ALABAMA STATE BOARD OF PHARMACY

BUSINESS MEETING

Wednesday, April 16, 2014

9:10 a.m.

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

REPORTER: Sheri G. Connelly, RPR

APPEARANCES

BOARD MEMBERS:

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

ALSO PRESENT:

Henry Burks, Chief Inspector
Susan Alverson, Director of Professional Affairs and Secretary
Jim Ward, Board Attorney
Dr. Mike Garver, Director Wellness committee
Rhonda Coker
Lynn Martin
Mark Delk, Inspector
Eddie Braden, Inspector
Terry Lawrence
Tracy Davis
Louise Jones

Jack Burns

Gary Mount

Cara Leos

Tammie Koelz

Ryan Teal

Christy Garner

Rick Stephens

Julie Hunter

Melanie Smith

Meredith Gray

Boopathy Sivaraman

Stephanie Adams

Matthew Muscato

Paul Rengering

Kim Watkins

Brian Wensel

Kristen Larremore

Kelli Newman

Clemice Hurst

Kayla Bratcher

Steve Bethea

Eddie Vanderver

Bart Bamberg

Kyle Frederick
Melanie Smith

Kristen Larremore
Cara Leos
Gary Mount
Louise Jones
Bart Bamberg
Matthew Muscato
Eddie Vanderver
Julie Hunter
Kyle Frederick
Clemice Hurst
Kelli Newman

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MR. CONRADI: Welcome to April 16 Alabama Board of Pharmacy meeting -- business meeting. Of course, if you've been here before, you know the first thing we do is everybody stand up, say who you are and who you represent,

if anybody, loud enough that this young lady to hear it and type it into the record, so we'll start here with Ms. Rhonda.

MS. COKER: Rhonda Coker, Board of Pharmacy.

MS. MARTIN: Lynn Martin, Board of Pharmacy.

MS. JONES: Louise Jones, Alabama Pharmacy Association.

MS. DAVIS: Tracy Davis representing Alabama Pharmacy Association.

MR. BURNS: Jack Burns with Capsa Solutions.

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

MS. LEOS: Cara Leos with ALSHP.

MS. KOELZ: Tammie Koelz, Walgreens Pharmacy.

MR. TEAL: Ryan Teal, Walgreens Pharmacy.

MR. LAWRENCE: Terry Lawrence, Board of Pharmacy.

MS. GARNER: Christy Garner, CVS

Pharmacy.

MR. STEPHENS: Rick Stephens, Senior Care Pharmacy.

MS. HUNTER: Julie Hunter, Omnicare.

DR. GARVER: Mike Garver, Wellness committee.

MS. SMITH: Melanie Smith, BuzzeoPDMA.

MS. GRAY: Meredith Gray, student at Creighton University.

MR. SIVARAMAN: Boopathy Sivaraman, Auburn University, fourth-year pharmacy student.

MS. ADAMS: Stephanie Adams, Samford University, pharmacy student.

MR. MUSCATO: Matthew Muscato, Walgreens Pharmacy.

MR. RENGERING: Paul Rengering, Walgreens Pharmacy.

MS. WATKINS: Kim Watkins, Wal-Mart Pharmacy.

MR. WENSEL: Brian Wensel, Cigna Health Spring.

MS. LARREMORE: Kristen Larremore, Waller Lansden.

MS. NEWMAN: Kelly Newman, Alabama Medicaid.

MS. HURST: Clemice Hurst, Alabama Medicaid.

MS. BRATCHER: Kayla Bratcher, fourth-year student at Samford.

MR. BRADEN: Eddie Braden, Alabama State Board of Pharmacy State drug inspector.

MR. DELK: Mark Delk, State drug inspector, State board.

MR. BETHEA: Steve Bethea, USA Medical Center Mobile.

MR. VANDERVER: Eddie Vanderver, CAPS, Incorporated.

MR. BAMBERG: Bart Bamberg, Publix Supermarkets.

MR. FREDERICK: Kyle Frederick, I'm not representing anyone.

MR. CONRADI: Thank you. To start it off, we'll need to get approval of the agenda.

MR. DARBY: Do you need a motion?

MR. CONRADI: I need a motion.

MR. DARBY: I move we approve the

agenda.

MR. BUNCH: Second.

MR. CONRADI: All in favor?

MR. DARBY: Aye.

