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ALABAMA STATE BOARD OF PHARMACY

BUSINESS MEETING

Wednesday, December 16, 2015

9:20 a.m.

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

REPORTER: Sheri G. Connelly, RPR

1 ATTENDEES

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3 BOARD MEMBERS:

4 Dan McConaghy, President

5 Tim Martin, Vice President

6 Buddy Bunch, Treasurer

7 David Darby, Member

8 Donna Yeatman, Member

9

10 ALSO PRESENT:

11 Susan Alverson, Ph.D., Executive Secretary

12 Ralph Sorrell, Incoming Board Member

13 Cristal Anderson, Director of Compliance

14 Mitzi Ellenburg, Director of Operations

15 Eddie Braden, Chief Inspector

16 Mark Delk, Drug Inspector

17 Peyton Zarzour, Drug Inspector

18 Glenn Wells, Drug Inspector

19 Erin Thibodeaux, Intern

20 Henry DePhillips, M.D.

21 Roger Bates

22 Tania Begum

23 Katie Webb

- 1 Cherry Jackson
- 2 Charlie Cook
- 3 Matthew Muscato
- 4 Paul Rengering
- 5 Monica Cooper
- 6 Louise Jones
- 7 Becky Sorrell
- 8 Ralph Sorrell
- 9 Bruce Harris
- 10 Nancy Bishop
- 11 Jim Easter
- 12 Rick Stephens
- 13 John Linna
- 14 Kelli Newman
- 15 Clemice Hurst
- 16 Kathy Ronan
- 17 Molly Johnson
- 18 Julie Hunter
- 19 Robin Stone
- 20 Jeff Sommer
- 21 Kipp Keown
- 22 Dorinda Cale
- 23 Amy Jones

- 1           Bart Bamberg
- 2           Eddie Vanderver
- 3           Sharon Hester
- 4           Chris Burgess
- 5           Cammie Burgess
- 6           C.J. Mark
- 7           Dan Bradshaw

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11                   MR. MCCONAGHY: We'll call the  
12 December 15, 2015, Alabama State Board of  
13 Pharmacy meeting to order. Seeing we have a  
14 quorum with all members present, and we'll start  
15 today asking folks to please stand up and tell  
16 us who you are and where you're from, what  
17 you're here for, and we'll start on the front  
18 row up here.

19                   DR. DEPHILLIPS: Good morning. It's  
20 an honor to be here. My name is Henry  
21 DePhillips. I'm a family physician. I'm also  
22 the chief medical officer for a company called  
23 Teladoc and I think I'm on the agenda to just

1 share some information about telemedicine in the  
2 state.

3 MR. BATES: I'm Roger Bates. I'm here  
4 in dual capacity today for the Pharmacy  
5 Association and with Teladoc.

6 MS. ELLENBURG: Mitzi Ellenburg, Board  
7 of Pharmacy.

8 MS. THIBODEAUX: Erin Thibodeaux, I'm  
9 a current student at the McWhorter School of  
10 Pharmacy and I work for the Board as well.

11 MS. BEGUM: Tania Begum, I'm a student  
12 at Auburn University, pharmacy student.

13 MS. WEBB: I'm Katie Webb. I'm a  
14 pharmacy student, Auburn University, P4.

15 MS. JACKSON: Cherry Jackson, ALSHP.

16 MR. COOK: Charlie Cook, ALSHP.

17 MR. MUSCATO: Matthew Muscato,  
18 Walgreens Pharmacy.

19 MR. RENGERING: Paul Rengering,  
20 Walgreens Pharmacy.

21 Ms. COOPER: Monica Cooper, I'm here  
22 with Roger Bates as well as Teladoc.

23 MS. JONES: Louise Jones, Alabama

1 Pharmacy Association.

2 MS. SORRELL: Becky Sorrell, Ritch's  
3 Pharmacy.

4 MR. SORRELL: Ralph Sorrell, Ritch's  
5 Pharmacy, next year Board member.

6 MR. HARRIS: Bruce Harris, APCI.

7 MS. BISHOP: Nancy Bishop, Department  
8 of Public Health.

9 MR. EASTER: Jim Easter, Baptist  
10 Health System.

11 MR. STEPHENS: Rick Stephens, Senior  
12 Care Pharmacy.

13 MR. LINNA: John Linna, Senior Care  
14 Pharmacy.

15 MS. NEWMAN: Kelli Newman, Alabama  
16 Medicaid.

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

19 MS. RONAN: Kathy Ronan, Auburn School  
20 of Pharmacy student.

21 MS. JOHNSON: Molly Johnson, fourth  
22 year Auburn student.

23 MS. HUNTER: Julie Hunter, Omnicare.

1 MR. STONE: Robin Stone, Blue Cross  
2 Blue Shield of Alabama.

3 MR. SOMMER: Jeff Sommer, Blue Cross  
4 Blue Shield of Alabama.

5 MR. KEOWN: Kipp Keown, Blue Cross  
6 Blue Shield of Alabama.

7 MS. CALE: Dorinda Cale, Blue Cross  
8 Blue Shield of Alabama.

9 MS. JONES: Amy Jones, Blue Cross and  
10 Blue Shield of Alabama.

11 MR. BAMBERG: Bart Bamberg, Publix  
12 Supermarkets.

13 MR. VANDERVER: Eddie Vanderver, CAPS,  
14 Incorporated.

15 MS. HESTER: Sharon Hester,  
16 Transdermal Therapeutics.

17 MR. BURGESS: Chris Burgess, Heritage  
18 Compounding Pharmacy.

19 MS. BURGESS: Cammie Burgess, UAB  
20 Hospital.

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

23 MR. ZARZOUR: Peyton Zarzour, State

1 Board of Pharmacy.

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

4 MS. MARK: C.J. Mark, Teladoc.

5 MR. BRADSHAW: Dan Bradshaw,  
6 Teladoc.

7 MR. MCCONAGHY: I need a motion to  
8 adopt the agenda.

9 MR. DARBY: I make a motion we adopt  
10 the agenda as published.

11 MS. YEATMAN: Second.

12 MR. MCCONAGHY: All in favor?

13 MR. DARBY: Aye.

14 DR. MARTIN: Aye.

15 MS. YEATMAN: Aye.

16 MR. BUNCH: Aye.

17 MR. MCCONAGHY: Hey, Roger, while  
18 we're on the record, can I ask you, are you  
19 billing both clients or just the highest paying?

20 MR. WARD: I was going to say, will  
21 you explain to me how that's done?

22 MR. BATES: You know I can't answer  
23 that question but I appreciate your concern.

1 MR. MCCONAGHY: I was just --

2 DR. DEPHILLIPS: I notice he drove up  
3 in a new car today.

4 MR. MCCONAGHY: All right. The  
5 presentations are first up on the agenda with  
6 Teladoc.

7 MR. BATES: Thank you for allowing us  
8 to be here today. There has been a lot of  
9 public discussion, and I know it's been talked  
10 about even in the Governor's Health Care Cost  
11 Containment Task Force, been a lot of discussion  
12 about the telehealth rules that the Board of  
13 Medical Examiners have passed and then had to  
14 retract after the North Carolina decision and  
15 there has been at least in some places some  
16 level of confusion about what is proper or good  
17 telemedicine, particularly as it pertains to the  
18 pharmacy area.

19 And so one of the ideas that I had  
20 about that was simply to bring the folks here  
21 who do that and who were approved by the State  
22 Board of Medical Examiners to do that so that  
23 you all would have as good an understanding of

1 that process as you could have but also to give  
2 you an opportunity to ask Dr. DePhillips any  
3 questions you've got about that because we need  
4 to eliminate confusion where it exists and  
5 understand what's going on in this particular  
6 area because it is evolving and growing and I --  
7 if you've done any research in advance of this,  
8 then you'll know that Teladoc is the nation's  
9 largest telehealth provider and has refined  
10 their medical protocols with regard to all of  
11 this in a huge way.

12 I was personally involved, as was  
13 Dr. DePhillips, with the Board of Medical  
14 Examiners two years ago in the writing,  
15 drafting, and bringing forth the Board of  
16 Medical Examiners telehealth rules that  
17 unfortunately, due to some litigation in North  
18 Carolina, had to be retracted.

19 So we're not really asking for  
20 anything today except clarification and to  
21 provide information to you so that you can  
22 understand better what the Teladoc model is and  
23 maybe why it's actually being used and it's all

1 right to do that, so Dr. DePhillips.

2 DR. DEPHILLIPS: Thank you, Roger.

3 Mr. Chairman, Board Members, thanks for allowing  
4 me to be here.

5 Mr. Chairman, is there a particular  
6 time frame you want me to stay within? Fifteen,  
7 20 minutes-ish.

8 MR. DARBY: Yeah, you're good.

9 MR. MCCONAGHY: Oh, yeah, that would  
10 be good. We'll let you know if it goes too  
11 long.

12 MR. MCCONAGHY: I mean, he's on the  
13 clock. It's your --

14 DR. DEPHILLIPS: I'm waiting for the  
15 elbow.

16 So very briefly on a sort of personal  
17 and professional note, I have a daughter who's a  
18 pharmacist, so I feel like I'm in good company  
19 here. As you can tell, we are fielding a  
20 football team for the Pharmacy Board today.  
21 Also, on a personal note, I live just up I-65  
22 just outside of Nashville, Tennessee. I drove  
23 down last night and I've enjoyed your state

1 immensely.

2           So I come here for fun as well as for  
3 work. Today is work, but I have several friends  
4 here in Birmingham, been a frequent spectator  
5 and track day participant at Barber Motorsports  
6 Park right down the street in Leeds, and also  
7 just finished a dirt bike event at Seven Springs  
8 with my 17-year-old daughter. It was a great  
9 22-mile ride in the woods over in Tuscumbia,  
10 Alabama, so thanks for having a great state to  
11 have recreation in.

12           On a professional note, I'm the chief  
13 medical officer for a company called Teladoc.  
14 Just by way of background, I am a board  
15 certified family physician. I recertified my  
16 boards last year. That was painful but I  
17 succeeded. I was in private practice as a  
18 family doc for ten years, moved into the health  
19 insurance phase for eight, and have now been a  
20 serial entrepreneur in health care information  
21 technology for 11-and-a-half, going on 12 years.

22           I joined Teladoc about two-and-a-half  
23 years ago and when I made the decision to join,

1 I took a really hard look at the company and the  
2 one thing that struck me about the company is  
3 really what I'm here to share with you today and  
4 that is the boards and the CEOs and the  
5 leadership team's focus on clinical quality  
6 first and foremost, even if it is at the expense  
7 of generating revenue for the company. So this  
8 board and this company has a long-term vision.

9 I've got a couple of points I want to  
10 make. I wrote down a very sophisticated note in  
11 my hotel room this morning and I'll go fairly  
12 quickly through them but please, feel free to  
13 stop and ask me questions if you'd like.

14 Teladoc itself is a 13-, going on  
15 14-year-old company. It was founded in 2002 in  
16 Dallas, Texas. The first remote consultation  
17 for medical care was done in 2005. I actually  
18 met one of the first physicians who credentialed  
19 with the company in 2004. I felt like I was  
20 talking to a piece of history.

21 Over that time, Teladoc has really led  
22 the entire industry of telemedicine across the  
23 entire United States. Fast-forward to today,

1 it's not because we're so smart but I think  
2 because of the business decisions that my  
3 processors made, we're now by far the largest  
4 primary care telemedicine company in the United  
5 States.

6 We currently have I think somewhere in  
7 the neighborhood of 13 million Americans, coming  
8 up on five percent of the U.S. population in our  
9 program. We operate in all states, temporary  
10 pause in Arkansas, we can talk about that if you  
11 like, including Alabama have had a great  
12 relationship with folks here and this year, the  
13 American Telemedicine Association tells us that  
14 there will be about 800,000 primary care remote  
15 visits performed -- telehealth visits performed.  
16 Teladoc will do 540,000 of those, so we're  
17 larger than the entire rest of the industry  
18 combined by about a factor of two. Again, not  
19 because we're so smart but I think we've made  
20 good clinical business decisions.

21 Let me jump to those because I think  
22 that's the key to the discussion. We have what  
23 I call guardrails in place. When we put this

1 business model together -- when my predecessors  
2 put the business model together many years ago,  
3 basically the concept was, and I'm going to be  
4 very transparent and really distill it down into  
5 very straightforward terms.

6           If you take a physician cross-cover  
7 situation where if Riser is a family doc and I'm  
8 a family doc and when have an arrangement where  
9 when he goes on vacation, I cover for his  
10 patients, what the Teladoc founders did was take  
11 that concept and structure it to a much higher  
12 degree and then export that for employers and  
13 health plans and hospital systems who use the  
14 system -- the program today to use.

15           So let me tell you what some of the  
16 guardrails are. First of all, we have a highly  
17 credentialed physician network. We're the first  
18 company in the history of telehealth to achieve  
19 National Committee for Quality Assurance  
20 certification for our credentialing program.  
21 There's now one other small company that has it,  
22 so we're not the only one anymore.

