue and we don't want it
21 confused. We're not really talking about that
22 issue. We're talking about using our present
23 system that's essentially a manual paper and pen

1 system and doing something that has security,
2 has accountability, has pharmacist oversight.

3 Now, the system that we have looked at
4 and chosen is by Pyxis Cubex and I'm going to
5 hush just a minute and let Scott Kruse from that
6 company show you. Believe me, it's a brief
7 PowerPoint and then if you have questions after
8 that we'll -- we'll talk. Scott.

9 MR. KRUSE: Excellent. Good morning,
10 everybody. Thank you for your time this
11 morning.

12 So as Rick said, why are they -- he's
13 already explained why they're looking at taking
14 the current tackle box system, which is very
15 manual, has a lot of if you will holes in it and
16 missed opportunities for accountability and in
17 looking at their ability to increase the
18 pharmacist control in emergency medication
19 administration at their homes. They want to
20 obviously ensure the regulatory compliance of
21 the DEA and the state board of pharmacy and most
22 importantly enhance the safety and reduce the
23 risk for their patients.

1 So today when a script comes in and
2 it's for an emergency situation, they get the
3 approval, they open the tackle box, they get the
4 medication for the patient. That's -- that's
5 their core focus but the pharmacy doesn't get a
6 chance to verify that until that tackle box
7 comes back that. That could be 24 hours. That
8 could be 48 hours or even longer so that -- so
9 that accountability of that information can be
10 potentially days after, where they might find a
11 discrepancy, they might find a situation where
12 it -- the paperwork says two was taken out but
13 there's really three missing and now there's a
14 whole process for them to go back to the home
15 and figure out who else had access to it, was it
16 another patient, a lot of opportunity for -- for
17 risk in that situation. So again, what Rick
18 said is they're looking to take, you know, the
19 current tackle box system and automate it.

20 So how does Cubex cases work. So we
21 developed a closed-loop process that helps the
22 pharmacy control everything -- control really
23 everything from the pharmacy itself and if I

1 divide the screens in half, the bottom half
2 represents the home so we place an electronic
3 device at the home. It has a biofingerprint ID
4 so I know when the nurse locks in. I know who
5 you are, do you have access to the device or
6 not. It then comes up because we're interfacing
7 automatically with the pharmacy information
8 management system, I know what patients are in
9 the home.

10 So the very next screen that comes up
11 is Ms. Smith and the list of other patients. So
12 I log in, I chose the patient, and then I have
13 access to the drugs that have already been
14 prescribed for her in this emergency situation.
15 I choose the drug, one drawer opens, and then
16 one lid for that one medication is given access
17 to that nurse. That is the -- that's the level
18 of accountability that we're giving at the home.
19 I know when they're taking it. I know what
20 they're getting access to and I know -- and then
21 the pharmacy is immediately notified
22 electronically via the system.

23 Any questions from the home

1 standpoint, very similar to --

2 DR. MARTIN: Give us a just an idea of
3 what constitutes an emergency.

4 MR. KRUSE: An emergency, so -- and
5 you will help me out so.

6 MR. STEPHENS: Well, remember,
7 emergency/ first dose. So in some cases, there
8 may be a need -- a situation that's an emergency
9 situation, blood pressure issue or something of
10 that sort, could be glucose issue, you need to
11 get an insulin out that the patient hadn't been
12 prescribed, for example. The physician would
13 write an order.

14 What we would foresee as big a use if
15 not more again is that first dose start. The
16 patient comes in, presents at the nursing home
17 at nine o'clock at night with 15 drugs and we're
18 going to supply them the next day but they may
19 have three bedtime doses and a morning dose that
20 we can't get there for them. Presently, if
21 they -- if it's within their 50-item tackle box,
22 they can go to that and get it or they would
23 call the pharmacy or the after-hours service and

1 arrange for backup in a pharmacy near that town,
2 providing there is one that's open.

3 DR. MARTIN: Right.

4 MR. STEPHENS: Not all places have 24-
5 hour pharmacies.

6 MR. KRUSE: So again, from a home
7 standpoint, they now have the comfort level.
8 They go to the system. They log in. They know
9 immediately, the pharmacy knows who's getting
10 access and what medication is being taken for
11 what patient and that's being logged and then
12 the pharmacy has realtime access to that
13 verification of that. What we've also done from
14 a pharmacist standpoint is given them the
15 control starting at the pharmacy. So today the
16 whole tackle box comes back, someone rifles
17 through it, verifies what they said was taken.
18 With Cubex, we actually load what these --
19 what's called a Cubie pocket at the pharmacy
20 because I get an electronic notification that
21 the home used these three meds or these five
22 meds, I need to replace it. So I'm notified. I
23 put -- I refill a new Cubie pocket at the

1 pharmacy. The pharmacist has the chance to
2 verify it. A bar code is slid inside it and
3 the -- there's a microchip at the bottom of this
4 that is programmed for that home, for that
5 drawer, for that pocket.

6 So when it leaves the pharmacy, it's
7 sealed, tamper evident, and I can't accidentally
8 send it to the wrong home. I can't accidentally
9 put it in the wrong pocket so it goes along with
10 tomorrow's driver that's on the normal med call
11 run and that bar code that is in here, on its
12 way there, is scanned, the drawer automatically
13 opens. The old one pops out, the new one pops
14 in, and what's key is during that process, no
15 one touched the meds after the pharmacist did
16 the verification. It could be 30 miles away.
17 It could be 150 miles away. They are in
18 complete control of the transfer and the
19 delivery and the exchange of the meds with the
20 old pocket that is now being sent back.

21 MR. DARBY: Who actually loads the
22 machine?

23 MR. KRUSE: Typically a pharmacist

1 tech does the process of the loading and then it
2 sits there --

3 MR. STEPHENS: You're talking about at
4 the facility though?

5 MR. DARBY: At the facility.

6 MR. KRUSE: Oh, I'm sorry, at the
7 facility?

8 MR. STEPHENS: Yeah.

9 MR. KRUSE: Usually because of the
10 security of this and the transport and then no
11 one touching it when it goes in the pocket,
12 usually we're given the approval or a nurse is
13 actually given the opportunity to do that which
14 helps pharmacy out because it's -- again, no one
15 is -- no one is touching the meds during this
16 process.

17 MR. STEPHENS: Generally on each shift
18 there will be one nurse that has a key to the
19 med room and it would probably be that nurse.

20 MR. WARD: How many -- how many drugs
21 are we talking about?

22 MR. STEPHENS: How many drugs are
23 what?

1 MR. WARD: How many different kinds
2 are in these things?

3 MR. STEPHENS: Well, I mean, the rule
4 change limited that to 50.

5 MR. WARD: Right.

6 MR. STEPHENS: Now there's no limit.
7 But now, it's not what we want to send, it's
8 what the facility and their medical director
9 want to decide on, you know. This is kind of
10 new ground so I would be hard pressed to say it
11 will be 85, 75, or whatever, but it would be a
12 decision that's signed off by the director of
13 nursing, the medical director, and the
14 pharmacy.

15 MS. YEATMAN: So how many doses are
16 going to be in each Cubie pocket?

17 MR. KRUSE: The doses again, it's
18 typically dependent on that --

19 MS. YEATMAN: Is it single use per
20 pocket?

21 MR. STEPHENS: No, it would be
22 multiple doses. Right now, for example in a
23 tackle box, one little segment there probably

1 would have three to six, maybe ten maximum on
2 something but if somebody needs to start an
3 antibiotic, for example, and it would be a day
4 to get there, if it's a q.i.d. antibiotic, you'd
5 need obviously four in there and so those --
6 right now, the homes have set those numbers that
7 they want this many.

8 MS. YEATMAN: Right.

9 MR. STEPHENS: And you know, in
10 changing over to this, we would use their
11 numbers.

12 MS. YEATMAN: So there is a potential
13 much like the tackle box, the nurse scans it,
14 opens it up.

15 MR. STEPHENS: And get more than
16 one.

17 MS. YEATMAN: And get more than one.

18 MR. KRUSE: That's a great question.

19 MS. YEATMAN: So you're still going to
20 have to have --

21 MR. KRUSE: Well, I'm glad you brought
22 that up because what we -- what we do is we have
23 the ability to turn on a flag that basically

1 creates what we call a blind count back. So in
2 that situation, I might have ten in there and
3 let's say I log in. Before I take it, it forces
4 me to count and so I count my ten and then I
5 take my one and now it knows there's nine in
6 there. So I'm actually writing two records.
7 One is I took one for Ms. Smith. The other is I
8 verified there was ten before I took it.