MR. BUNCH: Aye.

MR. MCCONAGHY: Aye.

DR. MARTIN: Aye.

MR. CONRADI: We do have a quorum, all five board members being present.

We'll go a little off the order. I'm going to have Mr. Mike Garver get up and give us the Wellness report. He has another meeting to go to. Mike.

DR. GARVER: Thank you. Good morning. Just a couple of remarks if I can. There's a big article in the USA Today that came out yesterday concerning the impairment of health professionals across the United States where they estimate there's over 100,000 untreated health professionals. The study revolves around the failed board and wellness attempt in California to where the program was actually shut down in 2008 because of a lot of lawsuits.

It also dwells on the lack of board oversight. It also talks about the program hiding of health professionals out, not monitoring them. It also talks about lack of discipline component in dealing with health professionals. It's by Peter Eisler, so if you get a chance, look at it online or look at it in the newspaper.

And I just want to tell you that the profession of pharmacy as I know it as a practicing dentist has more safeguards in play than any other profession in the United States. The retail pharmacies with their random urine screens and oversight through cameras and other means have really lowered the amount of problems that are facing other professions. So I just want to let the Board of Pharmacy know that you guys and the profession of pharmacy are light years ahead of dentistry, the physicians, the nurses, the respiratory therapists, and others.

Also, very quickly, the State Board -- this State Board does provide oversight of its Wellness committee. It also provides a

disciplinary component to every rehabilitation of every pharmacist. So you guys need to be proud that your program that you have here and what you do as Board members here are ahead of what other people are doing. You're ahead of the curve for what's going on in the United States, especially since we are now the number one consumer in the United States of hydrocodone in the world. That's a -- that's a pretty big indictment of the drug problem in the United States.

I'm going to read this into the record if you don't mind. There are presently 134 people in our screening program with signed contracts and consent orders. This number includes any individuals on a diagnostic monitoring contract but does not include any of the professionals listed below.

We have one pharmacist currently in treatment. We have three pharmacists in halfway house. There are six pharmacists waiting for a period of time to be reevaluated before coming to the Board. There are six other pharmacists

who need some sort of disposition and the staff is aware of these and we are currently working on them.

There are no techs presently in treatment. There are no students presently in treatment. There are seven techs who need disposition of some sort. They're either just getting out of treatment, just going into treatment, or waiting to be reevaluated, and all of these people that I've talked about are currently -- currently have suspended licenses, so none of them can leave and practice and there are 72 individuals in facility-driven aftercare and that's the April current report of the Wellness committee.

Are there any questions?

MR. CONRADI: Anybody have any questions of Dr. Garver?

DR. MARTIN: No questions.

MR. DARBY: No.

DR. GARVER: All right. Thank you.

MR. CONRADI: You're doing a great job. Thank you, Dr. Garver.

DR. GARVER: Thank you. See you next month.

MR. CONRADI: We have a presentation by First Dose. We'll let them go ahead and do that so we can get that machine out of the middle of everybody's way.

MR. BURNS: I want to start off by apologizing for having this machine. I wanted the Board though to take a look at it and see the physical footprint. That's why I did bring it in.

MR. CONRADI: What's your name?

MR. BURNS: My name is Jack Burns with Capsa Solutions. I do want to thank the Board for giving me a few minutes today to present the FirstDose product.

I'm going to just follow the slide presentation right here. If there's any questions throughout the presentation, please don't hesitate to jump in and ask me.

Capsa Solutions, we are currently making Artromick medication carts and MMI medication carts for the long-term care arena.

Our company has been doing that for well over 50 years. This month I will have been with the company 24 years.

This is a product that we introduced in August with a lot of feedback from pharmacies out there throughout the country that have been looking for something as an answer to their current solutions with the tackle box and handwriting documentation and doses. I do want to point out though with the picture that you see up here, to the left is a tackle box with a lot of different compartments to put the medications. Each state has different amounts of medications that can go in the tackle boxes.

Next to it is a med dispensing system called a Pyxis. The FirstDose is by no means a med dispensing piece of equipment. It is more in the line of an electronic tackle box.

MR. CONRADI: Does it cost more than than a tackle box?

MR. BURNS: Yes, sir, we're going to have to add -- we're going to have to add a couple of zeros here but we're not going to have

nearly the amount that we have right here, okay. Very good question.