23           We have put together, my predecessor,

1 a very highly academic physician, put together a  
2 consensus group of physicians nationally and  
3 developed a series of evidence-based clinical  
4 practice guidelines that introduced the remote  
5 nature of treatment for common, uncomplicated  
6 medical conditions. Those guidelines are unique  
7 in the world. They don't exist elsewhere.  
8 They're proprietary to us. They are part of our  
9 intellectual property and they are displayed to  
10 each of the physicians and other providers who  
11 perform medical consultations in our program  
12 realtime using technology so that they can  
13 follow those guidelines.

14 We have a clinical quality assurance  
15 program, which includes a physician peer-  
16 reviewed quality assurance committee, a data  
17 analytics team that allows us to take a data-  
18 driven approach. Consumer concerns or  
19 complaints are fed directly into that program.  
20 The physicians themselves are policing each  
21 other in that program. It's a tremendous  
22 program and with the ability we have to sort of  
23 look over the shoulder of the physicians who

1 practice telemedicine around the country,  
2 including Alabama, it's unlike anything that  
3 these physicians have in private practice where  
4 there is not quite that close oversight.

5 We have never in the history of the  
6 company allowed any DEA controlled substances to  
7 go through the program at any time. That's just  
8 a recipe for disaster. We choose not to go down  
9 that road. Maybe it cost us some business but I  
10 think the safety of the program is paramount.

11 We also do not allow any lifestyle drug  
12 prescribing, so erectile dysfunction drugs, off  
13 the table. Diet and weight loss drugs, off the  
14 table. We have no interest in any of those  
15 types of programs.

16 So truly we built this company on  
17 remote access to complicated medical problems  
18 when you can't get to your own primary care  
19 physician or if you don't have one timely. That  
20 is the backbone of the company. We don't want  
21 to replace any existing physician relationships,  
22 but we're available if the patient doesn't have  
23 a PCP, which is 20 percent of the U.S. today, or

1 if there's any difficulty getting ahold of their  
2 primary care physician.

3           We're a sponsored only program. We  
4 are not direct to consumers. Unfortunately,  
5 none of you could use the program today unless  
6 the State insurance program decides to sign  
7 everybody up. So employers buy it for their  
8 employees. Health plans buy it for their  
9 members. Hospital systems buy it for their  
10 patients and for their employees. It is not  
11 open to the general public at this point in time  
12 and currently we have no plans to do that.

13           So I think I've covered most of the  
14 guardrails. My teammate, Roger, will keep me  
15 honest if I miss anything.

16           Let me sort of frame up how we got to  
17 this table, at least as I -- as a former  
18 practicing physician and now health care  
19 information technology physician see it. All of  
20 you, I'm sure, are familiar, at least if you're  
21 my age or older, of the late 1990s, early 2000s  
22 issue with Internet prescribing pharmacies.  
23 Like you, that is the bane of our existence. It

1 drags down the industry. It's terrible  
2 medicine. It's not what we do. It's not what  
3 we condone and we really work hard to separate  
4 ourselves from Internet pharmacies.

5           So you know, for those in the audience  
6 who may not know, back in the day, you know,  
7 there were FDA -- there are FDA-approved  
8 indications for drugs and some entrepreneurial  
9 folks decided to develop a website, put out an  
10 Internet questionnaire. If you answer the  
11 questions in a sequence that allows the company  
12 to determine that you meet the FDA-approved  
13 indications for the drug, you get a prescription  
14 for the drug. It comes from who knows where.  
15 Those programs are largely outlawed, including  
16 here in Alabama, and should be. That is not  
17 what we do. That is not what the program is  
18 about.

19           The program in our world is that on a  
20 sponsored basis, when membership is available to  
21 have the benefit, the first thing that they have  
22 to do is create and aggregate an electronic  
23 health record. So we have a comprehensive

1 health record that's required before the first  
2 consultation can happen for every member in our  
3 program: Past medical issues, surgeries,  
4 medications, allergies, just the same medical  
5 record that you would have in existence  
6 everywhere else.

7           Thanks to our partnership with health  
8 plans like Blue Cross of Alabama, we actually  
9 have the ability to exchange data. We can  
10 receive claims summaries. We can receive care  
11 management data. We can receive pharmacy  
12 information. We have a full integration with  
13 Surescripts, who is our e-prescribing vendor.  
14 I'm sure you guys are familiar with Surescripts.

15           So a lot of the data around the  
16 medical record is shared between the physician  
17 and the patient before the platform allows the  
18 physician and patient to get together to have a  
19 care encounter. That's a requirement. That  
20 medical record is updated. That medical record  
21 is sent to the patient's PCP. It's made  
22 available to the patient to take to their next  
23 visit. It's shared with the partner, in this

1 case Blue Cross of Alabama, and the sharing of  
2 the electronic health record is critically  
3 important.

4 As far as the evaluation itself, there  
5 are three different forms that that takes. So  
6 the realtime interaction between the physician  
7 and patient is either a audio/video interaction.  
8 High definition photographs were exchanged as  
9 part of the electronic health record coupled  
10 together with the phone conversation or a pure  
11 phone conversation. For some common  
12 uncomplicated medical issues, that actually  
13 still is fine. There is -- you know, we have a  
14 fair amount of experience. We passed our  
15 millionth consult a couple of months ago.

16 We'll do two million by the end of  
17 next year and so we have good outcomes data now  
18 on the different modalities. Patients tend to  
19 prefer the high-definition photograph on the  
20 phone. Believe it or not, everybody has got one  
21 of these but people tend not to use video for  
22 phone calls or for accessing health care.

23 The request rate for that is somewhere

1 in the neighborhood of three to four percent.  
2 High definition photographs about nine to ten  
3 percent and then telephone consultations the  
4 rest. It is up to the physician to decide  
5 whether the information-gathering capability is  
6 appropriate given the modality, and if it's not,  
7 they're at liberty, no financial incentive one  
8 way or the other, to refer the patient out to an  
9 alternate setting or to use an alternate means  
10 to gather appropriate clinical information.

11 So where this has gotten us is I  
12 understand -- I'm a little bit surprised, maybe  
13 I shouldn't be, that the Internet pharmacy thing  
14 that I described earlier actually still does  
15 exist. I thought it was outlawed and didn't  
16 exist anywhere but apparently it still does. So  
17 I certainly understand the Board's concern.  
18 It's our concern as well.

19 As a result of the success and the  
20 program that I've outlined to you, we were able  
21 to work, Roger and I, Monica Cooper sitting in  
22 the second row as well, with the Alabama Board  
23 of Medical Examiners. I worked with that Board

1 behind the scenes as well as attended three open  
2 meetings and really helped the Board understand  
3 the industry, the data in the industry, which  
4 I'm happy to share with this group, it's very  
5 good when done right, and help them craft their  
6 regulation that's, you know, put sort of a limit  
7 on telemedicine in the state but allowed through  
8 a -- sort of an exception process companies like  
9 ours to operate.

10 We were the first company to go  
11 through the application to operate in the state.  
12 We were the first company, and up until recently  
13 the only company, that was allowed to operate in  
14 the State by the medical record. They  
15 essentially blessed our program in the state.

16 Subsequent to that, Blue Cross Blue  
17 Shield of Alabama sees the value of what it is  
18 that we offer and I can't speak for them. I  
19 don't work for them. They're represented very  
20 well here today, but they decided to enter into  
21 an enterprise relationship with Teladoc, our  
22 company, to bring a really good quality  
23 telemedicine program in my opinion to all of the

1 citizens in the State of Alabama that are  
2 insured by them.

3 I guess what that gets me to is yes,  
4 I'm nearing the end, I promise, is really two  
5 things: Number one is, we've looked at the  
6 regulation and the regulation appears to be  
7 sound at the Board of Pharmacy level. The  
8 restriction on Internet prescribing is very well  
9 done. We don't have any issues with that.  
10 That's not our model. That doesn't affect us,  
11 at least in our legal opinion. We have looked  
12 at the remote prescribing -- prescribing in  
13 remote situations, electronic health record,  
14 appropriate physical examination, and all of  
15 that is defined and I think that from a  
16 regulation standpoint, we're in pretty good  
17 shape with the Board of Pharmacy regulations. I  
18 don't think we haven't asked to amend or make a  
19 change to any of the regulations. I'll leave  
20 that to my legal colleagues.

21 So I guess lastly what I'll close  
22 with, and then I'm happy to take questions if I  
23 haven't bored you to death, is two things:

1 Number one is, thanks for allowing me to be  
2 here. I'm sorry it took me a little longer to  
3 get here than I wanted it to but I'm glad to be  
4 here today and just to share with you some  
5 information about the program. So if nothing  
6 else, you're at least more knowledgeable and  
7 understanding about what it is that we do in the  
8 realm of telehealth.

9           The second thing is, there are some  
10 pharmacists out there that have some concerns  
11 about filling a prescription absent an in-person  
12 physician visit. Telemedicine is here. It's  
13 growing. It's not a matter of if it's going to  
14 happen. It's a matter of how it's going to  
15 happen in my opinion at this point, and so I  
16 would just hope that the Board would give the  
17 pharmacists around the state some comfort that  
18 at least in a well-structured telemedicine  
19 environment, like the one that our company has  
20 in the marketplace and Blue Cross has in the  
21 marketplace, that it is an appropriate  
22 relationship, there is an electronic health  
23 record, it is okay to fill a prescription, and

1 with that, I'll ask my colleague if I've left  
2 anything out and if not, open for questions.

3 MR. WARD: I've got two questions.

4 DR. DEPHILLIPS: Yes, sir.

5 MR. WARD: There's still a medical  
6 board rule that says it's -- you have to have a  
7 actual visit. It's still there.

8 MR. BATES: Well, it is --

9 MR. WARD: I'm just pointing that out.  
10 I'm not arguing.

11 MR. BATES: Yeah, specifically what  
12 had to happen, Jim, with the rule that was  
13 adopted was they had to grant -- the Board had  
14 to grant an exception --

15 MR. WARD: Right, right.

16 MR. BATES: -- to that particular  
17 rule, which they did in February of 2014  
18 specifically to Teladoc by resolution.

19 MR. WARD: Now that's been  
20 rescinded.

21 MR. BATES: Well, the rule has. The  
22 exemption has not been withdrawn but that  
23 particular rule -- the health rules as a set

1     were.  So we're still fine with the Board of  
2     Medical Examiners as we sit because we have the  
3     exemption that they gave us.

4             MR. WARD:  Is that -- is that  
5     somewhere where a pharmacist knows that?

6             MR. BATES:  If they read -- it's in  
7     the minutes of the --

8             MR. WARD:  If you just go to the  
9     Medical Board -- just practically pharmacists  
10    out in the field, if they would --

11            MR. BATES:  How would they know it?

12            MR. WARD:  If they would go look at  
13    the Medical Board rule, it says that can't  
14    happen, okay.  So that's -- that's issue one.

15            MR. BATES:  Right.

16            MR. WARD:  Issue two is how does the  
17    pharmacist know that it's a patient with this  
18    plan.

19            MR. BATES:  Well, you know, I don't  
20    know what level of inquiry that burden is put on  
21    the pharmacist to go behind any physician  
22    prescription to know the detail of whether  
23    they're a member of a plan or not.  That's

1 putting a pretty high burden on a pharmacist to  
2 conduct an investigation of every script that  
3 comes through the door.

4 MR. WARD: Well, yeah, but the Board  
5 is getting calls about prescriptions that are  
6 being written without a patient visit.

7 MR. BATES: Well, there are --

8 MR. WARD: Isn't that right?

9 DR. ALVERSON: (Nods head.)

10 MR. BATES: Yeah, and I've had some  
11 conversation about that and at least in one  
12 instance, one of them was not a Teladoc, there  
13 was one -- not the ones that they know about,  
14 the ones I know about, was from someone totally  
15 out of another state. It wasn't even written by  
16 an Alabama licensed physician and I think that's  
17 something that maybe we didn't emphasize enough  
18 is that there are no prescriptions written for  
19 anyone in the Blue Cross network or in the  
20 corporate account such as a Home Depot, who has  
21 stores all over the state. Their employees have  
22 access to this. None of those people are  
23 allowed to present a prescription to a pharmacy

1 in Alabama that has not been issued after  
2 consult with an Alabama licensed physician and  
3 that script is written by an Alabama licensed  
4 physician. It doesn't come from somewhere else  
5 in America.

6 DR. DEPHILLIPS: Yeah.

7 MR. BATES: It comes from an Alabama  
8 licensed physician. So if you begin the process  
9 with does the physician have the authority to  
10 write the prescription and the chart was there,  
11 the medical relationship was there, then how far  
12 back are -- would the Board expect a pharmacist  
13 to go to conduct that level of inquiry.

14 MR. WARD: Not so much the Board is  
15 requesting the pharmacist to do it. The  
16 pharmacists are calling the Board and asking.