9 Now, if Rick walks up and he asks for
10 the same drug and he does a blind count back and
11 he counts seven, it might say are you sure
12 because I could hit, you know, the key twice.

13 MS. YEATMAN: Right.

14 MR. KRUSE: But if he puts seven,
15 he'll get his one for Mr. Smith and it will go
16 to six but then we'll have an immediate trigger
17 that's sent back to the pharmacy saying that we
18 have a discrepancy issue and we know immediately
19 that Scott was the one that created it because
20 there might have been, say, 12 in there and the
21 two prior people hit verify 12 and 11. So I
22 have that immediate opportunity for
23 accountability that I don't have with the tackle

1 box today. Once it's opened, I now don't know
2 who else gets access to it but I do know at
3 every step of the stage who said and the
4 quantity that they -- that they counted.

5 MS. YEATMAN: So you said it has the
6 ability to do that. Will that be something
7 you --

8 MR. STEPHENS: That's part of our
9 policy and procedures, yes.

10 MR. KRUSE: That's part of the
11 policy.

12 MR. STEPHENS: And the notification we
13 get now will be more or less immediate, next
14 day. Now, if you go to the system presently
15 used, if somebody does take multiple doses or it
16 doesn't match up with the sheet they'd send
17 back, we change that out once a week so it's a
18 week before we could really know that.

19 MR. WARD: How many does one -- how
20 many does one of those hold, pills?

21 MR. KRUSE: How many pills? So I
22 would say a normal quantity is ten but it could
23 be 20 depending on the type of item or it could

1 be as few as three or four depending on the
2 needs of that home.

3 MR. WARD: So if you just use one, you
4 just bring back one or do you wait to get to
5 five, I mean, just --

6 MR. STEPHENS: Oh, oh, you could set
7 levels in there --

8 MR. KRUSE: Right.

9 MR. STEPHENS: -- that triggers us to
10 know -- let's say it's set up for six. If it's
11 down to two, it can let us know without them
12 having to actually send an order for it.

13 MR. KRUSE: Correct.

14 MR. STEPHENS: So those are some
15 things that the system will allow.

16 DR. MARTIN: Does the discrepancy
17 notice appear on the screen for the user?

18 MR. KRUSE: No, I give them a chance.
19 I will actually ask them, which will be that
20 conscious moment of hey, I'm asking you one more
21 time, are you sure.

22 DR. MARTIN: Yeah, yeah.

23 MR. KRUSE: But then I'll write

1 whatever you type.

2 DR. MARTIN: Yeah. So they pretty
3 much know they're about to create a discrepancy.

4 MR. KRUSE: Yes, they do.

5 DR. MARTIN: And they say whoa, I
6 better slow down and recount.

7 MR. KRUSE: So on one hand, I'm giving
8 that nurse -- that next nurse who is verifying
9 that it's wrong --

10 DR. MARTIN: Right.

11 MR. KRUSE: -- their ability to move
12 on and go back to their patient.

13 DR. MARTIN: Sure.

14 MR. WARD: How many of these do y'all
15 have out?

16 MR. KRUSE: A little over 1,000, close
17 to 1,500 this year.

18 MR. WARD: Have you found anybody
19 smart enough to beat it yet?

20 MR. KRUSE: Well, I will tell you
21 this -- no. The only opportunity to beat it is
22 if we don't turn on the blind count back to --

23 MR. WARD: This is diversion proof?

1 MR. KRUSE: This is diversion --

2 MR. STEPHENS: No, don't go there.

3 She's pecking words down over there and we don't
4 want to go there but.

5 MR. WARD: Do you have any problems
6 with people stealing in your system?

7 MR. KRUSE: There is absolutely the
8 opportunity to take more because the next -- the
9 next person that takes it we will know. Today
10 we don't have, depending on how many nurses are
11 in that facility, I don't know who gets access
12 to that box after and so the diversion, which is
13 potentially seven days later, is a monumental
14 job to go figure it out. If there's diversion,
15 I know the person who actually created it.

16 MS. YEATMAN: Well, let me -- let me
17 challenge you then. So I'm the first nurse and
18 I think it's definitely better but I just want
19 to make sure that we -- we understand.

20 MR. KRUSE: Okay.

21 MS. YEATMAN: If I'm the first
22 nurse -- or maybe I need to understand -- I
23 count it. I say there's ten in there. I

1 withdraw one. My understanding is you said then
2 the system says, okay, if you withdrew one, I
3 subtracted the one, now I have nine.

4 MR. KRUSE: Correct.

5 MS. YEATMAN: But if I'm that second
6 nurse that comes in and I say there's seven,
7 well, I may say there's seven, I just popped a
8 lid, those two, so you really have two people
9 you need look at.

10 DR. MARTIN: That's right.

11 MS. YEATMAN: Because I can say
12 there's none in there when I opened it up and
13 then it's just a he said she said.

14 MR. BUNCH: But what it does --

15 MS. YEATMAN: So I still think it's
16 better but you don't necessarily know --

17 MR. STEPHENS: Because we know when we
18 look at it.

19 MR. WARD: You've narrowed it down.

20 MS. YEATMAN: You've narrowed it down
21 but you don't know for certain which one it
22 is.

23 MR. BUNCH: It's better than the old

1 tackle box but it's not foolproof.

2 MR. KRUSE: You're right, I'm down to
3 two.

4 MS. YEATMAN: So it's not diversion
5 proof but it is a better diagnosis --

6 MR. STEPHENS: More tracking.

7 MS. YEATMAN: -- on who to look for.

8 MR. BUNCH: Yeah.

9 DR. MARTIN: Talk to us a little bit
10 about two things I'd like to know more about.
11 One is when the old cube comes out and the new
12 cube goes in, there could be drugs in the old
13 cube coming OUT.

14 MR. STEPHENS: That's right.

15 MR. KRUSE: That's correct.

16 DR. MARTIN: Talk to us a little bit
17 about the security of that process.

18 MR. KRUSE: So on purpose, I usually
19 set a min higher than zero because I want to
20 have a notification --

21 DR. MARTIN: Sure.

22 MR. KRUSE: So that I can get the new
23 one there.

1 DR. MARTIN: Right. You don't want to
2 stock out.

3 MR. KRUSE: Correct. And I don't --
4 and the reason we created the Cubie exchange is
5 so that I'm not putting different expiration --
6 you know, different -- the same drug with
7 different expirations in the same pocket. It
8 allows the pharmacy to manage expirations much
9 easier from the pharmacy but -- so when the new
10 Cubie gets there, and let's say there's one
11 left, it's essentially a transfer of ownership.
12 So that old Cubie comes out, the system writes
13 essentially a transaction saying the old pocket
14 was removed, one quantity is in there.

15 DR. MARTIN: Yeah.

16 MR. KRUSE: And the pharmacy knows
17 that that Cubie with that particular serial
18 number is on its way back.

19 DR. MARTIN: With the dose that you
20 need.

21 MR. KRUSE: With a dose in there.

22 DR. MARTIN: And so that's the
23 checkpoint back to the pharmacy.

1 MR. KRUSE: That's the checkpoint and
2 that actually goes in the system back at the
3 pharmacy, pops in, it reads it, and that's their
4 opportunity to verify at that point. It says
5 one, there should be one, and if it's not, then
6 we know that that opportunity happened right at
7 the end.

8 DR. MARTIN: The second question I had
9 was you mentioned it had thumb reading
10 capability. Is that -- do you plan to take
11 advantage of that?

12 MR. STEPHENS: As far as I know, yeah.

13 MR. KRUSE: That is used in every
14 installation, there's always a backup. Somebody
15 cuts their finger. Everyone will be given their
16 own personal pin code, which is, you know, kind
17 of a standard for the backup situation.

18 MS. YEATMAN: So you'll also be able
19 to know if someone traditionally or has a habit
20 of not using their fingerprint --

21 MR. STEPHENS: Should, yeah.

22 MS. YEATMAN: -- in case a pin code is
23 compromised.

1 MR. STEPHENS: Would that show up?

2 That I don't know. --

3 DR. MARTIN: You'll know if they --
4 you'll be able to tell if they access this way
5 or this way.

6 MR. KRUSE: Correct.

7 DR. MARTIN: And if your policy says
8 do this and they're doing this, then you can --

9 MR. STEPHENS: We can call them on it.

10 DR. MARTIN: -- take corrective
11 action.

12 MR. STEPHENS: Yeah. I was going
13 to -- you were talking about the swap out of the
14 Cubies and all. There will not only be tracking
15 in the machine, we would use a paper trail
16 because generally, if we send something out and
17 particularly if it's got to come back, we use a
18 return authorization sheet because our drivers
19 don't want to be driving down the road at late
20 hour night and be stopped with drugs in their
21 car that doesn't have a sheet --

22 DR. MARTIN: Right.

23 MR. STEPHENS: -- that says you're

1 supposed to come back with.