What is an e-kit? We talked about that. What do nursing homes use an e-kit for? That's for new admits getting out the first doses of medication that may not be in a medication cart. They'll to a med room, go to the tackle box, break the safety seal, pull out the medications. A lot of facilities now have a lot of times three different tackle boxes: One for the narcotics, one is for the medications, and one for the IVs.

Our FirstDose product does allow all three of those to be in one unit where you have the narcotic box up top here that's double locked, the medications here, and down below in the deep drawer we can also put the IVs. What is wrong with the way it's done today? Well, it's fairly apparent from when pharmacies and facilities talk to me, they say, Jack, a lot of times the nurses are in a hurry. They go to the tackle box, break that safety seal, grab the medications, give the doses to the resident, and

a lot of times there could be family members or there should be some distractions, so a lot of times we don't get that documentation down on who got into it, what medication they got out, and who got that medication. So those are the three things that we at Capsa wanted to make sure we captured with our FirstDose product here.

The FirstDose cart is built off an ACSI. That is an acute care small integrated cart. This cart has been in the hospitals for well over 20 years. The software that runs the ACSI cart has been around for about 15, 18 years that does tracking of who got into the cart and what got into the cart. What we did is we've just tweaked that software a little bit and made it more toward a FirstDose product. The computer here is an all-in-one computer. It will talk realtime with the pharmacy on who got into the cart, what medications were taken out of the cart.

Here is a quick overview of what the cart looks like and some of the features and the

benefits here. That's why I wanted to bring it in here physically to see that it is a large screen. For some of our veteran nurses, they are able to see the screen very well right there. The -- a polite way of saying that we're all getting a little older.

We have different size bins right here to customize the cart. It can hold up to 330 medications. Each one of the individual bins right here can be customized for the size of the medication that's going to go in it. There are the four different models that we offer. We offer some right here that can be all oral solids. We also offer here with high density liquids and low density liquids with the deep drawer down below for the IVs.

There are the specifications. That's why I thought it might be a little bit better to bring it in. You could look at those and say, well, what does that actually look like? It's actually smaller than a treatment cart that most facilities have and again, it would be housed behind the med station in a med room where the

current tackle boxes are now.

Okay. Some of the key selling points right here, we talked about capturing and billing accountability. One of the most important things we write -- see right here it says, lowers pharmacy costs associated with on-call or emergency medication deliveries or back-up pharmacies. The latest medication management system for long-term care. This is a web-based software, so pharmacies and pharmacists can access this and view this remotely as can certain nurse managers that have the ability and the rights to look at that.

Some of the key selling points here is it's a little bit safer. I'm hoping that I can point that out that a tackle box of what they're currently using. It maintains and organizes the medication inventory that can be arranged to pharmacy and facility preferences. We talked about the ability for a pharmacy to customize it for each individual facility. The all-in-one features a large, crisp interface. The cart also locks and unlocks itself automatically and

everything is accessed through the mouse and on the cart. So that locks it, unlocks it, and there's a second authorization code that would get into the narcotic drawer, so there would be two ways to get into the narcotic drawer.

Some of the selling points we talked about here -- the three basic things we talked about: Who's getting into the cart, what's being taken out, and who is it for. When a nurse at a facility needs to access or wants to access the FirstDose, he or she will come up to the screen in the dashboard and on the desktop, there's only going to be one icon. It's not going to be cluttered. It's going to be one icon and it's going to say FirstDose. The nurse would then click on the FirstDose icon and what would pop up would be a log-in screen here and the nurse would log in the user name and a password that would be given to him or her from a nurse manager at the facility. So right there we've immediately captured who got into this cart, okay.

Then the next thing is who is the

medication for, okay. There's just a few spots right here that they need to fill out -- the first and last name. We wanted to make this as simple as we could because if it's a little bit cumbersome, the nurses aren't going to want to use it and therefore it's going to render this product ineffective. So we feel that logging in should be a fairly simple step, what resident is getting the medication, and what medication are they getting.

MR. CONRADI: Is there a list of residents in there so they don't have to type them all in?

MR. BURNS: No, sir, no, sir. We elected at this time for the nurses to enter the resident's name in case there's a John Smith and they click on the wrong John Smith from a long drop-down. So right now we would like the nurses to enter John Smith's name.