17 MR. BATES: Well --

18 MR. WARD: They somehow know. That's  
19 all I'm trying to --

20 MR. BATES: Yeah, I would think that  
21 perhaps -- and I don't know, maybe today is the  
22 first time that the Board or staff would realize  
23 and understand that the Teladoc model itself is

1 separate and different from anything else  
2 perhaps because this conversation has never  
3 occurred. Nobody even knew about this unless  
4 they were a part of the rulemaking process that  
5 went on with the Board of Medical Examiners, so  
6 no one would know about these nuances in the  
7 program. Now, we could do a mailer to Alabama  
8 pharmacists ourselves. We could put the word  
9 out that if they're Teladoc, they're different,  
10 but I don't know that the prescription doesn't  
11 come in with Teladoc.

12 DR. DEPHILLIPS: It does not.

13 MR. BATES: It doesn't identify  
14 Teladoc.

15 MR. WARD: I don't know how -- I don't  
16 know how the pharmacist knows.

17 MR. BATES: Yeah, I don't know either.  
18 From my information, all they get is a  
19 prescription. If you see that it's from some  
20 out-of-state physician, I would think a  
21 pharmacist would say, well, where did that come  
22 from or maybe inquire but if you get a  
23 prescription from an in-state physician --

1 MR. DARBY: In the case I was telling  
2 you about earlier, the patient told me.

3 MR. BATES: Yeah, the patient did.

4 MR. DARBY: She came in -- she came in  
5 and she said, yeah, I went to an Internet doctor  
6 and now I've got a dilemma.

7 MR. BATES: From Arizona or somewhere.

8 MR. DARBY: Right.

9 DR. DEPHILLIPS: So just two quick  
10 comments. First of all, my colleagues are  
11 silently kicking me under the table for leaving  
12 one thing out. Our physician network is  
13 physically present in and licensed in all 50  
14 states, so Roger is correct, the only physicians  
15 who would render care through our program for  
16 any citizen in the State of Alabama is an  
17 Alabama licensed physician. The majority, over  
18 two-thirds, are going to be physically resident  
19 in the state but as you know, some -- the  
20 Medical Board does grant licenses to docs who  
21 are in an adjacent state, for example, and we  
22 allow those docs as long as they have a license  
23 in Alabama to render care as well.

1 MR. BATES: Some are state lines.

2 MR. DARBY: We actually have a rule,  
3 680-X-2-.33. You might want to take a look at  
4 that and it talks about -- I'll read it to you.

5 MR. BATES: We've got it right here.

6 DR. DEPHILLIPS: We have it.

7 MR. DARBY: You've got it, okay.

8 MR. BATES: Yeah, we're familiar with  
9 it.

10 MR. DARBY: Okay. And I think that's  
11 what gives the Board a little heartache. That's  
12 what gives the pharmacists a lot of heartache.

13 DR. DEPHILLIPS: Yeah, so I think the  
14 key sentences -- the phrases at the very end,  
15 without a valid preexisting patient practitioner  
16 relationship. Through the 2014 rulemaking  
17 process, it's our opinion that the Medical Board  
18 clearly determined that a valid physician  
19 patient relationship can be created through the  
20 use of remote technology like the types that we  
21 offer.

22 MR. WARD: That would go a long way  
23 for us to help us --

1 DR. DEPHILLIPS: I figured.

2 MR. WARD: There's no way that anybody  
3 knows that from looking at that, including me.  
4 I read it again yesterday, so these things to me  
5 are helpful so people would know.

6 MR. BATES: Yeah, well, that's why we  
7 wanted to come and visit with you about it  
8 because I thought it would be extremely --  
9 extremely helpful. Now, I don't know in a  
10 particular situation what the pharmacists that  
11 contacted y'all --

12 DR. ALVERSON: We have --

13 MR. BATES: What was their --

14 DR. ALVERSON: We have --

15 MR. BATES: I guess what was -- what  
16 was it that brought about the question of the  
17 physician relationship, I guess.

18 DR. ALVERSON: We have had a number of  
19 calls to the office and we had investigators out  
20 all over the state calling on all kinds of  
21 pharmacies and they're being asked over and over  
22 where does the Board stand. So as I understand  
23 it right now, Teladoc has gotten an approval

1 from the Alabama Board of Medical Examiners but  
2 nobody else has; is that correct?

3 MR. BATES: UAB has another pilot  
4 program and I'm not sure all the parameters of  
5 that because I wasn't involved in it.

6 DR. ALVERSON: Right.

7 MR. BATES: But like what we do,  
8 Teladoc is the only one that I'm aware of. Now,  
9 I will say this, that may very well be why there  
10 was concern about the rules in light of the  
11 North Carolina case because there may be other  
12 folks that are more Internet-based operations  
13 that are being excluded by that rule and there's  
14 antitrust concerns about that. That's -- I  
15 mean, Jim, you're familiar with that, so.

16 DR. ALVERSON: But as mentioned,  
17 Doctor, you would not be in support of filling  
18 out a form --

19 DR. DEPHILLIPS: Oh, no.

20 MR. BATES: Absolutely not.

21 DR. ALVERSON: But UAB is filling out  
22 a form only. There is no communication  
23 whatsoever.

1 DR. DEPHILLIPS: I don't know anything  
2 about that program, but that would surprise me.

3 MR. BATES: I just know BME gave them  
4 some sort of approval --

5 DR. ALVERSON: They were here. They  
6 testified. We're telling you. So on that  
7 basis, we've told our pharmacists they may not  
8 fill those prescriptions but other programs are  
9 going to come along other than Teladoc, I  
10 assume, and the pharmacists have no way of  
11 knowing this is an approved program, this isn't  
12 an approved program. The patients aren't going  
13 to be able to identify this was tele-this or  
14 tele-that, hence the question, how are the  
15 pharmacists supposed to know.

16 MR. WARD: That's what we are saying,  
17 how does the pharmacist know. I think that's  
18 the dilemma for y'all to make sure that somehow  
19 that they make sure that they know because they  
20 don't.

21 MR. DARBY: Couldn't you identify that  
22 on the Surescript?

23 DR. DEPHILLIPS: I'm sorry?

1 MR. DARBY: Couldn't you identify on  
2 the Surescript that this is a Teladoc physician?

3 DR. DEPHILLIPS: So I'm not a  
4 technology person. I'm a doctor, but my  
5 suspicion is we probably can.

6 MR. DARBY: Yeah.

7 DR. DEPHILLIPS: And that's an  
8 interesting -- so I'm interested in opinions  
9 about how we can proactively communicate the  
10 program. By way, we're always branded so the  
11 patients do -- you know, Teladoc brought to you  
12 by Alabama Blue Cross, for example, so every  
13 patient knows that they have Teladoc as the --  
14 how they got there. But I agree, I think  
15 proactively communicating to the pharmacist,  
16 either in a blanket way, a letter writing,  
17 whatever, or on a per-prescription basis. To  
18 me, that makes sense.

19 MR. DARBY: Yeah. Just in the  
20 comment -- yeah, there's a comment field down  
21 there.

22 DR. DEPHILLIPS: Yeah.

23 MR. DARBY: It could be there. It

1 could be in the address.

2 DR. DEPHILLIPS: I will take that back  
3 and I -- like I said, I'm not -- I can't speak  
4 for our chief technology officer but I suspect  
5 we can make that happen and that's a very good  
6 idea.

7 MR. DARBY: I will give validity to  
8 your statement. I tried to create an account  
9 while you were talking and it wouldn't let me.  
10 It told me to call y'all.

11 DR. DEPHILLIPS: Yay, the technology  
12 worked as designed.

13 DR. MARTIN: I think actually what  
14 would help is if we could do both of those.

15 DR. DEPHILLIPS: I'm sorry?

16 DR. MARTIN: If we could do both of  
17 those. If we can -- if you can help us put  
18 something in the pharmacist's hands that  
19 connects the dots.

20 DR. DEPHILLIPS: Yeah.

21 DR. MARTIN: Back to the BME that says  
22 it's okay --

23 DR. DEPHILLIPS: Yes.

1 DR. MARTIN: -- so that can go out and  
2 then also per --

3 DR. DEPHILLIPS: On a per-prescription  
4 basis.

5 DR. MARTIN: Yeah.

6 DR. DEPHILLIPS: Yeah, that makes  
7 perfect -- I appreciate that. That makes  
8 perfect sense to me. Roger, are you okay with  
9 that?

10 MR. BATES: Yes, yes.

11 MR. BUNCH: Yeah, that was one of my  
12 questions on specifying if it was a Teladoc  
13 prescription. Just like Susan says, everybody  
14 and their brother is going to have some type of  
15 system. And the second question I had was more  
16 of curiosity: What disease states will you  
17 treat? How deep -- is it going to be like an  
18 ear infection, sore throat, or what are we doing  
19 here as far as --

20 DR. DEPHILLIPS: That's a great  
21 question. So top three for all of '14 and up  
22 until the present in '15 have been sinusitis,  
23 bronchitis, and urinary tract infection. Those

1 are the top three. Beyond that, you know, you  
2 get the smattering -- at the end of the day, we  
3 have highly credentialed physicians and we have,  
4 I think, a great training program but at the end  
5 of the day, we empower the docs to make the  
6 decision about whether whatever the presentation  
7 is can be handled remotely or not. In about  
8 four percent of cases, the docs wind up  
9 referring to an in-person setting because they  
10 don't believe there's enough to go on.

11 MR. BUNCH: So the patient -- the  
12 patient could go on -- the patient could  
13 theoretically go online and say, I'm having  
14 chest pains or whatever and I mean, you would  
15 be -- you wouldn't be surprised but --

16 DR. DEPHILLIPS: We actually saved the  
17 life, I think, of a truck driver who did just  
18 that.

19 MR. BUNCH: Yeah.

20 DR. DEPHILLIPS: Pulled over to the  
21 side of the road, got 911 activated to his  
22 location, and he wound up being in the emergency  
23 room before his heart -- with a heart attack.

1                   MR. BUNCH:  Didn't the UAB thing, it  
2 was just those, like, three items that they --  
3 the patient could even fill the form out for  
4 like a -- I think the same thing.

5                   DR. ALVERSON:  It was very limited.

6                   MR. BUNCH:  Very limited, so your  
7 program is not limited.  They can -- they can  
8 ask for any kind of treatment.

9                   DR. DEPHILLIPS:  Well, we do a lot of  
10 member -- because it's sponsored, we do a lot of  
11 proactive communication as the benefit is  
12 rolling out.  So we do a lot of coaching about  
13 what's appropriate for telehealth versus what's  
14 not appropriate, you know, bleeding, broken  
15 bones, chest pain are not appropriate for  
16 telehealth.  So I'm -- and I think the  
17 four-percent referral rate really shows that  
18 we're doing a reasonably good job.  When I first  
19 came to the company, I thought for sure that  
20 would be ten or 15 percent of calls would be  
21 things we couldn't handle, so I think the  
22 communication goes well.

23                   I'll just share, you know, the

1 anecdotal stories are about as entertaining as  
2 they are informative. We actually still have  
3 people, despite all of the materials, that will  
4 call us at 3:00 in the morning and say, I've got  
5 this kind of heaviness and I'm sweating and it's  
6 down my arm. Do you think I need to go the  
7 emergency room. And the answer, of course, is  
8 yes. Thank you very much, \$40, hang up the  
9 phone. They're happy. They got what they  
10 wanted. They didn't know whether to go back to  
11 bed or go get help and so we still get those  
12 calls occasionally, although we really try to  
13 limit that.

14 MR. DARBY: This might be a Blue Cross  
15 question but how many groups and how many lives  
16 do y'all have in Alabama right now?

17 DR. DEPHILLIPS: Oh, boy, Dan, C.J.,  
18 groups and lives in Alabama total?

19 MR. KEOWN: In terms of employers,  
20 it's north of 25, I think and --

21 MR. BRADSHAW: Come 1/1, we'll have  
22 another 200,000 lives come on, so it's an  
23 individual market.

1 MR. DARBY: 200,000 in addition to  
2 what you have right now?

3 MR. BRADSHAW: Correct.

4 MR. DARBY: And what do you have right  
5 now?

6 MS. MARK: We can get that to you.

7 DR. DEPHILLIPS: So we sell direct to  
8 employers, as well as in conjunction with Blue  
9 Cross. So we have a lot of national -- I think  
10 36 of the Fortune 500 are in our portfolio, so  
11 Home Depot, Costco, you know, the nationals are  
12 in our portfolio today. And then, of course,  
13 with the Blue Cross partnership, which really  
14 launches in earnest on 1/1, it will be a  
15 significant -- significant number.

16 MR. DARBY: Are the state employees  
17 and the local governing boards, are they going  
18 to be included in it?

19 MS. MARK: There is one state entity  
20 going live January 1.

21 COURT REPORTER: Can I get your names,  
22 please, that have spoke on behalf of Blue Cross.

23 MS. MARK: This is Cynthia Mark, C.J.

1 Mark, with Teladoc.

2 COURT REPORTER: Your name, sir?

3 MR. BRADSHAW: Dan Bradshaw from  
4 Teladoc.

5 MR. BATES: C.J., can you say that  
6 again? They couldn't hear what you said. Stand  
7 up. Speak loudly.

8 MS. MARK: Hello, I'm small and short,  
9 so I'll try to be loud. We do have one large  
10 government entity -- State of Alabama entity  
11 going live this -- this January. Yeah, it's a  
12 local government health insurance plan, so  
13 LGHIP.