2 DR. MARTIN: So Rick, tell us a little
3 bit -- I know you've thought about this because
4 you've thought, you know, through the whole
5 piece. Tell us like the driver comes over,
6 leaves the Cubies, the Cubie is swapped out and
7 you've got the old Cubie and that's going to sit
8 there for 24 hours?

9 MR. STEPHENS: Well, probably 24 hours
10 because it probably won't be swapped out that
11 night. It will be swapped out on first shift.

12 DR. MARTIN: Yeah.

13 MR. STEPHENS: And then they will --
14 they will send a pickup.

15 DR. MARTIN: So they'll have to have a
16 way to secure those old ones.

17 MR. STEPHENS: Uh-huh, and there will
18 be someone in the pharmacy that's assigned to
19 this system and they -- a pharmacist and they
20 will be the ones to communicate and if we don't
21 get it back the next day, we're going to be on
22 the phone we've got to have it because we can't
23 let those things be out. They've got drugs in

1 them or even if they're empty, we still need
2 them back.

3 MR. KRUSE: I'm tracking each serial
4 number. If I popped five out, I know that there
5 are five coming back.

6 DR. MARTIN: Yeah.

7 MR. KRUSE: And I expect five back and
8 I'll have report from the pharmacy that says
9 from home one I'm expecting five back tonight.

10 MR. LAMBRUSCHI: Who changes those
11 Cubies out?

12 MR. KRUSE: Who changes them out at
13 the home?

14 MR. LAMBRUSCHI: Right.

15 MR. STEPHENS: The nurse at the
16 home.

17 MR. LAMBRUSCHI: The nurse.

18 MR. STEPHENS: Generally, I guess it
19 would be the nurse. It could be one assigned
20 specifically for it or it could be the one that
21 has access to the med room. Not every nurse has
22 that med room access.

23 MR. LAMBRUSCHI: But you would know

1 who was swapping those out?

2 MR. STEPHENS: Right, right.

3 MR. KRUSE: But they'll be logging in
4 also and they'll be performing -- and they have
5 the security to actually perform the Cubie
6 exchange so I know when Susie logs in and all
7 they're doing again is scanning the bar code,
8 the drawer opens, the old one pops out, the new
9 one pops in. Great question. Thank you.

10 MS. YEATMAN: So it sounds like the
11 Cubie is plastic?

12 MR. KRUSE: It is.

13 MS. YEATMAN: So what is the plan or
14 the understanding for ones that get broken?

15 MR. KRUSE: The ones that get
16 broken -- again, that's part of the tamper
17 evidence. If something is broken, we know there
18 is an opportunity for a diversion, so if there
19 was drugs in there, we know something
20 happened.

21 MS. YEATMAN: Okay.

22 MR. KRUSE: So -- does that answer
23 your question?

1 MS. YEATMAN: Yeah, I'm just -- I
2 mean, like, transport, I mean, they're plastic.

3 MR. STEPHENS: Well, they're pretty
4 durable.

5 MR. KRUSE: They're very rigid.

6 MR. STEPHENS: It's pretty tough.

7 MS. YEATMAN: Sorry.

8 MR. KRUSE: No, I understand. So
9 that -- the only way that can be opened is when
10 it's placed in the machine in its pocket.

11 DR. MARTIN: So Rick, it's really --
12 correct me if I'm wrong and I don't -- I don't
13 want to misstate this. It's really an automated
14 drug cabinet that you're envisioning is going to
15 be used only for emergency drugs.

16 MR. STEPHENS: Emergency and again,
17 I'm going to say first dose.

18 DR. MARTIN: First doses.

19 MR. STEPHENS: Right. And it would
20 not be -- I mean, Scott's company has got to get
21 the cost way down if it turns into something
22 universal.

23 DR. MARTIN: Yeah. J.

1 MR. STEPHENS: But it would be certain
2 facilities that might be high acuity, high
3 turnover facilities, that kind of thing. So I
4 don't know, you know, a number that -- but the
5 rollout would be one, two, or three, probably,
6 something like that. I don't know what it ever
7 grows to but there is a cost factor and we've
8 got homes now that utilize the drugs in their
9 box, they don't need any more. They don't even
10 have 50 items in there so they may not be
11 candidates, you know. So it's just another tool
12 that we -- we're trying to look at the increased
13 amount of drugs and giving better accountability
14 and security on those.

15 DR. MARTIN: So at some point in the
16 future when y'all -- if y'all decide to use an
17 automated drug cabinet for a more extensive
18 purpose, you might use this or you might use
19 something else.

20 MR. STEPHENS: As I told somebody
21 earlier, when they get to that point, maybe I'm
22 home on the porch, I don't know. So I -- I'm
23 not getting further than this right now.

1 DR. MARTIN: It could -- theoretically
2 it could, that could be --

3 MR. STEPHENS: Theoretically, yeah,
4 they could replace us all theoretically, so.

5 MS. CONNOR: I wouldn't say that this
6 would be that for us, this -- not this system
7 but we don't -- we're not even there. It's just
8 a technology to control our emergency kits and
9 first doses.

10 DR. MARTIN: Sure.

11 MS. YEATMAN: I know you said the
12 number of drugs and all of that is yet to be
13 determined but what is the capacity?

14 MR. KRUSE: It grows. There are
15 different sizes of machines. I have pharmacies
16 that need 50 to 60 meds and that's all that they
17 have, but then it grows essentially in groups of
18 50, so I've got a small table top that it can go
19 up to 120 and then I go to a machine like this
20 that can be anywhere from 200 to 360 maximum in
21 this machine.

22 MS. YEATMAN: Okay.

23 MR. KRUSE: So it all depends on, you

1 know, the site's needs, the distance.

2 MS. YEATMAN: Okay.

3 DR. MARTIN: And then you could chain
4 another one on to it if you had to.

5 MR. BUNCH: But it looks like an
6 improvement on what we're doing now.

7 MR. STEPHENS: I think it is.

8 MR. BUNCH: It's not a perfect
9 mousetrap but I don't know that anything is, so
10 it looks like it's an improvement on the
11 standard deal that we're doing now.

12 MR. KRUSE: I'm not sure that I had
13 actually to be honest, it's -- it's what you
14 guys have seen, so it's a closeup of the Cubie
15 before it's -- as it's loaded, again the bar
16 code with all of the information with that drug,
17 including the item, the NDC number, the
18 expiration or lot number, and again, the site
19 and location is all programmed on that bar code
20 and then in the microchip on the bottom of that.
21 So you know, that security piece of the
22 transport is what, you know, we're really kind
23 of most proud of and once it gets there, no one

1 is touching the meds and then they just start
2 using it.

3 DR. MARTIN: Does your software or
4 your system include the packaging piece and the
5 bar coding and the labeling that goes into here?

6 MR. STEPHENS: That's all done at the
7 pharmacy.

8 MR. KRUSE: Not the packaging of
9 the --

10 MR. STEPHENS: Oh, oh, oh.

11 DR. MARTIN: The packaging of the drug
12 and the labeling of the drug, is that a separate
13 system?

14 MR. STEPHENS: No, we would -- we
15 would -- for almost 100 percent, we would use
16 standard purchased unit dose drugs.

17 DR. MARTIN: Okay.

18 MR. STEPHENS: Occasionally if
19 something had to be unit dosed by us, we
20 would -- we would do that but even presently in
21 the system we use now, it's almost totally
22 commercial unit dosed.

23 MS. YEATMAN: So I'm also assuming

1 that you have different sized Cubies?

2 MR. KRUSE: Yes.

3 MS. YEATMAN: So with this there would
4 be no need to have a tackle box anymore.

5 MR. STEPHENS: Right, yeah.

6 MS. YEATMAN: This would replace that.

7 MR. STEPHENS: No, those homes that
8 might have this, we wouldn't have the tackle
9 boxes.

10 MR. KRUSE: I brought you what I call
11 a one by one.

12 MS. YEATMAN: Right. I thought like
13 that but I just wanted to --

14 MR. STEPHENS: And for the record, Dan
15 said Rick Stephens. Senior Care Pharmacy is
16 who's presenting here. I'm just a mouthpiece.