14 MR. BUNCH: Yeah, I've got one more  
15 question.

16 COURT REPORTER: Your name?

17 MR. KEOWN: Yeah, Kipp, K-I-P-P, last  
18 name K-E-O-W-N, and our individual market is  
19 going on 1/1/16, which is around 200,000.

20 MR. BUNCH: If you -- I guess I'm  
21 reading this as maybe kind of an emergency type  
22 thing or is it? Let's say -- let's say the  
23 physician -- it's not an earache or a

1 bronchitis, so the prescriber would send the  
2 prescription for more of a maintenance  
3 medication with refills. Am I -- am I reading  
4 you -- will that happen or --

5 DR. DEPHILLIPS: So let me -- let me  
6 share with you. So first of all, we are really,  
7 really clear when we sell to employers and  
8 health plans that this is for common,  
9 uncomplicated medical problems. There's a  
10 subset of medical issues that are perfectly  
11 suited for telehealth and then a large group of  
12 medical issues that are not perfect for  
13 telehealth, so common, uncomplicated, think  
14 that.

15 We've actually wrestled with the  
16 refill thing. In the past, we did not allow any  
17 refills of maintenance medication. More  
18 recently with people who travel for business,  
19 you know, families whose kids leave home without  
20 their whatever, we actually will allow -- we  
21 have a very narrowly defined refill policy and  
22 we will allow a very limited number of refills  
23 for people who their documentation of the

1 illness for which the refill is being requested  
2 has already been worked up and documented,  
3 there's documentation that they are actually on  
4 that maintenance drug and it's not a new  
5 prescription, and we have a limit to the number  
6 of times we'll do it. In other words, we don't  
7 want to start becoming a refill center.

8 MR. BUNCH: Well, that was my  
9 question, you know, is this doc in cyberspace  
10 going to be Ms. Jones' doctor, you know, with  
11 reoccurring prescriptions for the same problem  
12 or do they need to have a physician in a brick-  
13 and-mortar building to go into and see or are  
14 we -- are we turning it over -- the patient over  
15 to a doctor somewhere.

16 DR. DEPHILLIPS: No, it's the former,  
17 not the latter. We allow an intermittent refill  
18 for an emergency, you know, travel or ran out on  
19 a Saturday situation to get them to their next  
20 fill but we will not take on the maintenance  
21 medications at this point.

22 MR. BUNCH: Okay.

23 DR. DEPHILLIPS: That's excluded from

1 our program.

2 MR. BUNCH: Okay.

3 DR. DEPHILLIPS: And by the way, the  
4 docs in cyberspace are licensed and most of the  
5 time resident right here in the State of  
6 Alabama. So they have a -- they all work for us  
7 part-time and they all have a bricks-and-mortar  
8 practice.

9 MR. BUNCH: You said at this time. Do  
10 you think that's something you would -- you  
11 would look at later?

12 DR. DEPHILLIPS: Our goal is to  
13 increase the number and percentage of consult  
14 requests that are responded to by -- all of them  
15 have to be licensed in the state. Our goal is  
16 to get it to where it's as close to 100 percent  
17 as we can get. They're also physically present  
18 in the state.

19 MR. BUNCH: Right.

20 DR. DEPHILLIPS: We don't want to  
21 exclude docs who have a license in an adjacent  
22 state --

23 MR. BUNCH: No, no, no.

1 DR. DEPHILLIPS: But we want to  
2 preferentially -- we actually have a five-minute  
3 lead time -- I guess I can say this publicly.  
4 We have a five-minute lead time so that when a  
5 consult request comes in, all of the available  
6 and appropriate docs who are physically resident  
7 in the state get access to the request first,  
8 and then if it's not picked up in five minutes,  
9 then we throw it out through the platform to the  
10 docs who are licensed in Alabama but perhaps not  
11 physically present in the State of Alabama. So  
12 we as a corporate goal have a mission to drive  
13 as much business to docs who are physically  
14 present here as possible.

15 MR. WARD: How many doctors here?

16 DR. DEPHILLIPS: Nationwide or here in  
17 the state?

18 MR. WARD: In the state.

19 DR. DEPHILLIPS: Oh, boy, I probably  
20 should have known that coming in. I want to say  
21 at the moment it's probably in the 30-ish range.  
22 I don't know the exact number but that's -- that  
23 will give you a ballpark number.

1 MS. YEATMAN: Let me --

2 MR. BATES: Let me say too, I don't  
3 think the Board of Medical Examiners will ever  
4 license or approve this practice for a non-  
5 Alabama licensed physician.

6 DR. DEPHILLIPS: Nor should they.

7 MR. BATES: From a safety standpoint,  
8 we don't think they should, but there's also  
9 practice protection considerations.

10 MR. BUNCH: Well, my concern was more  
11 the -- the ongoing refills --

12 DR. DEPHILLIPS: Right.

13 MR. BUNCH: -- you know, this type of  
14 thing.

15 MR. BATES: Which is not what the  
16 program is designed for at all.

17 MR. BUNCH: I understand, yeah.

18 MS. YEATMAN: And I'm just going to be  
19 very specific.

20 DR. DEPHILLIPS: Okay.

21 MS. YEATMAN: So are you saying if I  
22 thought I had a cold, if I thought I had  
23 whatever, strep throat, upper respiratory

1 infection, that's going to be what you're going  
2 to consider an uncomplicated case? Are you  
3 going to do hypertension, you know, a little bit  
4 more than a faint report of what your physicians  
5 are actually going to be prescribing?

6 DR. DEPHILLIPS: Sure. So sinusitis,  
7 bronchitis, urinary tract, those are the top  
8 three. They're very consistent year to year.  
9 During flu season, influenza is a significant  
10 portion. You don't want them coming to the  
11 office anyway and infecting others, and so  
12 there's -- if I understand your question  
13 correctly, there's sort of two tiers of thought.  
14 First of all, is this a standalone issue or is  
15 it bronchitis in the setting of a diabetic who  
16 may be out of control, so those are two separate  
17 issues.

18 If it's the former, probably going to  
19 be pretty well suited but we'll still look for  
20 any red flags -- fever above 104, duration of  
21 therapy, failure of previous therapy, you know,  
22 things that docs would ask for whether you're in  
23 person or not, and if there's any red flags

1     there, that might be a reason the doc would  
2     refer to an in-person setting.  Also, in the  
3     setting of a complex medical history with  
4     bronchitis on top of it, so if they're asthmatic  
5     or diabetic or whatever, then obviously the doc  
6     is going to dive a little bit deeper into how  
7     are the underlying issues doing with bronchitis  
8     layered on top.  That patient is more likely to  
9     be referred to an in-person setting than the  
10    patient without those underlying issues.

11                 So again, we do leave it up to the  
12    doc.  Our clinical practice guidelines address  
13    all of those issues and I can tell you, the top  
14    three -- the top three classes of prescriptions  
15    through our program consistently, year after  
16    year -- generic antibiotics, generic anti-  
17    allergy meds, and generic inhalers.  Those are  
18    the top three.  We have a 98-percent generic  
19    prescribing rate and those are the three classes  
20    that comprise the most.

21                 MR. BUNCH:  This is probably not our  
22    concern at the State Board but how does that  
23    affect the physician's malpractice insurance if

1 they're -- you know, they've never seen the  
2 patient and they prescribe something that they  
3 have a reaction to and unfortunately a lot of  
4 times the pharmacies get sued also although, you  
5 know, we didn't prescribe the medication we get  
6 brought into it. But just curiosity question,  
7 have you had any problems with lawsuits with  
8 patients who come back and say, well, yeah, I  
9 did it. I did it online but now I've been  
10 injured.

11 DR. DEPHILLIPS: So the answer is no,  
12 no issues, and let me just give you a little  
13 detail. Since day one, we have engaged a  
14 reputable medical liability carrier to cover the  
15 activities of every doctor who works for us part  
16 time on the platform. So when the work in their  
17 office, they have their own liability insurance.  
18 When they work, do consultations for us under  
19 contract, then they're covered by our policy.  
20 Our policy has been in place since the company  
21 started. We passed a million consults a month  
22 or two ago. We'll do two million by the end of  
23 next year and not once in the history of the

1 company has even a claim been filed with our  
2 carrier, never mind carried through to  
3 completion. And I think those guardrails that  
4 we --

5 MR. WARD: Shhh, shhh.

6 DR. DEPHILLIPS: Yeah. I hope I can  
7 say it five years from today.

8 MR. WARD: You'll be sued by the end  
9 of the year. Bad, bad, bad karma.

10 MR. DARBY: What information do you  
11 have to have at a minimum to establish a  
12 preexisting patient-practitioner relationship?  
13 Like name, address, telephone number, what  
14 beyond that?

15 DR. DEPHILLIPS: Right. So because  
16 we're a sponsored program, we get a eligibility  
17 file from the plan sponsor. So if Blue Cross  
18 Blue Shield of Alabama, since they're here, I'll  
19 use them as an example, they will -- for all the  
20 200,000 members that are available, they will  
21 actually send us a complete data file with all  
22 of their demographic information, so that we --  
23 the system can identify them as having the

1 benefit when they call in. So we have, you  
2 know, social security number, all of the -- I  
3 don't know all the data on this but all of the  
4 ones that you would expect. So that's step one.

5 Step two is when they do contact us,  
6 an account is created, either through our phone  
7 center or they can do it online through the app  
8 that you just used. How do you like it by the  
9 way? No, I'm just kidding.

10 And then that's when the electronic  
11 health record information is gathered, so their  
12 entire past medical history, all the things I  
13 talked about that you're familiar with. And  
14 then there's a couple of things they have to  
15 tell us, you know, what state are you calling  
16 from, age so that we can assign the right  
17 specialty. We do have pediatricians in addition  
18 to family docs, emergency med, and internal med,  
19 and so all of that has to be gathered before the  
20 first encounter can take place and then all of  
21 that has to be updated subsequently.

22 So you know, I don't know if you're  
23 getting at this: People ask me regularly, you

1 know, how do you prevent fraud. Well, first of  
2 all, with no DEA controlled substances, no  
3 lifestyle drugs, no diet pills, there's not a  
4 lot of fraud to get amoxicillin but that's not a  
5 really good answer. The real answer is that we  
6 actually use the same algorithmic matching  
7 that's used by the banking industry. So if you  
8 were to call the bank and try to, you know, move  
9 money from one account to another, they're going  
10 to ask you some interesting questions that 99  
11 percent of the time you're only going to be the  
12 only one to know the answer to and we use that  
13 same type of matching.

14 MS. ANDERSON: Do y'all utilize  
15 mid-level practitioners?

16 DR. DEPHILLIPS: It's funny that you  
17 ask that. We have not to date but that's --  
18 it's not because we can't or don't want to.  
19 It's because we haven't needed to -- the uptake  
20 on physicians but we -- it's funny because I  
21 just sent a note to the senior management team  
22 as a 2016 initiative that I think it's time we  
23 start working with nurse practitioners,

1 physician assistants, and others. It's totally  
2 appropriate. Obviously it's state by state as  
3 far as the scope of license and we have to do a  
4 regulatory review, but we're wide open to using  
5 mid-level practitioners in our program and we're  
6 already -- with our behavior health program that  
7 we're rolling out, we already are using social  
8 workers, marriage and family therapists, and  
9 other non -- you know, psychologists, other  
10 nonphysician providers in our program.

11 MR. MCCONAGHY: So when -- are they  
12 necessarily speaking screen to screen with a  
13 physician when they're -- when they're having  
14 their conference or teleconference or whatever  
15 it is?

16 DR. DEPHILLIPS: So we have a series  
17 of programs. In the general medical program,  
18 sinusitis, bronchitis, UTI, that's always today  
19 with a physician. That's a board certified  
20 physician in one of the four specialties that I  
21 named. There's no other type for the general  
22 medical -- behavioral health, different story.  
23 Dermatology, we have board certified

1 dermatologists. Tobacco cessation, it's going  
2 to be nurses, so the specialty varies based on  
3 the product that the patient is accessing.

4 MR. MCCONAGHY: Like as far as what  
5 Blue Cross has signed on so far, is that all a  
6 doctor doing that or could it be --

7 DR. DEPHILLIPS: I believe they  
8 have -- they'll correct me if I'm wrong, loudly  
9 probably and appropriately -- I think they've  
10 signed for the general medical program  
11 exclusively so far. I may be wrong about but if  
12 that's the case, there would only be board-  
13 certified physicians who are licensed in the  
14 State of Alabama.

15 DR. MARTIN: At what point would you  
16 refer a patient to one of those other allied  
17 health professionals like physical therapy,  
18 counseling, or whatever those things were you  
19 just named?