17 MR. MCCONAGHY: On your process, I was
18 reading some of your rules that you had down in
19 policies and procedures, but I assume there will
20 be controlleds in there.

21 MR. STEPHENS: There will be.

22 MR. MCCONAGHY: Is there any intent to
23 prospectively see those orders before they're

1 released?

2 MR. STEPHENS: We're -- ideally that
3 would be our intent and we're looking at that.
4 The -- the one piece that's not completely
5 determined is after -- well, approximately about
6 after nine o'clock, nobody is in the pharmacy,
7 so the ability of the on-call people to be able
8 to access the system, but this system by far is
9 more accountable that way than the system we use
10 now because it can be set to only open upon, you
11 know, proof of a -- of a valid prescription.

12 MR. MCCONAGHY: Is it linked in any
13 way so that, say if you've got a patient that
14 needed a dose of Coumadin and there was going to
15 be an interaction, is there any -- is it linked
16 in any way to know that it shouldn't dispense
17 that drug to that patient?

18 MR. STEPHENS: No, I don't -- I don't
19 think so other than -- that would have to come
20 out of the pharmacy system on that I think.

21 DR. MARTIN: Or at least a warning to
22 a user.

23 MR. STEPHENS: Right. Now, we have

1 several facilities now that if -- if they were
2 going to administer a dose like that and they
3 for some reason don't know for sure on their --
4 their MAR whether that patient would receive an
5 interaction, they call the pharmacy after hours
6 or during hours and we'll run the profile. So
7 there would always be someone available to look
8 at that.

9 DR. MARTIN: Does the technology allow
10 for a rule based stop like that?

11 MR. KRUSE: For giving them access to
12 only --

13 DR. MARTIN: Like if there's a -- what
14 we would call a serious or a level five
15 interaction, the patient is on one drug and the
16 interacting drug is -- the nurse is attempting
17 to remove it, can the technology from a rule
18 standpoint block that or caution the warning to
19 the user?

20 MR. KRUSE: Yeah, so one of the -- one
21 of the features we have when we interface to the
22 pharmacy information management system is if
23 we -- they have the ability to control all of

1 that by not only pushing the patient admission
2 but pushing down what we call the patient
3 profile. So the entire script of that -- of
4 that patient can be limited and fully accessed
5 if that is what we determine needs -- you know,
6 needs to be moved on.

7 DR. MARTIN: So what you're describing
8 is a profile limitation.

9 MR. KRUSE: Uh-huh.

10 DR. MARTIN: But what if -- what if
11 the patient is on a drug and the drug is on a
12 profile, I mean, I'm just going to make up
13 something, okay, amiodarone, they're already on
14 amiodarone, heaven forbid they be in your
15 facility on that, and along comes somebody and
16 orders Levaquin and that should like virtually
17 never happen.

18 MR. KRUSE: Right.

19 DR. MARTIN: Can your system say, time
20 out?

21 MR. KRUSE: I'm not sure we're going
22 to be at that level of, you know --

23 DR. MARTIN: Okay. Just curious.

1 MR. KRUSE: -- helping it.

2 DR. MARTIN: That's fine.

3 MS. KRUPS: If I could speak to that
4 issue, the homes where we are considering
5 placing this type of a system, they are
6 electronic medical records and so at the level
7 where the nurses would enter the order in, an
8 interaction would be detected.

9 DR. MARTIN: You mean on the eMAR?

10 MS. KRUPS: On the eMAR system.

11 DR. MARTIN: So they're using
12 electronic MARs --

13 MS. KRUPS: Yes.

14 DR. MARTIN: -- and the MAR would give
15 them the warning --

16 MS. KRUPS: Yes.

17 DR. MARTIN: -- of that type
18 interaction?

19 MS. KRUPS: There would be a hard stop
20 where they would have to override an
21 interaction.

22 COURT REPORTER: Your name, ma'am?

23 MS. KRUPS: Carrie Krups.

1 DR. MARTIN: Well, if they can
2 override it, it wouldn't be a hard. It would be
3 a soft. If it's a hard stop, they can't. They
4 just -- they're dead in the water.

5 MS. KRUPS: Well, they would have to
6 have a supervisor override, something like that.

7 MR. STEPHENS: Well, we thank you for
8 your time if there's no other questions or if
9 there are, we'll be glad to answer them but
10 we're just submitting the policy and procedure
11 and the system for your consideration and
12 approval.

13 DR. ALVERSON: May I ask --

14 MR. STEPHENS: Yes.

15 DR. ALVERSON: If I remember
16 correctly, federal guidelines say you have to
17 record why the product was used in some cases.

18 DR. MARTIN: P.r.n.

19 DR. ALVERSON: Right and controlled
20 drugs there has to be --

21 MR. STEPHENS: Uh-huh.

22 DR. ALVERSON: Is that recorded using
23 the system or is that hand-recorded in the -- in

1 the medical record?

2 MS. KRUPS: The reason and result is
3 required on p.r.n. medication for pain. If
4 you're talking about like an antibiotic, then
5 you would have the diagnosis of the inpatient.

6 DR. ALVERSON: Right. And on
7 controlleds, wasn't there a requirement to
8 actually show the -- I used to have 21, now I
9 have 20, or the system is automatically going to
10 do that for you?

11 MR. STEPHENS: Well, I think the blind
12 count that he talked about would take care of
13 that, yes.

14 DR. ALVERSON: That would be recorded
15 that way so you don't have to worry about
16 counting that anymore.

17 MR. STEPHENS: Well, I think
18 procedurally we would -- we would like for them
19 to count or poll the machine as they do now.
20 I'm not sure this takes their obligation to --
21 at the home --

22 DR. ALVERSON: Right.

23 MR. STEPHENS: -- to maintain a count.

1 I think we want them to be able to do that but I
2 know we probably don't want them opening things
3 up.

4 DR. ALVERSON: Right.

5 MR. STEPHENS: So we're able to look
6 at it realtime at the same time they are is
7 what --

8 MR. MCCONAGHY: Rick, the -- I know
9 you worked on that committee with the automated
10 dispensing in the long-term care and all.
11 That -- that was more geared towards your
12 whole -- everything that you're giving.

13 MR. STEPHENS: Right.

14 MR. MCCONAGHY: But it's a real
15 similar concept as far as how it's being done.
16 Would it be an issue -- that is going to be
17 presented next month, the automated dispensing
18 thing, and I'm not sure until we have that on
19 the books that we've got the, you know, the
20 ability to approve this at this time.

21 MR. STEPHENS: Yeah. Well, now
22 you've -- I don't know about approval. You've
23 seen other -- I think last year sometime

1 Artromick presented a system and we've seen
2 others and that's -- that's fine. I just
3 wanted -- I didn't want to be confused with the
4 automated dispensing system.

5 MR. MCCONAGHY: Yeah, yeah.

6 MR. STEPHENS: Because that really is
7 not what we're trying to do and we're just
8 looking at a more technological tackle box again
9 if you will.

10 MR. MCCONAGHY: And just a
11 technicality there, as far as some folks don't
12 know when you talk about you're going to drop
13 them off and the nurses will do the exchange,
14 when you're doing just the old timey bingo card,
15 you dropped those cards off and what happens
16 with them then.

17 MR. STEPHENS: A regular order like
18 the regular orders we send, they would go out
19 with a manifest. The nurse -- really it's the
20 same procedure here. They go out actually with
21 two manifests. The nurse would check it off
22 with the driver and send one back with the
23 driver and they keep one at the facility.

1 MR. MCCONAGHY: That's what I wanted
2 to get at.

3 MR. STEPHENS: Yeah.

4 MR. MCCONAGHY: It's the same process,
5 just a different --

6 MR. STEPHENS: And so -- yeah,
7 dropping the Cubies off --

8 MR. MCCONAGHY: End point.

9 MR. STEPHENS: -- would be no
10 different than dropping a blister pack card
11 off.

12 MR. MCCONAGHY: Okay. I guess we
13 thank you for your presentation.

14 MR. STEPHENS: All right.

15 MR. MCCONAGHY: And we'll look at it
16 further but next month that other should be on
17 the agenda --

18 MR. STEPHENS: Okay.

19 MR. MCCONAGHY: -- and I think it's
20 going to be addressed in that too.

21 MR. STEPHENS: Fits better there, all
22 right. Thank you for your time.

23 DR. MARTIN: Thank you, Scott.

1 MR. KRUSE: Thank you very much.

2 MR. MCCONAGHY: Treasurer's report
3 from Buddy Bunch.

4 MR. BUNCH: The treasurer's report is
5 in your Dropbox and it's not much changed from
6 last month. We're at about 92 percent of budget
7 to income and nothing really outstanding to talk
8 about except we've still got plenty to pay the
9 bills and it's in your Dropbox if you have any
10 questions. If I can't answer them, we'll get
11 Blake up here.

12 MR. MCCONAGHY: Could you arrange him
13 to maybe come one time and just kind of give
14 everybody an overview of exactly how he's doing
15 things now?

16 MR. BUNCH: We'll do that next
17 month.

18 MR. MCCONAGHY: Okay.

19 DR. MARTIN: I make a motion we accept
20 the treasurer's report.

21 DR. MARTIN: Second.

22 MS. YEATMAN: Second.

23 MR. MCCONAGHY: All in favor?

1 MR. DARBY: Aye.

2 MR. BUNCH: Aye.

3 DR. MARTIN: Aye.

4 MS. YEATMAN: Aye.

5 MR. MCCONAGHY: All opposed?

6 (No response.)

7 MR. MCCONAGHY: Motion carries.

8 MR. DARBY: Wellness report.

9 MR. MCCONAGHY: Wellness Committee
10 report, anybody with that?

11 DR. ALVERSON: That's me. Since
12 Dr. Garver is not here today, there are 142
13 people in the screening program with signed
14 contracts or orders. This includes individuals
15 who have a diagnostic monitoring contract but
16 does not include any of the following: There
17 are two pharmacists in inpatient treatment, one
18 pharmacist going for evaluation, one tech in
19 treatment, one student in inpatient treatment,
20 one student set for evaluation.

21 For the first three months of 2015,
22 four pharmacy techs have been identified with
23 problems and Dr. Garver is working with them.

1 Four pharmacists have been identified and he is
2 also working with them and two students have
3 been identified for a total of ten people in the
4 first quarter. I added that by myself but he
5 put a note at the bottom that it's ten.

6 All individuals who are in treatment
7 or in evaluation or undecided are presently out
8 of the workplace and are without a license.
9 There have been about a dozen others who are
10 working their way through a halfway house and
11 who are in the process of being -- or who are in
12 the process of being investigated or scheduled
13 for hearings. There are presently 87
14 individuals in facility-driven aftercare.

15 It says, we have met personally with
16 all licensees returning to work to sign
17 contracts and explain how monitoring works. All
18 returning licensees have been placed in a
19 caduceus, either pharmacy or health
20 professional.

21 He offers his thanks to the Board and
22 notes that appropriate reports have gone to
23 inspectors and to the attorney.

1 MR. DARBY: I move we accept the
2 Wellness Committee report.

3 MS. YEATMAN: Second.

4 MR. MCCONAGHY: All in favor?

5 MR. DARBY: Aye.

6 DR. MARTIN: Aye.

7 MS. YEATMAN: Aye.

8 MR. BUNCH: Aye.

9 MR. MCCONAGHY: Opposed?

10 (No response.)

11 MR. MCCONAGHY: Okay. We'll do our
12 Board minutes and we have multiple minutes here
13 and I'm sure everybody has read all of them and
14 we go through that process of individually
15 approving each set. I need some motions.

16 MR. DARBY: I will move that we
17 approve the Board of Pharmacy business meeting
18 minutes from February 25.

19 MS. YEATMAN: Second.

20 MR. MCCONAGHY: All in favor?

21 DR. MARTIN: Aye.

22 MR. DARBY: Aye.

23 MS. YEATMAN: Aye.

1 MR. BUNCH: Aye.

2 MR. MCCONAGHY: All opposed?

3 (No response.)

4 MR. DARBY: I will move that we
5 approve the Board of Pharmacy rulemaking minutes
6 from February 25, 2015.

7 MS. YEATMAN: Second.

8 MR. BUNCH: Second.

9 MR. MCCONAGHY: All in favor?

10 DR. MARTIN: Aye.

11 MR. DARBY: Aye.

12 MR. BUNCH: Aye.

13 MS. YEATMAN: Aye.

14 MR. MCCONAGHY: Opposed?

15 (No response.)

16 MR. DARBY: We've got several
17 interview minutes that we have got to get caught
18 up on. I will make a motion that we approve the
19 interview minutes from October 14, 2014.

20 MS. YEATMAN: Second.

21 MR. MCCONAGHY: All in favor?

22 MR. DARBY: Aye.

23 DR. MARTIN: Aye.

1 MS. YEATMAN: Aye.

2 MR. BUNCH: Aye.

3 MR. MCCONAGHY: Opposed?

4 (No response.)

5 MR. DARBY: I make a motion that we
6 approve the interview minutes from November 19,
7 2014.

8 MS. YEATMAN: Second.

9 MR. MCCONAGHY: All in favor?

10 MR. DARBY: Aye.

11 DR. MARTIN: Aye.

12 MS. YEATMAN: Aye.

13 MR. BUNCH: Aye.

14 MR. MCCONAGHY: Opposed?

15 (No response.)

16 MR. DARBY: I make a motion that we
17 approve the interview minutes from December 17,
18 2014.

19 MS. YEATMAN: Second.

20 MR. MCCONAGHY: All in favor?

21 MR. DARBY: Aye.

22 DR. MARTIN: Aye.

23 MS. YEATMAN: Aye.

1 MR. BUNCH: Aye.

2 MR. MCCONAGHY: Opposed?

3 (No response.)

4 MR. DARBY: I make a motion that we
5 approve the interview minutes from September 17,
6 2014.

7 MS. YEATMAN: Second.

8 MR. MCCONAGHY: All in favor?

9 MR. DARBY: Aye.

10 DR. MARTIN: Aye.

11 MS. YEATMAN: Aye.

12 MR. BUNCH: Aye.

13 MR. MCCONAGHY: Opposed?

14 (No response.)

15 MR. DARBY: I make a motion that we
16 approve the interview minutes from February 25,
17 2014 [sic].

18 MS. YEATMAN: Second.

19 MR. MCCONAGHY: All in favor?

20 MR. DARBY: Aye.

21 DR. MARTIN: Aye.

22 MS. YEATMAN: Aye.

23 MR. BUNCH: Aye.

1 MR. MCCONAGHY: Opposed?

2 (No response.)

3 MR. DARBY: And finally, I will make a
4 motion we approve the interview minutes from
5 March 4, 2015.

6 MS. YEATMAN: Second.

7 MR. MCCONAGHY: All in favor?

8 MR. DARBY: Aye.

9 DR. MARTIN: Aye.

10 MS. YEATMAN: Aye.

11 MR. BUNCH: Aye.

12 MR. MCCONAGHY: Opposed?

13 (No response.)

14 MR. MCCONAGHY: Okay. That's all the
15 Board minutes. Can we get an inspector's report
16 from Eddie Braden.

17 MR. BRADEN: Yes, sir, Mr. President.
18 If you look in the Dropbox, we have the
19 inspections that were completed last month,
20 which includes some 795 and 797 inspections and
21 complaints that we received during the month of
22 February and the complaints that were completed
23 in the month of February.

1 Just to give you an update, since the
2 first of the year, we've had 57 investigations
3 that are -- have been initiated and out of
4 those, we still have approximately 40 that are
5 still outstanding since the first of the year.
6 We have completed -- only a few left of the 2014
7 investigations that were started, so we only
8 have a couple of those that are still
9 outstanding and those were pretty intense
10 investigations.

11 As you see we have met with other
12 agencies to try to help us get more information
13 to -- to help us do our job and I want to make a
14 comment about the 795 inspections, thanks to
15 Dr. Alverson and Cristal, we have -- we have
16 gotten the training and the inspectors on the
17 795. I feel comfortable with them doing those
18 at this point. The 797 we're still training and
19 getting more training scheduled to -- to get
20 more involved in those but because of the
21 assistance from these two ladies, we have made
22 great strides in that effort.

23 MR. MCCONAGHY: Do you think that

1 computer system will help you out any?

2 MR. BRADEN: I think so.

3 MR. MCCONAGHY: Secretary's report,
4 Susan.

5 DR. ALVERSON: Could I make a side
6 comment, when we approved some of the minutes,
7 did the March and February say 2015 rather than
8 2014? I think it was Mitzi's concern.