20 DR. DEPHILLIPS: It's really at the  
21 physician discretion. So if the physician says  
22 hey, you know, I'm glad to have the opportunity  
23 to fix your sinus infection, but it sounds like

1 with the holidays coming you're a little  
2 depressed, I think you need to XYZ. And so we  
3 actually will make those referrals, not  
4 necessarily to our own program but whatever  
5 environment the patient is in. If they're a  
6 Blue Cross patient, we'll refer them back to  
7 Blue Cross, for example, to get appropriate care  
8 and that does happen. We do make those kinds of  
9 recommendations when we pick those up.

10 DR. MARTIN: Would the physicians have  
11 the opportunity if they encounter a patient with  
12 a very complicated medication regimen or past  
13 history of allergies or duplicate therapy to  
14 refer the patient to a pharmacist for a review?

15 DR. DEPHILLIPS: Today, no, but that's  
16 one of the new programs that we have planned for  
17 2016 is to bring on a panel of pharmacists for  
18 medication issues, obviously near and dear to my  
19 heart since my daughter is a practicing  
20 pharmacist.

21 MR. BATES: Oh, she might make it on a  
22 test question.

23 MR. MCCONAGHY: Roger can probably

1 tell you too that, you know, in the past we've  
2 had groups or other boards pass rules that are  
3 directly in conflict with pharmacy rules that  
4 the Pharmacy Board was never consulted about, so  
5 that's one reason I really wanted y'all to come  
6 and present, but also as far as public -- the  
7 public health goes, I think one area that it's  
8 been fairly well proven that you have a lot  
9 better compliance and outcomes is in the  
10 pharmacy world where there is face-to-face  
11 interaction with the patient and not on the  
12 phone or tele-Internet whatever, you know.

13           That's pretty well documented and  
14 proven and it's easy to see the, you know, this  
15 system being something where you get a  
16 teleconference going on and then that doc sends  
17 it to whoever Blue Cross says is their mail  
18 order prescription pharmacy and you know,  
19 that's -- I don't necessarily think that's good  
20 for the public health of Alabama, so that would  
21 be some of the things I think -- I'll be going  
22 off this Board but that they would be highly  
23 concerned with and you've addressed a lot of

1     them.

2                   DR. DEPHILLIPS:  Yeah, bringing -- you  
3     know, basically, you know, telemedicine is not  
4     about the technology.  It's about what the  
5     technology enables, right.  It's not about the  
6     video thing.  It's about connecting a pharmacist  
7     with a patient who can't drive to the window at  
8     the Walgreens or whatever, right, so it's  
9     bringing that expertise to the patient in a more  
10    convenient, accessible way.

11                   The other thing we're working on, just  
12    so you know that our corporate mission is  
13    aligned with you, is a three-way conversation  
14    between a parent who's on nine medications, a  
15    son or daughter who is the sort of home  
16    caretaker of that person, and then the  
17    pharmacist or other treating entity, so we're  
18    working hard to develop that three-way  
19    capability within HIPAA, you know, there's HIPAA  
20    requirements and things like that, but using  
21    technology, that can be done and we will be  
22    doing it.

23                   DR. ALVERSON:  One or two more

1 questions. Is there anything in the system now  
2 that -- where the physician would turn the  
3 patient over to a mail order program or is that  
4 in the works? Are you thinking about it?

5 DR. DEPHILLIPS: It's really not our  
6 business model. There's no business model we  
7 have at the moment where that would happen. I  
8 guess if I had to -- and this is reaching a  
9 little bit, you can tell -- you know, our  
10 behavioral health program is going to be a  
11 little bit different than what we've done.

12 What we've done in the past is respond  
13 to incoming calls on an episodic basis. With  
14 our behavior health program, there's going to be  
15 longitudinal care. You'll be able to schedule  
16 an hour visit a week for eight weeks with a  
17 psychologist. In those situations, again, no  
18 DEA controlled substances, so ADHD meds are  
19 done, the anxiety meds are done, so we're going  
20 to stay away from those.

21 But for, you know, antidepressants as  
22 an example, there may be an ongoing longitudinal  
23 prescription and that's probably the nearest

1 scenario I can think of where the 90-day supply,  
2 which financially benefits the patient, might be  
3 appropriate. Is that helpful?

4 DR. ALVERSON: That's a possibility,  
5 you will be referring some of it possibly in the  
6 future to -- could be mail order.

7 DR. DEPHILLIPS: Yeah. So we'll issue  
8 the prescription and if we're taking on, for  
9 example, behavioral health, the ongoing  
10 counseling for the patient, it's theoretically  
11 possible we'll issue a 90-day prescription and  
12 then the patient will fill it through mail order  
13 rather than at the pharmacy, I guess. I'm not  
14 sure where you're going, but that's the scenario  
15 that gets closest to --

16 DR. ALVERSON: Obviously that's an  
17 issue with the pharmacists we deal with is  
18 that -- because those prescriptions are going to  
19 go out of state someplace and not be filled by  
20 an Alabama pharmacist.

21 DR. DEPHILLIPS: Yeah, that's a good  
22 point.

23 DR. ALVERSON: So that is an issue for

1     them.

2                   DR. DEPHILLIPS:   That's a good point.  
3     If there are sensitivities around that that we  
4     need to be aware of as we -- our business model,  
5     I'm happy to --

6                   MR. WARD:   And you understand that the  
7     Board can't make a pharmacist do anything.

8                   DR. DEPHILLIPS:   Understood, totally  
9     understood.

10                  MR. WARD:   Ultimately it's the  
11     pharmacist's decision.

12                  DR. DEPHILLIPS:   I totally get that,  
13     totally get that.

14                  MR. BATES:   Yeah, we get that,  
15     absolutely.

16                  DR. DEPHILLIPS:   My colleague just  
17     handed me some information.  Prior to the Blue  
18     Cross Blue Shield of Alabama deployment, we have  
19     98,000 members in Alabama under 885 different  
20     employers in the state.

21                  DR. MARTIN:   Will you give us those  
22     numbers once again, please?

23                  DR. DEPHILLIPS:   Currently, 98,000

1 members have the benefit under 885 different  
2 clients who do business in the state.

3 DR. ALVERSON: Two more comments.

4 DR. DEPHILLIPS: No mail orders.

5 DR. ALVERSON: I don't know if you're  
6 aware or not, but all insurance companies  
7 inspect pharmacies and if they feel the pharmacy  
8 didn't do something exactly the way they wanted  
9 it or expected it to be done, they rescind the  
10 money they paid to the pharmacy for that  
11 prescription, both what they paid for the work  
12 but also for the cost of the drug, even though  
13 the patient got the drug. So it's one of the  
14 reasons we are very concerned about the law  
15 being very well defined because if you filled  
16 it, the Blue Cross Blue Shield and it wasn't  
17 Teladoc, there's a good chance that they're  
18 going to take the money back. You goofed and  
19 that's hard on business.

20 DR. DEPHILLIPS: Yeah, no kidding.

21 DR. ALVERSON: And then I wondered  
22 about this release that Blue Cross Blue Shield  
23 put out saying, we see telemedicine as a

1 possibility to solve cardiological conditions,  
2 behavioral health, dermatological conditions,  
3 infectious disease, and neurological diseases  
4 including stroke, which sounds a little  
5 different than sinusitis and bronchitis and I'm  
6 just wondering, is that in the future?

7 DR. DEPHILLIPS: I'm sorry, ask me the  
8 last part of that question again.

9 DR. ALVERSON: Is that where you're  
10 going?

11 DR. DEPHILLIPS: Well, that's a -- so  
12 I'm an officer of a publicly held company and  
13 I'm not allowed to make any forward-facing  
14 comments. Did you catch that?

15 DR. ALVERSON: I did.

16 DR. DEPHILLIPS: So I'm going to give  
17 you my own personal opinion.

18 DR. ALVERSON: All right.

19 DR. DEPHILLIPS: Separate from  
20 Teladoc's opinion, although they might merge at  
21 some point down the road. My personal opinion  
22 is every specialty can have some representation  
23 in the remote care world. Do we diagnose heart

1 attacks over the telephone, absolutely not. But  
2 once the patient has been through their episode  
3 and is stabilized, on their medications and the  
4 stress test is good, can the follow-up visits be  
5 done without the necessity for the patient to  
6 travel to a center? Absolutely. So there's a  
7 cardiology example.

8           Somebody -- we're not going to  
9 diagnose and treat stroke remotely but once  
10 somebody is stabilized post stroke and they're  
11 on their antiplatelet therapy and we're  
12 titrating medications, can the follow-up visits  
13 be done remotely, absolutely. So my sense of  
14 the industry is that there's a component of  
15 every specialty that can allow access remotely  
16 to care for patient convenience and still be  
17 done medically safely. That's my own personal  
18 opinion.

19           DR. ALVERSON: I appreciate that --

20           DR. DEPHILLIPS: And I'm sticking with  
21 it.

22           DR. ALVERSON: -- very much.

23           MR. BATES: Yeah, I just need to add

1 one thing to that. Those services that she was  
2 talking about in there, those aren't part of the  
3 Teladoc model. That's not what we're doing, so  
4 whatever the model that Blue Cross will work  
5 out, work through, deal with the Board of  
6 Medical Examiners or whatever they're doing,  
7 number one, that's not our -- I just want y'all  
8 to understand that's not our issue.

9 MR. BUNCH: It's not your issue now.

10 MR. BATES: Well, it's not because  
11 it's not our model. It's not what we do and  
12 Blue Cross will have to deal with whoever -- you  
13 know, that's in their domain with the Board of  
14 Medical --

15 MS. YEATMAN: So you're saying Blue  
16 Cross may have more than one telemedicine  
17 delivery?

18 MR. BATES: They certainly could.  
19 They certainly could.

20 MR. DARBY: Have you seen this, Roger?

21 MR. BATES: No.

22 MS. YEATMAN: Do you want to see this?

23 MR. DARBY: Would you like to see it?

1 MR. BATES: I'm always -- I'm always  
2 interested in information. It's just --

3 DR. ALVERSON: And I apologize for --

4 MR. BATES: You know, that's kind of  
5 springing it on me.

6 DR. ALVERSON: I apologize, Roger.

7 MR. BATES: I need to know -- nobody  
8 ever told me.

9 MR. DARBY: It was a public press  
10 release. I mean, it wasn't -- we weren't trying  
11 to hide it from you.

12 MR. BATES: Yeah, I've never seen  
13 this. I don't know. This is not us. That's  
14 all I can say.

15 MR. DARBY: Okay.

16 DR. ALVERSON: It was on my desk and I  
17 wanted to ask.

18 MR. BUNCH: I think that's why I think  
19 Susan said, the rule, the law, whatever, needs  
20 to be very specific because I've been told  
21 before by an insurance company that we're not  
22 going to do mail order and then -- on a  
23 particular deal and then the very next week,

1 letters go out to -- to their subscribers and  
2 offer them mail order with the comment of why  
3 stand in line at a pharmacy. So what is true  
4 today may not be true tomorrow. I'd just like  
5 to make sure we, you know, that that's noted and  
6 in the rule.

7 DR. MARTIN: Let's connect the dots.  
8 I want to kind of piggyback on that, Buddy, and  
9 it's not -- it's not that we exist to protect  
10 the business interests of the pharmacists in the  
11 state, we don't. We exist to protect the  
12 patients' welfare, safety in the health system.  
13 So you've got to tie it back to what Dan said  
14 earlier about the benefit of those face-to-face  
15 encounters, that somebody along the way is  
16 touching that patient, so that's -- that's the  
17 concern.

18 DR. DEPHILLIPS: And we support that  
19 existing in-person chronic med management  
20 relationship. Our model is designed  
21 specifically to not interfere with that  
22 scenario.

23 DR. MARTIN: Correct.

1 DR. DEPHILLIPS: Are we up to -ish?

2 MR. MCCONAGHY: You're dismissed, I  
3 guess.

4 MR. BATES: Well, personally, let me  
5 thank y'all.

6 MR. DARBY: Thank you for coming.

7 MR. BATES: This took far longer and  
8 more of your time than I ever anticipated.

9 DR. MARTIN: It was helpful to us  
10 also.

11 MR. BATES: I hate that. I didn't  
12 intend for that to happen but the conversation  
13 was very helpful for us.

14 DR. ALVERSON: Right.

15 MR. BATES: And I hope we were at  
16 least educational --

17 DR. ALVERSON: We appreciate it.

18 MR. BATES: -- and helpful to you and  
19 we'll try to communicate as best we can to the  
20 pharmacists and if anyone calls here and has a  
21 concern, if you want to refer them to Teladoc to  
22 verify the information so that you have a backup  
23 plan.