9 MR. DARBY: If not -- the February and
10 March should have been 2015.

11 DR. ALVERSON: We've spent a fair
12 amount this month talking about legislation
13 that's in the -- in the State House. There have
14 been a few pieces of legislation introduced in a
15 impacted us or would impact us. The one that
16 seems to still be at issue was a proposal having
17 to do with PDMP and who would all have access to
18 it and in fact, we are meeting with ALEA this --
19 excuse me, tomorrow afternoon to discuss access
20 and at least our opinion on that.

21 DR. MARTIN: Who will be there, do you
22 know? Who will be at the meeting tomorrow?

23 DR. ALVERSON: We have representatives

1 from ALEA coming and also from the attorneys'
2 group that is within ALEA.

3 MR. MCCONAGHY: Can you tell me
4 exactly who ALEA encompasses now?

5 DR. ALVERSON: Eddie will have to help
6 me.

7 MR. BRADEN: ALEA is the Alabama Law
8 Enforcement Agency. What that is is when the
9 governor put several -- several agencies that
10 have enforcement powers within the state under
11 one umbrella and now they are called the Alabama
12 Law Enforcement Agency. If any of you have
13 noticed the trooper cars on the streets, if you
14 notice, they have a new emblem on the side and
15 it actually says, Alabama Law Enforcement Agency
16 now, but that is who ALEA is. In fact, we were
17 under that umbrella when the legislation started
18 and they took all health care enforcement out of
19 that so -- and we're glad that we weren't put
20 under that but it was -- it was -- that's who
21 that agency was.

22 MR. WARD: Logan -- Logan suggested
23 this meeting because they're trying to mess with

1 the databank.

2 MR. MCCONAGHY: I'm just curious, is
3 it state troopers and --

4 MR. WARD: Yeah.

5 MR. MCCONAGHY: -- and who all is it?

6 DR. MARTIN: Game wardens.

7 DR. ALVERSON: Forestry is in there.

8 MR. BRADEN: Right.

9 DR. ALVERSON: There are a number of
10 agencies that have nothing -- right, have
11 nothing to do with health care --

12 MR. WARD: Conservation cops.

13 MR. BRADEN: Forensic sciences.

14 DR. ALVERSON: -- and we were just
15 concerned about security of data and who would
16 have access.

17 MR. BRADEN: What that legislation
18 proposal is going to do is allow analysts and
19 what our concern was, the way it read, it was
20 like analysts would be able to go into the
21 pharmacies and we had -- had concerns about that
22 and so the way it's been rewritten because they
23 have modified it is analysts will be able to

1 review information in regard to doctor shoppers
2 basically.

3 DR. MARTIN: So who will be
4 representing our board at the meeting tomorrow?

5 DR. ALVERSON: Eddie and I, we're
6 going to be there. We'd be glad to have a Board
7 member if one of you chose to be there but the
8 draft has been modified radically.

9 DR. MARTIN: How do you feel about the
10 current version?

11 DR. ALVERSON: There is a version that
12 has been in practice but it said public safety
13 had access to that.

14 MR. WARD: The language is really
15 loose and what Susan and Eddie want to make sure
16 is that -- not carte blanche access to a bunch
17 of people that have no business seeing.

18 DR. ALVERSON: Right.

19 DR. MARTIN: So it's not -- I think
20 what I heard you say was it's better but it's
21 not where it needs to be.

22 DR. ALVERSON: We just want assurance
23 of need to know or that if a problem is

1 identified with a pharmacy, we would be informed
2 as opposed to an outside group going into a
3 pharmacy.

4 MR. MCCONAGHY: There's also a bill
5 floating out there that one doctor writes -- two
6 doctors writes for the same patient during a
7 certain period of time and they're just filing
8 bills like you wouldn't believe.

9 DR. ALVERSON: So that has -- has been
10 adjusted from this draft.

11 MR. MCCONAGHY: I also heard the word
12 attorney and you know, I don't like attorneys
13 having too much access. Why would they need
14 access?

15 MR. WARD: Analysts, she said.

16 MS. YEATMAN: I think it's attorneys
17 at the meeting tomorrow is what you said.

18 MR. WARD: I'm not -- just Susan
19 and --

20 DR. ALVERSON: Well, there is a state
21 attorney organization that is part of what was
22 all rolled into this one new organization.

23 MR. WARD: It's probably the DA's

1 association.

2 MR. BRADEN: It is. They're called
3 Prosecution Services now. That's what that is.

4 MS. YEATMAN: What time is the meeting
5 tomorrow?

6 DR. ALVERSON: We have downloaded
7 HIPAA regulations and HIPAA regulations say that
8 you can look at data if you're looking for a
9 specific case but you can't go on a fishing
10 expedition just looking at data and we want to
11 be sure that's -- that's what happens.

12 MR. WARD: What time is the meeting
13 tomorrow?

14 DR. ALVERSON: One o'clock.

15 MR. MCCONAGHY: Is anybody, a Board
16 member, available at that time?

17 MS. YEATMAN: I'll be here.

18 MR. MCCONAGHY: Okay. That would be
19 good, Donna.

20 MS. YEATMAN: I'll be here.

21 DR. ALVERSON: We'll fill you in a
22 little bit on it before you leave today or if
23 you want to come early or however you want to do

1 that.

2 The other thing I wanted to report is
3 that a group of us went to Washington last week
4 to meet with the FDA as a follow-up on federal
5 legislation on compounding and Dan accompanied
6 us, Dave accompanied us, Cristal, myself, Eddie,
7 and Jim went to Washington and I'll try to
8 summarize two days in a short period of time. A
9 lot of this discussion focused on the memorandum
10 of understanding and if you remember, we went to
11 Washington for a similar meeting this time last
12 year. The FDA listened to what we had to say
13 and came back with a new draft of a memorandum
14 of understanding, and when we left, I think
15 every state said, we can't sign this even if we
16 wanted to. The way you've written it this time
17 pretty much assures that we'll be back here in
18 March next year after you take another crack at
19 it.

20 The issues that came up were that the
21 draft now said, this applies to pharmacists,
22 pharmacies, and dispensing physicians and
23 every -- just about every state said, we don't

1 control physicians. There's no way we can sign
2 something that says what physicians are going to
3 do and we did ask FDA, have you contacted AMA,
4 have you contacted state physician
5 organizations, and they said they had not, so we
6 did suggest that they do some work at their end
7 or remove that part.

8 There was a lot of discussion that for
9 compounding pharmacies the FDA wants to restrict
10 compounding that can go across state lines to 30
11 percent of what is compounded. There was an
12 issue about 30 percent, is that a quality
13 measure. Someone said what if you are the best
14 at making something specific, does that mean
15 you're restricted. We have a number of
16 compounders in the state who do ship more than
17 30 percent across state lines, so there was a
18 lot of pushback on that.

19 For 503B pharmacies, they changed or
20 said that the maximum amount of time that you
21 could give an injectable preparation that you
22 compound is 14 days after you receive tests back
23 that say, yes, this product is sterile and

1 pyrogen free. So right now the law says that
2 when you get that data back, the pharmacist has
3 the option to read material and pharmacists can
4 decide how long you're going to give a product.
5 Most people won't go beyond three months but
6 some pharmacies have gone as far as a year. So
7 the FDA said they want to remove any possibility
8 of the pharmacists extending that -- that time.

9 The FDA is preparing a list of items
10 which can be compounded by 503B facilities
11 because there is to be a list and you cannot
12 compound anything that's not on the FDA approved
13 list. We -- there was a lot of discussion about
14 what information the FDA can share with us but
15 we had the same concern about the information we
16 are supposed to supply to FDA, what can they do
17 with it, how can we be assured that it's
18 confidential.

19 So the memorandum of understanding
20 states that if we investigate a compounding
21 pharmacy and they are not doing just patient-
22 specific compounding but rather are compounding
23 for physician offices that we would report then

1 to the FDA because they should be a 503B agency
2 or if we find gross negligence in a compounding
3 pharmacy that we would share that and personally
4 I feel we have to know from our attorney general
5 what are we allowed to disclose to an outside
6 agency.

7 MR. WARD: Also, if they go above 30
8 percent, we've got to report it.

9 DR. ALVERSON: Correct, and the
10 difficulty is what's 30 percent. Is that -- do
11 you count the prescriptions? In some cases
12 they're counting the number of tablets but if
13 you send a 90-gram tube, that counts as one
14 unit, so we're not sure we know how -- what
15 standards there are going to be. What if a
16 place goes to 31 one month, are we going to call
17 FDA and say, send an investigator immediately.