1 DR. ALVERSON: That would be great if  
2 we had a phone number and say, just call this  
3 number.

4 MR. BATES: I'll provide that for  
5 you.

6 MR. MCCONAGHY: We just want Doc's  
7 number.

8 MR. BATES: You just want to call Doc,  
9 just call Henry.

10 DR. DEPHILLIPS: My cell phone is  
11 public.

12 MR. BATES: Thank y'all very much.

13 DR. DEPHILLIPS: Thanks for allowing  
14 me to be here.

15 DR. ALVERSON: Or your daughter.

16 DR. DEPHILLIPS: Yeah, my daughter.

17 MR. MCCONAGHY: All right. Buddy  
18 Bunch and the treasurer report is next on the  
19 docket.

20 MR. BUNCH: All right. My usual  
21 informative treasurer's report: There are --  
22 the treasurer's report is in your Dropbox. This  
23 will be my last treasurer's report for the year

1 and David will inherit the treasurer, I assume,  
2 position next year and I'll leave him with a  
3 nice bank account and hopefully he spends it  
4 well.

5 MR. DARBY: I plan to spend it all.

6 MR. BUNCH: But we -- you have it  
7 there. Look it over. If you see anything, any  
8 questions, we'll go over it but income is good.  
9 Again, this is the year that we have the income.  
10 Next year we spend it. It's not a lot of  
11 income -- as much income, so anyone have any  
12 questions on what you see in your Dropbox?

13 MR. MCCONAGHY: Yeah, I've got some  
14 questions, Buddy.

15 MR. BUNCH: All right.

16 MR. MCCONAGHY: Nobody has ever asked  
17 you one so I thought I would ask you one. Are  
18 we on budget?

19 MR. BUNCH: Yes, we are very well on  
20 budget.

21 MR. MCCONAGHY: I thought so. Okay.  
22 That's all I had.

23 MR. DARBY: I make a motion we accept

1 the treasurer's report.

2 MS. YEATMAN: Second.

3 MR. MCCONAGHY: All in favor?

4 MR. BUNCH: Aye.

5 MR. DARBY: Aye.

6 DR. MARTIN: Aye.

7 MS. YEATMAN: Aye.

8 MR. MCCONAGHY: The Wellness Committee  
9 report.

10 DR. ALVERSON: From Dr. Garver:

11 "Ladies and Gentlemen, We are presently at 152  
12 people in our screening program with signed  
13 contracts or orders. This number includes  
14 anyone with a diagnostic monitoring contract but  
15 does not include the professionals that I am  
16 about to mention."

17 "We have two pharmacists in inpatient  
18 treatment, one pharmacist going for evaluation,  
19 two techs in treatment, and two techs going for  
20 evaluation. The total number of pharmacy  
21 professionals identified and worked with in 2015  
22 is 37. This does not include any holdovers from  
23 the previous year for whatever reason. All of

1 those individuals who are in treatment or in  
2 valuation or undecided are out of the workplace.  
3 There are over a dozen others who are working  
4 their way through halfway houses, Timeout for  
5 Recovery, or in the process of being  
6 investigated or scheduled. There are 80  
7 individuals in facility-driven aftercare."

8 "We have met personally with all  
9 licensees returning to work to sign contracts  
10 and to explain how monitoring works. All  
11 returning licensees have been placed in the  
12 caduceus, either pharmacy or health  
13 professional."

14 "Thank you for letting me serve  
15 recovering pharmacy professionals."

16 MR. MCCONAGHY: Thank you, ma'am. If  
17 we have no corrections to the Board minutes, we  
18 need a motion.

19 MR. DARBY: I make a motion we approve  
20 the November 10, 2015, Board business meeting  
21 minutes.

22 MS. YEATMAN: Second.

23 MR. MCCONAGHY: All in favor?

1 MR. DARBY: Aye.

2 DR. MARTIN: Aye.

3 MS. YEATMAN: Aye.

4 MR. BUNCH: Aye.

5 MR. MCCONAGHY: I make a motion we  
6 approve the November 10, 2015, interview  
7 minutes.

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: Eddie, you're next up  
15 with the inspector's report.

16 MR. BRADEN: Yes, sir, Mr. President,  
17 Members of the Board: As you see what we -- had  
18 completed inspections for November and  
19 complaints received and completed in November  
20 and then how we broke it down for the year. As  
21 you can tell, other is always the larger  
22 classification. We're working with our software  
23 company to identify those closer so that you can

1 see exactly what those will be, so we're working  
2 with them right now to get that done. And then  
3 also the other activities the inspectors were  
4 involved in in the month of November is at the  
5 bottom.

6 MR. MCCONAGHY: All right.

7 Secretary's report, Susan, have you got one of  
8 those today?

9 DR. ALVERSON: I only had really one  
10 thing to tell you, so I'm sure you know the  
11 office is closed in line with the State with  
12 what the Governor had mentioned, which will be  
13 the 24th and 25th of December. The office will  
14 also be closed on New Year's Day but not on New  
15 Year's Eve.

16 The last number I heard on technicians  
17 being registered was at 4,000. We have received  
18 more than that but we are still dealing with  
19 people who have not proven their citizenship, so  
20 we will be very happy when we finish this year  
21 and we've gotten through that process, all  
22 right.

23 We will post this on our website. The

1 computer program that we're using after December  
2 31, people still have the option to register  
3 through January with the standards that we have,  
4 so the program does not show them as late or  
5 deleted so we have to leave it open until the  
6 end of January, all right. We can correct that  
7 for next time but we did not think ahead enough  
8 to change that for this year.

9 MR. DARBY: Be sure I understand what  
10 you're saying. So like if I go on January 2 to  
11 check and see if my technicians are current and  
12 they have not renewed, what will it tell me?

13 DR. ALVERSON: It will show that they  
14 haven't renewed, all right. But let's say they  
15 did send in their application but we have not  
16 received information about their citizenship.  
17 It's going to say they've renewed because the  
18 application has been processed.

19 MR. WARD: Oh, Lord.

20 DR. ALVERSON: We realized that and so  
21 we will be able to identify those people within  
22 the office but we can't at this point show  
23 renewed but citizenship isn't finished.

1 MR. BUNCH: Any wild guess about how  
2 many that would be?

3 DR. ALVERSON: I think a couple  
4 hundred.

5 MR. BUNCH: Okay. I think we -- we  
6 need to --

7 DR. ALVERSON: We could create a list  
8 and post that list on the website of -- with a  
9 notice saying --

10 MR. BUNCH: Yeah, you know, even  
11 though it's their responsibility to get that  
12 done, I think if anything we can do since it is  
13 a new thing for them to -- to really kind of  
14 help them with it, then we need to get it done  
15 and save us a lot of problems down the road with  
16 hearings and all. So we can post it or you  
17 know, 200 is a manageable number if it's that  
18 many.

19 DR. ALVERSON: We have not sent their  
20 license out, so even though it says they've  
21 renewed, they would not have a license.

22 DR. MARTIN: So for hospitals, for  
23 example, we can't just go on the fact that they

1 have a license or don't have a license. We have  
2 to do primary-source verification, so as we do  
3 the primary-source verification, we're going to  
4 see approval -- well, it's going to say  
5 pending.

6 DR. ALVERSON: Yes, it will say  
7 renewed or approved.

8 DR. MARTIN: So if --

9 DR. ALVERSON: If they have an active  
10 license.

11 DR. MARTIN: So even though the  
12 citizenship portion is outstanding, it will say  
13 they are active.

14 DR. ALVERSON: Correct.

15 DR. MARTIN: So from a primary-source  
16 verification standpoint, it should not cause a  
17 problem for hospitals going on the website, say  
18 the last week in December, to confirm that  
19 people have renewed. I think your answer was  
20 yes, that's not going to be a problem.

21 DR. ALVERSON: It will say that  
22 they've renewed.

23 DR. MARTIN: Yes.

1 DR. ALVERSON: But it's possible we  
2 don't have their citizenship documentation  
3 yet.

4 DR. MARTIN: Yeah, yeah, well and I  
5 guess I'm looking at it from two perspectives.  
6 One, the perspective of the Board and what that  
7 means and whatever Jim, you know, wants to  
8 comment on about that. But also from the  
9 perspective of hospitals in the state that are  
10 going to go on that last week of December to do  
11 that primary-source verification, there should  
12 not be a problem from that end if they've  
13 renewed.

14 MR. WARD: It's not accurate to say  
15 renewed.

16 MS. ELLENBURG: It's not accurate,  
17 no.

18 DR. ALVERSON: No, it's not.

19 MR. WARD: So we need to figure out --

20 DR. ALVERSON: We need to put it -- we  
21 will put a notice on the website saying, please  
22 check to see --

23 MS. ELLENBURG: The best way to verify

1 it is they should have it in their hand if it's  
2 been processed and everything is through with  
3 us, it's mailed.

4 DR. MARTIN: Yeah, but Joint  
5 Commission accredited sites aren't allowed to  
6 take that as evidence of licensure. We have to  
7 do primary-source verification.

8 MR. WARD: There's not a pending thing  
9 on it?

10 DR. ALVERSON: No, there's not a  
11 pending thing, but we can put a list of people  
12 who have gone through the renewal process but  
13 for whom we do not have proof of citizenship.  
14 We can post that list on our website.

15 MS. ELLENBURG: Can you not go back  
16 and change their status to pending?

17 DR. ALVERSON: I don't know.

18 MS. ELLENBURG: I mean, that is an  
19 option but I don't know if it would mess the  
20 entire program up if you changed it.

21 DR. ALVERSON: I'll call -- we'll call  
22 the computer company and see if --

23 MR. WARD: That would be great

1 pending. That would solve -- that would solve  
2 the problem.

3 DR. MARTIN: And then it throws the  
4 problem downstream.

5 DR. ALVERSON: Yes.

6 DR. MARTIN: You know, but -- you  
7 know, taking it to the next logical step is so  
8 what if someone doesn't provide that information  
9 in a timely manner and it's after the first of  
10 the year, are we at that point bringing  
11 charges --

12 MR. WARD: Yeah, that's the point.  
13 I'm more worried about the pharmacy who looks at  
14 the Board's website and says, oh, they're  
15 renewed and lets them work and then all of a  
16 sudden they get a statement of charges, you  
17 know, that's not fair.

18 DR. ALVERSON: And I think our office  
19 has to be very cognizant of that before we issue  
20 any statement of charges.

21 DR. MARTIN: Yes.

22 MS. ELLENBURG: But does that  
23 nondisciplinary penalty not come in in the month

1 of January.

2 DR. ALVERSON: Yes, that's the issue  
3 exactly.

4 MR. WARD: Just see if you can say  
5 pending. That -- that solves the problem,  
6 pending. See if we can do that.

7 DR. ALVERSON: I will.

8 MR. WARD: Probably -- that's probably  
9 too simple for the computer people.

10 MR. MCCONAGHY: Plus that word got a  
11 lot of people burned when we had the computer  
12 problem last time.

13 DR. ALVERSON: Right.

14 MR. MCCONAGHY: It said pending, so  
15 they're thinking they're waiting on a response  
16 from the Board and some of them hadn't even  
17 filed.

18 MR. WARD: Susan, I'm working the  
19 31st. Alabama kicks off at 7:00, so don't call  
20 after that.

21 DR. ALVERSON: I'm also working the  
22 31st.

23 MR. WARD: Yeah, last year we were

1 crazy that day.

2 DR. ALVERSON: Yes. Thank you.

3 That's all.

4 MR. MCCONAGHY: We don't see how that  
5 affects anything.

6 MR. WARD: Well, the day before I'm  
7 going to the Birmingham Bowl to see the  
8 Tigers.

9 MR. DARBY: I'll give you a shirt to  
10 wear.

11 MR. WARD: All right. I'll wear it  
12 under my other shirt.

13 DR. ALVERSON: Thank you.

14 MR. MCCONAGHY: Does that mean you're  
15 done?

16 DR. ALVERSON: It does mean I'm  
17 done.

18 MR. MCCONAGHY: Mr. Ward.

19 MR. WARD: Sir, I've got about four or  
20 five cases that we need to discuss in executive  
21 session.

22 MR. MCCONAGHY: That's the attorney's  
23 report.

1                   Moving on to old business, the first  
2    item is amendment 680-X-2-.14 to include  
3    background check. I hope one of y'all knows  
4    what's going on with that.

5                   MS. YEATMAN: I do but my note  
6    disappeared. Is it in your paper?

7                   MS. YEATMAN: So as has been discussed  
8    in previous board meetings, we want to add  
9    background screening required for all  
10   technicians -- criminal background, so I'm going  
11   to read the proposed rule and then I'll make a  
12   motion.

13                   Proposed pharmacy technician criminal  
14   background check requirement would read as  
15   follows: "In addition to all other applicable  
16   requirements for registration as a pharmacy  
17   technician and as a prerequisite for  
18   consideration of an application for registration  
19   as a pharmacy technician, each individual  
20   seeking registration as a pharmacy technician  
21   shall consent and be subject to a Board-approved  
22   criminal background check, the cost of which to  
23   be paid by the applicant. The information

1 received as a result of the background check  
2 shall be relied upon in determining whether the  
3 applicant meets the applicable qualifications to  
4 obtain the referenced registration." So at this  
5 point I'd like to make a motion for this  
6 requirement to go into the process of rulemaking  
7 in order to be published and part of the comment  
8 period.

9 DR. MARTIN: Second.

10 MR. MCCONAGHY: Any discussion?

11 (No response.)

12 MR. MCCONAGHY: All in favor?

13 MR. BUNCH: Aye.

14 DR. MARTIN: Aye.

15 MR. DARBY: Aye.

16 MS. YEATMAN: Aye.

17 DR. ALVERSON: Will you provide that  
18 to Mitzi?

19 MS. YEATMAN: I will.

20 MR. MCCONAGHY: All right. Item  
21 number two, 680-X-2-.18, institutional  
22 pharmacies, I think, Tim, you did all the  
23 reading last time. Are we going to have to read

1 that again?

2 MR. WARD: No, sir, you do not unless  
3 we have a pain management doctor here, we do not  
4 have to read it.

5 DR. MARTIN: You know, we -- Susan, I  
6 don't know if I'm doing your job when I say this  
7 but if I am, just kind of grab me and tell me  
8 and I'll stop.

9 There were some comments submitted.  
10 Of course, we had -- we had a comment period at  
11 the last meeting when it was read into the  
12 record. We have received some written comments  
13 and those have been reviewed and they're all  
14 very much in line and reasonable and don't --  
15 from our perspective don't provide -- don't  
16 present any conflicts or what we would consider  
17 substantial changes to the document as it was  
18 proposed. These all need to be addressed in  
19 some fashion and explanation in some way but I  
20 don't think they rise to the level where we need  
21 to go back and write things different.

22 MR. WARD: When the rule -- if it's  
23 adopted, you have to submit something that says

1 these -- these comments were made and the  
2 reasons you're not using them as part of the  
3 rule.

4 DR. MARTIN: Yes.

5 MR. MCCONAGHY: I think we have to  
6 adjust some of the language to clarify.

7 DR. MARTIN: Do you.

8 MR. MCCONAGHY: I don't think it  
9 changes any of the intent of it but yeah, I  
10 don't -- a couple of them may take a little  
11 more, you know, clarification as far as --

12 DR. MARTIN: Is that within our  
13 purview? Can we do that at this point, Jim?

14 MR. WARD: You can amend it, as  
15 amended.

16 DR. MARTIN: As amended, okay. Do we  
17 need to consider the individual comments --

18 MR. WARD: No.

19 DR. MARTIN: -- in this session to do  
20 that?

21 MR. WARD: Yes, you should -- if you  
22 haven't, you should consider them as a body and  
23 decide whether or not you're going to change

1 the -- the substance of the rule based on it.

2 DR. MARTIN: Right.

3 MR. MCCONAGHY: Well, like I said, I  
4 think most of them are we just needed to have a  
5 little more clarifying language. The intent is  
6 not really changed but for instance, one of them  
7 was there was basically the -- they had to  
8 notify the Board every time something -- I mean  
9 within 30 days and get approval when in essence  
10 what we're meaning is once they got their system  
11 approved and everything in place, that when they  
12 went into another home or a different location,  
13 that they just notify the Board that they were  
14 taking the same system and the same -- and they  
15 wouldn't have to go back through the whole  
16 approval process for every little thing they did  
17 and I think that's just tweaking the language a  
18 little bit and I guess we need to do that before  
19 we put it into the -- before we approve it.

20 DR. MARTIN: Well, I guess that's --  
21 I'm asking a procedural question that we can --  
22 we have some options and one is to say that here  
23 are the comments and here's the Board's position

1 on those comments or if I'm hearing Jim right,  
2 we actually need verbiage in there to say we're  
3 amending but they're not substantial and moving  
4 forward.

5 MR. WARD: It's two separate things.  
6 When you adopt -- when there are comments made  
7 to the rule and you do not change the substance  
8 of the rule based on those comments, when you  
9 send the rule as adopted down to the Legislative  
10 Reference Service --

11 DR. MARTIN: Right.

12 MR. WARD: -- there's a -- there's an  
13 explanation that you have to submit. For  
14 example, it would be, comments were received and  
15 reviewed but they did not change the substance  
16 of the rule.

17 DR. MARTIN: Right.

18 MR. WARD: Okay. They have to address  
19 it somehow.

20 DR. MARTIN: Right.

21 MR. WARD: And that's a separate  
22 piece.

23 DR. MARTIN: Correct.

1                   MR. WARD: Today you decide whether  
2 you're going to adopt the rule and if you're  
3 going to amend it in any way, that's what you do  
4 today.

5                   DR. MARTIN: Yes, sir.

6                   MR. MCCONAGHY: But we can -- we can  
7 amend it today, correct language, and then send  
8 it to that --

9                   MR. WARD: Yes, sir, and that's  
10 what -- and that's what's sent down there,  
11 correct, with those -- with those changes.

12                   MR. MCCONAGHY: All right. Well, I  
13 guess we address them one by one then.

14                   DR. MARTIN: And then the -- can we  
15 adopt -- I hate to be so particular but I don't  
16 want to have to do this twice. I don't want to  
17 send it once and then send it a second time.

18                   MR. WARD: That's why we should have  
19 done the public hearing -- so next time remember  
20 to do that, okay.

21                   DR. MARTIN: Right.

22                   MR. WARD: So we can get this through  
23 all at one time.

1 DR. MARTIN: Right.

2 MR. WARD: They are available.

3 Anybody can have a copy of what they want. I'm  
4 not going to say we have to go through it. As  
5 long as y'all can generally describe what they  
6 are, they're available. Anybody who wants a  
7 copy of them, the comments, can have them.

8 DR. MARTIN: Well, let's make an  
9 attempt at doing this, Mr. President. Here's  
10 what I'd recommend that we do: Take the topics  
11 and have some brief discussion about those at  
12 this point and make it clear what -- well, first  
13 off, when we determine that there is consensus  
14 at the Board that this was not a substantial  
15 change and here's what we plan to do about it  
16 but we won't have the exact wording today.

17 MR. MCCONAGHY: Yeah, that's what I  
18 was fixing to say, we can -- we can put the  
19 wording down and intent. This is the intent  
20 anyway.

21 DR. MARTIN: Right, right.

22 MR. MCCONAGHY: That's what I --  
23 that's all I'm worried about, that we get the

1 intent down.

2 DR. MARTIN: Let's do that. Do you  
3 want me to proceed with the ones I have or do  
4 you want to --

5 MR. MCCONAGHY: Go ahead and start  
6 with what you've got because all I've got is --

7 DR. MARTIN: If I leave something out,  
8 someone please jump in.

9 There was a question about how  
10 caregivers in skilled nursing facilities might  
11 be able to access a stat kit or an emergency kit  
12 prior to having an order reviewed by the -- by  
13 the pharmacist and the question particularly  
14 concerned that this would introduce the  
15 requirement that pharmacists would have to  
16 review the order before the drug could be  
17 acquired and that was not the intent and we'll  
18 go back and read the rule once again and clarify  
19 any -- any confusing language related to that.  
20 Any questions from the Board members about that?

21 (No response.)

22 DR. MARTIN: Does that seem  
23 reasonable?

1 MR. MCCONAGHY: Yeah.

2 DR. MARTIN: Okay. There was another  
3 question about -- I believe it was the last  
4 section in the proposed rule dealing with ISMP's  
5 practices and I believe the verbiage was  
6 intended to indicate that the ISMP best  
7 practices are being provided just as that, a  
8 list of best practices, but would not be a  
9 standard to which those sites -- those  
10 pharmacies and those sites would be measured  
11 against.

12 So as someone setting up automated  
13 dispensing cabinets in the skilled nursing  
14 facility, they would in the rule have a list of  
15 what's considered best practice and they could  
16 choose to, for example, write a policy that  
17 follows that outline or address any of those or  
18 not address those but they're not -- they're not  
19 in there in the form of standards to be surveyed  
20 against or inspected against.

21 MR. MCCONAGHY: Yeah, it would  
22 basically be that we're -- we're providing a set  
23 of minimum standards and those are suggestions

1 if you want to go above and beyond or follow  
2 those so -- but I don't think we need to change  
3 anything with that other than it's just an  
4 informative piece that's added in there.

5 DR. MARTIN: Are y'all in agreement  
6 about that?

7 MR. DARBY: Yes.

8 MR. BUNCH: I agree.

9 DR. MARTIN: Okay. Let's see, we had  
10 another one I believe, Dan, this may have been  
11 the one that you were talking about notifying  
12 the Board of Pharmacy about a specific location  
13 and language to where once the managing pharmacy  
14 and technology approved the location, it's  
15 simply a matter of notification of the Board,  
16 not approval of the Board, and that is correct  
17 that if I'm understanding this, that the Board  
18 doesn't want to know -- doesn't have to approve.  
19 I won't say doesn't want to know. You don't --  
20 we don't have to approve that you're moving an  
21 automated drug cabinet from building one to  
22 building two or floor A to floor B, that that  
23 does not require Board approval.

1                   MR. MCCONAGHY: Right, yeah, and I  
2 think the intent was that they would get  
3 approval for the basic system and if they took  
4 that system to another nursing home or whatever,  
5 that they would notify the Board that they were  
6 taking that same system but they wouldn't have  
7 to go through a whole another approval process  
8 for each location and the way it reads kind of  
9 makes you think that it's -- they're going to  
10 have to get approved for every -- every location  
11 that they put one in. I don't think -- now, I  
12 know it wasn't the intent but if we need to  
13 clarify that.

14                   MR. BUNCH: But they could keep it --  
15 as long as they kept it in the same facility,  
16 they could move it where they wanted to but if  
17 they moved it to one of the other facilities.

18                   MR. MCCONAGHY: Well, even say you've  
19 got somebody that wants to try it and they've  
20 got three nursing homes and they want to try it  
21 in one. They go through that approval process  
22 in the first one and they like it and they want  
23 to put it in the other two.

1 MR. BUNCH: Right.

2 MS. YEATMAN: Uh-huh.

3 MR. MCCONAGHY: Then I think the  
4 intent was that they could just say, hey, we're  
5 notifying the Board that we're going to put that  
6 same system and that same process into the other  
7 two homes without having to come back to get  
8 each site individually.

9 MR. BUNCH: Right, right.

10 MS. YEATMAN: Yes, absolutely.

11 DR. MARTIN: Are y'all okay with that?

12 MS. YEATMAN: Yes.

13 DR. MARTIN: The last one I have --  
14 there is a mention of a typo. Of course, we'll  
15 correct that.

16 The last one I had on this one had to  
17 do with allowing a registered pharmacy  
18 technician of the managing pharmacy to conduct  
19 on-site physical inventory and yes, that would  
20 be perfectly fine and if we need to insert some  
21 minor verbiage to allow that, that's not going  
22 to be difficult.

23 MR. MCCONAGHY: Yeah, I don't know if

1 it -- I don't think there's anything in there  
2 that prohibits it. It just doesn't specify it;  
3 right?

4 DR. MARTIN: I believe that's the  
5 case. Is everybody okay with that?

6 MR. WARD: Yeah, that's fine.

7 DR. MARTIN: Did you have any others?

8 MR. MCCONAGHY: That was all that I --  
9 that I remember seeing.

10 MR. DARBY: Were there any other  
11 comments y'all received?

12 DR. ALVERSON: (Shakes head.)

13 DR. MARTIN: That's it?

14 DR. ALVERSON: Yeah.

15 DR. MARTIN: Well, with that said, I'd  
16 propose that we move forward with these changes  
17 since they don't appear to be of a substantial  
18 nature.

19 MR. MCCONAGHY: Yeah, as long as it's  
20 no problem, Jim, with changing, you know, the  
21 language or just clarifying that language and  
22 then sending it down there.

23 MR. WARD: I think that would be -- I

1 think that would be all right. You just do it  
2 as amended and you say how it's amended.

3 MR. MCCONAGHY: Okay.

4 MR. WARD: I think that would be fine.

5 DR. MARTIN: Thank you, Mr. President.

6 I assume we need a motion.

7 DR. MARTIN: I move we continue the  
8 process of rulemaking and send the proposed rule  
9 forward to LRS as specified in the requirements  
10 of rulemaking indicating these updates as  
11 previously discussed just a few minutes ago.

12 MS. YEATMAN: Second.

13 MR. MCCONAGHY: Any more discussion?

14 (No response.)

15 MR. MCCONAGHY: All in favor?

16 DR. MARTIN: Aye.

17 MR. DARBY: Aye.

18 MR. BUNCH: Aye.

19 MS. YEATMAN: Aye.

20 MR. DARBY: Are we done with that?

21 MR. MCCONAGHY: I think we're done  
22 with that. Is there any other old business?

23 MS. ELLENBURG: The one on the mail

1 order.

2 DR. MARTIN: .07?

3 MR. MCCONAGHY: Oh, yeah.

4 MR. DARBY: Do we have any comments on  
5 that one?

6 MS. ELLENBURG: I think there -- all  
7 the comments we got were put in the Dropbox. I  
8 can't remember if it was just the mail order or  
9 for both of them.

10 MR. MCCONAGHY: The only comments I  
11 saw were on the long-term care.

12 MR. DARBY: Yeah.

13 MR. MCCONAGHY: To tell you the truth,  
14 I'm not sure I remember exactly what the mail  
15 order part of it was, so.