18 DR. MARTIN: How would we know that?

19 DR. ALVERSON: Pardon?

20 DR. MARTIN: How would we know they
21 did 31 instead of 30?

22 DR. ALVERSON: Oh, they want us to
23 audit that.

1 MR. WARD: We're going to become --
2 board inspectors are going to become
3 accountants.

4 DR. ALVERSON: Right. There's a lot
5 of work that's going to be moved from the FDA to
6 the state board inspectors.

7 MR. WARD: And there's a lot of talk
8 about board of pharmacy, like Phenix City
9 Pharmacy, it's only, what, a mile to Columbus.

10 DR. ALVERSON: Right.

11 MR. WARD: Yeah.

12 DR. ALVERSON: Last year when we were
13 there, they assured us that there would be a
14 50-mile radius, so if you were right on the
15 border, you could ship within a 50-mile radius
16 and it wouldn't be considered interstate. This
17 year they withdrew that so if you're right on
18 the border --

19 MR. WARD: The way it is worded now,
20 if you drive from Columbus, Georgia, to Phenix
21 City and pick it up, it doesn't count but if you
22 mail it to them, the same person, it does
23 count.

1 DR. ALVERSON: Or if your driver takes
2 it.

3 MR. WARD: Yeah.

4 DR. ALVERSON: That's considered part
5 of your 30 percent. So as I said, there was a
6 lot of pushback on that and then they're saying
7 that a 503A regular pharmacy may not compound
8 anything for office use and there was a lot of
9 pushback about that. I mean, there's a
10 difference between sending dozens and dozens of
11 something versus a product to be used in the
12 office that you most certainly would rather have
13 a pharmacist compound than have the physician's
14 office try to compound it. So -- there were
15 five other people there.

16 MR. MCCONAGHY: One of the things that
17 concerned me was that they wanted you to report
18 to them any complaint that you got within 72
19 hours, regardless of whether you found out it
20 was not even a real complaint, you know, it was
21 an issue. That one -- that one bugged me and
22 the fact --

23 DR. ALVERSON: And whether it was over

1 Saturday, Sunday, if it was on your machine when
2 you got in Monday morning, you had just lost 48
3 hours.

4 MR. MCCONAGHY: But they didn't define
5 units. They put the word insure in there. They
6 really didn't define what a month is.

7 MR. WARD: How about that health
8 system one, they didn't define that either.
9 Tell them about that.

10 MR. MCCONAGHY: Yeah, within a health
11 system, you could -- the 30 percent I think
12 didn't -- didn't apply within a health system
13 but they didn't have a definition whether Humana
14 is a health system and it could encompass huge
15 amounts or whether DCH was a health system. It
16 did not define what was within a health system.
17 One patient -- I mean, one place it mentioned
18 inpatient and the next patient it just said
19 anybody within the health system, so there was
20 no clarification there and they used words like
21 when you did your record review, you basically
22 need to do forensic accounting to insure that
23 the pharmacy wasn't doing over 30 percent or

1 anything that they're not supposed to be doing
2 so and -- and of course, the big one to me was
3 they can't tell you what an inordinate amount
4 is. So you know, 30 percent of ten is probably
5 not an inordinate amount but it doesn't give any
6 clarification on any of that kind of stuff and I
7 don't think they intend to.

8 MR. WARD: Vegas says the odds are
9 that Alabama will elect a Democratic governor
10 before this is figured out. We will go back
11 next year again; right?

12 DR. ALVERSON: Right.

13 MS. ANDERSON: One other thing they
14 did mention is that if you plan on becoming a
15 503B, your whole facility will practice under
16 federal regulation. Everything will be -- your
17 best practices will be from the GMP.

18 DR. MARTIN: That's new.

19 DR. ALVERSON: Right.

20 DR. MARTIN: It used to be split.

21 MS. ANDERSON: So you cannot perform
22 as a 503A and a 503B in the same facility.

23 MR. WARD: And the only way you can

1 do -- the only way you can do nonsterile is if
2 you do -- and be a 503B is you also do sterile;
3 right?

4 MS. ANDERSON: So GMP would still
5 apply to you.

6 MR. DARBY: You cannot be a 503B
7 unless you are doing some sterile.

8 MR. WARD: Some sterile compounding.

9 And I want to brag, it was apparent in
10 the midst of all this confusion that because of
11 Susan and Cristal and Eddie and all the
12 inspectors that Alabama is light years ahead of
13 everybody else on what they're doing, how
14 they're doing it, the standards they have,
15 stopping things that all of you would be
16 delighted to know are being stopped, the drugs
17 coming in here are based upon how people are
18 trying to compound them. You can just tell from
19 the questions we're way -- way ahead of the
20 game, so for once, Alabama is not last.

21 DR. ALVERSON: That occupied our
22 month.

23 MR. MCCONAGHY: Jim, do you have an

1 attorney's report today -- a short one?

2 MR. WARD: I just gave it. I just
3 gave it. How short was that?

4 MR. MCCONAGHY: That's very good.
5 Okay.

6 MR. WARD: Oh, I've got one executive
7 session matter.

8 MR. MCCONAGHY: We'll move into old
9 business and I think we had one item on there
10 about the amendment to Rule 680-X-2-.18. Yeah,
11 where we had the rule change and then we had an
12 amendment to that to leave a line out and David
13 will go over that.

14 MR. DARBY: I'll make a motion that we
15 approve the amendment to Rule 680-X-2-.18 on
16 institutional pharmacies. In paragraph three we
17 will strike this sentence, "The number of drugs
18 provided by a pharmacy to a long-term care
19 facility shall be limited to 50. There should
20 be a limited number of doses of any medication
21 not to exceed a 48-hour supply of any drug
22 dosage form per 50 beds and," and then at that
23 point add the sentence, "all medications" or add

1 the phrase, "all medications" and it will
2 continue, "shall be packaged in an appropriate
3 manner in the stat cabinet based on the
4 established needs of the facility. Need for
5 such medication shall be reviewed by the
6 pharmacist annually."

7 MR. MCCONAGHY: That was a motion.

8 MR. BUNCH: Second.

9 MR. MCCONAGHY: Any discussion?

10 (No response.)

11 MR. MCCONAGHY: I will discuss that we
12 had one comment that Mitzi gave me. It was
13 submitted by Rick Stephens and I spoke with him
14 earlier and he didn't realize that the other
15 line is what we had amended and left out and he
16 said he would withdraw his comment because that
17 in essence fulfilled what he was commenting on.
18 Any other discussion?

19 (No response.)

20 MR. MCCONAGHY: All in favor?

21 DR. MARTIN: Aye.

22 MR. DARBY: Aye.

23 MS. YEATMAN: Aye.

1 MR. BUNCH: Aye.

2 MR. MCCONAGHY: All opposed?

3 (No response.)

4 MR. MCCONAGHY: Okay. New business.

5 The proposed changes to the employee personnel
6 handbook is going to be handled by --

7 DR. ALVERSON: Mitzi.

8 MR. MCCONAGHY: -- Mitzi.

9 MS. ELLENBURG: As y'all know the
10 examiners or public accountants are here and she
11 was going over the personnel handbook and she
12 made a couple of suggestions that the State has
13 now adopted since our personnel policies were
14 originally drafted from what was on State books
15 at the time. In accordance to office hours of
16 operation, employee work hours, which is policy
17 number two, most -- it states in State holidays
18 that the county of Mobile will get Mardi Gras
19 Day and if you don't live in Mobile County,
20 you'll be given a personal holiday.

21 MR. DARBY: Mobile and Baldwin County,
22 isn't it?

23 MS. ELLENBURG: Oh, okay.

1 MR. DARBY: Southwest isn't South
2 Alabama.

3 MS. ELLENBURG: South Alabama.

4 MR. MCCONAGHY: Thank you.

5 MS. ELLENBURG: And she suggests that
6 since we are given a personal holiday instead
7 and it cannot be carried over and it cannot be
8 taken at the end of the year to accumulate
9 vacation or whatever, she just suggested we add
10 the sentence, "Mardi Gras is observed in Baldwin
11 and Mobile counties only. All other employees
12 are granted a personal leave day on January 1,
13 which shall be taken as their first day of leave
14 granted," and then that way it would make sure
15 everyone is given that day and you wouldn't have
16 to keep track of by the end of the year to make
17 sure it's been taken.