16 MR. WARD: You were removing -- you  
17 were repealing the part that required you to  
18 first notify the home state to take an action.  
19 It's the very last part of the rule.

20 MR. MCCONAGHY: Okay. Do we have any  
21 further discussion on that?

22 MR. DARBY: No.

23 MS. YEATMAN: No.

1 DR. MARTIN: So apparently there have  
2 been no written comments?

3 MR. WARD: Just make a motion that it  
4 be adopted and sent down to the Legislative  
5 Reference Service as -- as written.

6 MR. DARBY: I make a motion we send  
7 the proposed rule to LRS as written --

8 MR. WARD: Adopted.

9 MR. DARBY: -- adopted and sent to LRS  
10 as written.

11 MS. YEATMAN: Second.

12 MR. MCCONAGHY: Any more discussion on  
13 that?

14 (No response.)

15 MR. MCCONAGHY: All in favor?

16 DR. MARTIN: Aye.

17 MS. YEATMAN: Aye.

18 MR. BUNCH: Aye.

19 MR. DARBY: Aye.

20 MR. MCCONAGHY: Any more old business,  
21 Mitzi?

22 MS. ELLENBURG: No, sir.

23 MR. MCCONAGHY: Susan.

1 DR. ALVERSON: We had discussed  
2 setting a date for people to come into  
3 compliance with compounding requirements or just  
4 nonsterile compounding.

5 MR. MCCONAGHY: Yeah, Donna, do you  
6 remember that?

7 MS. YEATMAN: I do remember it.

8 MR. DARBY: Yeah, I think it was Donna  
9 that proposed that.

10 MR. BUNCH: January 2025.

11 MR. DARBY: I don't think we're ready  
12 to --

13 MS. YEATMAN: No, there's still not  
14 agreement within the Board at this time --

15 DR. ALVERSON: All right.

16 MS. YEATMAN: -- or with our  
17 attorney.

18 DR. ALVERSON: All right.

19 MR. MCCONAGHY: Okay. We'll move on  
20 to new business and number one to amend the  
21 680-X-2.14 to include background checks.

22 MR. DARBY: That's already been done.

23 MR. MCCONAGHY: We've already done

1 that one.

2 MR. DARBY: We need to do officers --  
3 elect officers.

4 MS. YEATMAN: Well, before we get to  
5 officers, it wasn't on the agenda but part of  
6 new business, and this may not be the right  
7 place to bring it up, but the Board of Pharmacy  
8 has begun discussions with the Board of Medical  
9 Examiners around collaborative practice  
10 agreement and in continuing to pursue that with  
11 the Board of Medical Examiners, I'd like to have  
12 representation from the Board and I just want it  
13 on the record that we have an institutional, a  
14 chain, and a community pharmacist together when  
15 we're having those discussions with the Board of  
16 Medical Examiners so that those practice  
17 settings are represented to make sure as we go  
18 forward that we are addressing all practice  
19 settings and issues.

20 MR. DARBY: And I mean, I would like  
21 to just offer that if one of those practice  
22 settings is excluded from the -- from the  
23 proposed bill, then that -- that person be also

1 dropped off the committee if it doesn't apply to  
2 them.

3 MR. MCCONAGHY: Do you need some -- I  
4 don't know if we need a motion.

5 MS. YEATMAN: I don't know that that's  
6 a motion. I just wanted it to come out on  
7 public record that's how we're proceeding.

8 DR. MARTIN: That sounds good.

9 MR. MCCONAGHY: Since you brought it  
10 up, you just have to make sure it happens,  
11 Donna.

12 MS. YEATMAN: Well, I mean, I think  
13 two of the positions are pretty much -- I'll  
14 represent the chain and Tim will represent  
15 hospital and then it could be the Board members  
16 in those practice settings.

17 MR. WARD: We won't need any further  
18 discussion about those -- about you being the  
19 chain and Tim being the institutional.

20 DR. ALVERSON: There's no other  
21 option.

22 MS. YEATMAN: Do you want it on record  
23 I'm with CVS? Is that what you're doing?

1 MR. WARD: No, no, no.

2 MR. DARBY: Who does she work with?

3 MR. MCCONAGHY: Now, Buddy is  
4 community. He hasn't spoke up down there yet.

5 MS. YEATMAN: So I would say that from  
6 that standpoint, the community representative,  
7 we will defer that decision until January since  
8 we have a new community. You two can duke it  
9 out.

10 DR. ALVERSON: And David.

11 MS. YEATMAN: David's already -- I  
12 think he --

13 MR. DARBY: Donna leaves me out of  
14 everything.

15 MR. WARD: There will be -- there will  
16 be three to duke it out.

17 MS. YEATMAN: That's right. I forgot  
18 about that. Sorry, David. I'll let the three  
19 of them duke it out.

20 DR. MARTIN: Yes.

21 MS. YEATMAN: I was trying to pick  
22 somebody that was a little closer. I was trying  
23 to be considerate of your time.

1 MR. DARBY: Thank you. Thank you.

2 MS. YEATMAN: Next.

3 MR. MCCONAGHY: Any other new  
4 business?

5 MR. WARD: You have to elect officers  
6 this month.

7 MR. MCCONAGHY: Until we get to  
8 that.

9 MS. YEATMAN: No, I don't have  
10 anything else.

11 MR. MCCONAGHY: All right.

12 MR. DARBY: Are you ready for this?  
13 Are you ready?

14 MR. MCCONAGHY: Yeah, y'all -- I'm not  
15 going to be elected so y'all better -- just  
16 handle that, David.

17 MR. DARBY: I make a motion that we  
18 elect Susan Alverson as the executive secretary  
19 to the Board.

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: Aye.

4 MR. DARBY: I make a motion that we  
5 elect Dr. Tim Martin to be president of the  
6 Board.

7 MS. YEATMAN: Second.

8 MR. MCCONAGHY: All in favor?

9 MS. YEATMAN: Aye.

10 MR. BUNCH: Aye.

11 MR. DARBY: Aye.

12 I make a motion that we elect Buddy  
13 Bunch to be the vice president of the Board.

14 MS. YEATMAN: Second.

15 MR. MCCONAGHY: All in favor?

16 MR. DARBY: Aye.

17 DR. MARTIN: Aye.

18 MS. YEATMAN: Aye.

19 MR. MCCONAGHY: Opposed?

20 (No response.)

21 MR. DARBY: I'm not going to nominate  
22 myself.

23 DR. MARTIN: I move we select David

1 Darby as the treasurer for the coming year for  
2 the Board.

3 MS. YEATMAN: Second.

4 MR. MCCONAGHY: All in favor?

5 DR. MARTIN: Aye.

6 MS. YEATMAN: Aye.

7 MR. BUNCH: Aye.

8 MR. MCCONAGHY: Okay. We have  
9 officers elected. No other new business.

10 MR. WARD: You have an executive  
11 session motion when you're ready.

12 DR. ALVERSON: Would you like to  
13 introduce Ralph?

14 MR. MCCONAGHY: Yeah, that's what I  
15 was going to say. We've got Ralph Sorrell, if  
16 you would, stand up. He will be taking my  
17 place, thank goodness.

18 MR. SORRELL: I won't be taking Dan's  
19 place but I will be the new member of the Board  
20 but I will never fill those shoes, I assure  
21 you.

22 MR. MCCONAGHY: Thank goodness. And  
23 we had -- some of the discussion that we had

1 about Ralph being sworn in, I think we finally  
2 clarified that he actually can't be sworn in  
3 until I'm out, which is December 31, and there  
4 was a 30-day discussion in there and that --  
5 that's what if I'd have dropped dead or  
6 something, then you've got to name somebody else  
7 and then they had -- you know, he would have to  
8 be sworn in within 30 days. So I think we've  
9 clarified all of that so that that's not -- and  
10 hopefully some of these guys that will write  
11 this Board manual will get that done like Tim  
12 and I started on four years ago and we haven't  
13 got it done yet.

14 DR. MARTIN: He can take his oath  
15 through a judge at any point. He just can't  
16 become a member of the Board --

17 MR. WARD: -- until Dan goes off.

18 MR. MCCONAGHY: I don't think  
19 officially it even has to be a judge to tell you  
20 the truth. A lot of people have traditionally  
21 done that. I know when I did it, the judge  
22 wanted to swear me in because he was running for  
23 reelection and he thought it might help him. I

1 don't know why.

2 MR. DARBY: How did that election turn  
3 out?

4 MR. MCCONAGHY: He's still -- he's  
5 still there. Louise, did you have a comment?

6 MS. JONES: I did. I would just like  
7 to say that on behalf of the 2,700 plus members  
8 of APA, we would like to thank you for your  
9 years of service on the Board of Pharmacy.  
10 You've done an excellent job of representing the  
11 profession and protecting the public health and  
12 some very positive changes have happened during  
13 your five years of service at the Board and  
14 we're appreciative.

15 MR. MCCONAGHY: Thank you.

16 MR. WARD: Just so -- just so those of  
17 you in the audience don't think we -- we spent  
18 three hours last night telling him how wonderful  
19 he was.

20 MR. MCCONAGHY: Yeah, I don't know  
21 what that was all about.

22 MR. BUNCH: Most of it was positive.

23 MR. MCCONAGHY: Yeah. Some things

1 don't need to be repeated.

2           If we haven't got any other business  
3 then, at this time we will -- I want to  
4 entertain a motion to go into executive session  
5 and I'll tell you why then.

6           MR. DARBY: I make a motion we go into  
7 executive session.

8           MS. YEATMAN: Second.

9           MR. MCCONAGHY: Mr. Ward has expressed  
10 in his report that he has business for executive  
11 session, so at this time, we will go into  
12 executive session for the purpose of discussing  
13 the qualifications, competencies of  
14 professionals, permitholders, registrants, and  
15 other legal matters that may include the  
16 resolution of currently existing cases or any of  
17 those that may be pending.

18           We'll start the executive session at  
19 about 11:15 and hopefully adjourn it by 11:45.  
20 At that time, we will resume the business  
21 session but no other business will be discussed  
22 other than to read in the results of the  
23 executive session.

1           MR. WARD: Sheri, you probably know it  
2 by heart, as attorney for the Board licensed to  
3 practice law in the State of Alabama, I certify  
4 that one of the reasons for going into executive  
5 session is to discuss the resolution of pending  
6 cases.

7           MR. DARBY: I vote yes.

8           MR. MCCONAGHY: We are adjourned  
9 for --

10          MR. DARBY: I vote yes.

11          MR. MCCONAGHY: Oh, I'm sorry. Tim,  
12 how do you vote?

13          DR. MARTIN: Yes.

14          MR. MCCONAGHY: Buddy?

15          MR. BUNCH: Aye.

16          MS. YEATMAN: Yes.

17          MR. MCCONAGHY: I vote yes too. Okay.  
18 Well, I didn't get it right. I'm consistent, 12  
19 out of 12. Thank y'all.

20

21           (Whereupon, a recess was taken for  
22 executive session from 10:56 a.m. to  
23 12:21 p.m.)

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MR. DARBY: On case number 15-0134, I make a motion that we accept the recommended action of a warning letter.

MS. YEATMAN: Second.

MR. MCCONAGHY: All in favor?

MR. DARBY: Aye.

MS. YEATMAN: Aye.

MR. BUNCH: Aye.

MR. DARBY: Case number 15-0140, case number 15-0144, I make a motion we accept the recommended action of permanent surrender.

MS. YEATMAN: Second.

MR. MCCONAGHY: All in favor?

MS. YEATMAN: Aye.

MR. BUNCH: Aye.

MR. DARBY: Aye.

Case number 15-0141, I make a motion that we accept the recommended action of a letter of concern.

MS. YEATMAN: Second.

MR. MCCONAGHY: All in favor?

MR. DARBY: Aye.

1 MS. YEATMAN: Aye.

2 MR. BUNCH: Aye.

3 MR. MCCONAGHY: Aye.

4 MR. DARBY: Case number 15-0145, I  
5 make a motion we accept the recommended action  
6 of a plan of action.

7 MS. YEATMAN: Second.

8 MR. MCCONAGHY: All in favor?

9 MR. DARBY: Aye.

10 MR. BUNCH: Aye.

11 MS. YEATMAN: Aye.

12 MR. DARBY: Case numbers 15-0146,  
13 15-0148, and -- I'm sorry, 15-0101, I make a  
14 motion we accept the recommended action of no  
15 violation.

16 MS. YEATMAN: Second.

17 MR. MCCONAGHY: All in favor?

18 MS. YEATMAN: Aye.

19 MR. BUNCH: Aye.

20 MR. DARBY: Aye.

21 And that's all. I make a motion we  
22 adjourn.

23 MR. MCCONAGHY: I second that.

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(Whereupon, the meeting was concluded  
at 12:23 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 hearing was taken down by me in stenotype and the questions, answers, and statements thereto were transcribed by means of computer-aided transcription and that the foregoing represents a true and correct transcript of the said hearing.

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

/s/ Sheri G. Connelly

SHERI G. CONNELLY, RPR

ACCR No. 439, Expires 9/30/2016

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