18 MR. MCCONAGHY: Do we need a motion to
19 approve that?

20 MS. ELLENBURG: (Nods head.)

21 MR. DARBY: I make the motion we
22 approve the change suggested in the hours of
23 operation.

1 MS. YEATMAN: Second.

2 DR. MARTIN: Second.

3 MR. MCCONAGHY: All in favor?

4 MR. DARBY: Aye.

5 DR. MARTIN: Aye.

6 MS. YEATMAN: Aye.

7 MR. BUNCH: Aye.

8 MR. MCCONAGHY: Opposed?

9 (No response.)

10 MS. ELLENBURG: The next suggestion
11 was on policy ten, employee leave benefits. We
12 already have in place that the maximum number of
13 hours that you can carry over per calendar year
14 is 1,200 for any existing sick leave and 480
15 hours for vacation and it goes on to state that
16 upon termination you will be paid half of the
17 number of sick leave, all the 480 hours or ever
18 however many hours you've accumulated to your
19 date of termination, and she suggested we just
20 make a clarification that the most you would be
21 paid if you had earned them was half of 1,200
22 for sick leave and all up to 480 on vacation.

23 DR. MARTIN: That's a little bit

1 ambiguous.

2 MS. ELLENBURG: Well, the reason she
3 stated that was like say January 1 of this year,
4 I had 1,200 hours sick leave. I worked through
5 June, so I've earned another 60 hours. She's
6 suggesting that we cap it at 12 so we won't -- I
7 wouldn't be eligible for half of 1,260.

8 DR. MARTIN: All right. I understand
9 the intent. The way it's written, I mean, maybe
10 I'm being too picky about it, but upon
11 termination of employment payment shall be made
12 to the employees for one-half of the existing
13 sick leave hours up to a maximum of 1,200. Does
14 that mean one-half is the maximum of 1,200 or
15 half of 1,200.

16 MS. ELLENBURG: One-half of 1,200.

17 DR. MARTIN: That's not what it
18 says.

19 MS. ELLENBURG: Okay. How would you
20 prefer it to read and I'm sure vacation reads
21 the same way so.

22 DR. MARTIN: Get my drift.

23 MR. DARBY: Yeah. Why don't we just

1 say one-half of existing sick leave hours with a
2 maximum of 600 hours to be paid.

3 MS. YEATMAN: Yeah, change it to
4 600.

5 DR. MARTIN: Yeah.

6 MS. YEATMAN: Because 1,200 is the
7 maximum.

8 DR. MARTIN: I agree with what he
9 said.

10 MS. YEATMAN: Change that to --

11 MS. ELLENBURG: Up to the maximum of
12 600 hours?

13 DR. MARTIN: Up to maximum -- say it
14 again, David.

15 MR. DARBY: Where it now says payment
16 shall be made to the employee for one-half of
17 the existing sick leave hours.

18 MS. ELLENBURG: Yes, sir.

19 MR. DARBY: Put up to the maximum
20 amount to be paid would be 600 hours.

21 DR. MARTIN: That's it.

22 MS. ELLENBURG: Okay. So you want
23 maximum to be paid in there?

1 DR. MARTIN: Right, yeah.

2 MR. DARBY: Uh-huh.

3 MS. ELLENBURG: Okay. What about
4 vacation?

5 MR. DARBY: Same way.

6 MS. YEATMAN: Well, vacation is fine
7 because you get paid up to a maximum of 480.
8 There's no partiality --

9 MR. DARBY: Yeah, you're right, yeah.

10 MS. YEATMAN: -- so I think that one
11 is fine.

12 DR. MARTIN: That's okay.

13 MS. ELLENBURG: And that's all I
14 have.

15 DR. MARTIN: I move we approve the
16 revised policy related to employee leave
17 benefits as proposed with the noted change.

18 MS. YEATMAN: Second.

19 MR. MCCONAGHY: Any discussion?

20 (No response.)

21 MR. MCCONAGHY: All in favor?

22 DR. MARTIN: Aye.

23 MR. DARBY: Aye.

1 MS. YEATMAN: Aye.

2 MR. BUNCH: Aye.

3 MR. MCCONAGHY: All opposed?

4 (No response.)

5 MR. MCCONAGHY: Any other new
6 business?

7 (No response.)

8 MR. MCCONAGHY: Well, I need a motion
9 to go into executive session.

10 DR. MARTIN: Do you have the verbiage?
11 Are you going to read it?

12 MR. MCCONAGHY: Yeah, I will. Well, I
13 guess we need to pass it first though.

14 When we go into executive session, it
15 will be a private session with just the Board
16 and it's for the purpose of discussing the
17 qualifications or competencies of professionals,
18 permit holders, registrants, and other legal
19 matters to include the resolution of existing
20 cases. We will go into executive session at
21 11:30 and we should be out by 11:45. There
22 won't be any further business conducted other
23 than just to vote on the cases as they're

1 numbered and then we will adjourn. You're
2 welcome to come back but I don't think you'll
3 have any entertainment listening to the numbers
4 that we read, so thank you for coming and we
5 need to do a vote.

6 MR. WARD: I've got to say that as an
7 attorney licensed to practice law in the State
8 of Alabama, I verify and certify that one of the
9 reasons for entering into executive session is
10 to talk about resolution of pending cases.

11 DR. MARTIN: I move we adjourn to
12 executive session.

13 MS. YEATMAN: Second.

14 MR. MCCONAGHY: All in favor?

15 MR. MCCONAGHY: Aye.

16 MR. DARBY: Aye.

17 DR. MARTIN: Aye.

18 MS. YEATMAN: Aye.

19 MR. BUNCH: Aye.

20 DR. MARTIN: It has to be a voice
21 vote.

22 MR. MCCONAGHY: Buddy? How do you
23 vote Buddy?

1 MR. BUNCH: Aye.

2 MR. MCCONAGHY: Donna?

3 MS. YEATMAN: Aye.

4 DR. MARTIN: Aye.

5 MR. DARBY: Aye.

6 MR. MCCONAGHY: Aye.

7

8 (Whereupon, a recess was taken for
9 Executive Session from 11:23 a.m. to
10 12:30 p.m.)

11

12 MR. DARBY: On case number 14-0035, I
13 make a motion that the case be sent to Jim for
14 possible charges against the pharmacy and/or the
15 owner.

16 MS. YEATMAN: Second.

17 MR. MCCONAGHY: All in favor?

18 MR. DARBY: Aye.

19 DR. MARTIN: Aye.

20 MS. YEATMAN: Aye.

21 MR. BUNCH: Aye.

22 MR. MCCONAGHY: All opposed?

23 (No response.)

1 MR. DARBY: Case number 14-0171, make
2 a motion that we send the insurance company a no
3 action letter.

4 MS. YEATMAN: Second.

5 MR. MCCONAGHY: All in favor?

6 DR. MARTIN: Aye.

7 MR. DARBY: Aye.

8 MS. YEATMAN: Aye.

9 MR. BUNCH: Aye.

10 MR. MCCONAGHY: All opposed?

11 (No response.)

12 MR. DARBY: Case number 14-0183, make
13 a motion that we send a letter of concern to the
14 pharmacist.

15 MS. YEATMAN: Second.

16 MR. MCCONAGHY: All in favor?

17 MR. DARBY: Aye.

18 DR. MARTIN: Aye.

19 MS. YEATMAN: Aye.

20 MR. BUNCH: Aye.

21 MR. MCCONAGHY: Opposed?

22 (No response.)

23 MR. DARBY: Case number 14-0185, make

1 a motion that we accept the recommended action
2 of a permanent surrender.

3 MS. YEATMAN: Second.

4 MR. MCCONAGHY: All in favor?

5 DR. MARTIN: Aye.

6 MS. YEATMAN: Aye.

7 MR. MCCONAGHY: Aye.

8 MR. MCCONAGHY: Opposed?

9 (No response.)

10 MR. DARBY: Case numbers 14-0194 and
11 case number 15-0010, I make a motion that we
12 accept the recommended action with no
13 violation.

14 MS. YEATMAN: Second.

15 MR. MCCONAGHY: All in favor?

16 DR. MARTIN: Aye.

17 MR. BUNCH: Aye.

18 MS. YEATMAN: Aye.

19 MR. MCCONAGHY: Opposed?

20 (No response.)

21 MR. DARBY: I make a motion we
22 adjourn.

23 MS. YEATMAN: Second.

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MR. MCCONAGHY: Adjourned.

(Whereupon, the meeting was adjourned
at 12:32 p.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 meeting 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

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