Now, the medications will be entered from a master list from the pharmacy and as the nurse starts entering characters, it will tighten that window from what medications they

have to choose from. Now, a nurse could essentially type in Mickey Mouse, Babe Ruth, whatever, but I log in initially so therefore a nurse manager can see what name I put in there, okay. So now we have captured who got into the cart, which was me, who got the medication, and what medication they got, and that is a very good and proper way to get the medications to the right resident at the right time.

Okay. There's all kinds of reports that can be printed out, a fulfillment report on when the medications get low, transaction report who got into the cart, when they got into it, what they took. That can all be viewed at the facility from a nurse manager and be printed out. It can also be viewed remotely from the pharmacy. They can also let know when the medications are low.

To remove an item, once the nurse enters the resident, the med, and a room number or birthdate or both, it's going to tell them where in this cart that medication is located. It's going to highlight the individual bin and

it's highlighted in green there and when the nurse clicks on this little green box here, it's going to pull up a mirror image of the individual bin and what cell that medication is. It's not going to spit out that dose.

Right now the nurse -- the process is they go to the tackle box, they open it up, they kind of hunt and peck for the medication or they look at a list of where it is supposed to be. Here we're trying to help them locate that medication by highlighting it. Once they highlight it, it says, okay, tell us how many you took out and we'll also have an expiration date there. If there's one that expires before that, it's going to pop up a little window to remind the nurses, hey, Jack, you've got a med in there that expires before this one.

The fulfillment report is what we talked about on the mid-max level here. It's a dashboard that pharmacies can pull up every morning to find out the level of each cart and again, this can be done remotely throughout the state. If pharmacies have multiple first does

in multiple facilities, it will give them kind of a little fuel gauge if you will right here on the mid-max level.

Stocking the cart, there's a couple of ways -- we have a little over 60 of these units out in the field throughout the United States. We introduced this product in August. Pharmacies are doing it different ways. Some of them are actually using a cassette exchange and that was why I went ahead and gave you all the brochure up there. Inside the brochure, if I could get you just to take a peek, in the left-hand side you will see a nurse pulling out a cassette. That in essence is a tackle box, very similar to the process what the pharmacies are doing now and I will show you real quick here, this is one way to exchange the medication just like a removable tackle box here, put a safety seal here, bring one from the pharmacy that is full, and exchange it out just like they're doing the tackle boxes now.

Or there is a possibility that the pharmacy can fill on demand. It's whatever the

pharmacies would like to do, how they want to customize the exchange on restocking the cart. We've already talked about that.

This is the expiration report. There are four very important reports that we have right now. We talked about the expiration report, the fulfillment report. The most important report that we are finding feedback from pharmacies and facilities is the transaction report -- who got into that cart, when they got into the cart, what time they got into it, and what they took out of that cart and that's kind of it in a nutshell because I know I am under a time window here for about 45 minutes but I wanted to leave it open for questions but I hope I'll be able to answer. If not, I do have a field service technician waiting on standby on his cell phone or I could get some email questions and answer them for you.

MR. CONRADI: On controlled drugs --

MR. BURNS: Yes, sir.

MR. CONRADI: -- it says two ways to get in.

MR. BURNS: Yes, sir.

MR. CONRADI: When you open that drawer, is there other controls they could get to?

MR. BURNS: Not on -- not on the narcotics.

MR. CONRADI: Okay.

MR. BURNS: Only -- only on the regular medications. So you're right, it's just like a tackle box, if I open up the tackle box, I could get other ones but not on the narcotics. Each individual one is sealed and secure.

MR. CONRADI: Okay.

MR. BURNS: Yeah. Very --

MR. CONRADI: How many typical drugs do you see put in those in a nursing home -- numbers -- different drugs?

MR. BURNS: Well, I live in Atlanta and I cover five states in the Southeast. Tennessee, I've got six units up there that have about 175, 180; down in Florida, close to 220. Georgia, I'm just starting to make headway there and it's well over 100. Please help me here, is

it 60?

MR. CONRADI: Fifty.

MR. BURNS: Fifty, okay, and I think Mississippi is also a lower number too. So again, it's kind of all over the map with what pharmacies are putting in there. I do have some pharmacies that are going to set this up as an oral solid medication all the way down and a separate IV cart where they just have deep drawers and you can put them side by side. Again, right now pharmacies tell me, hey, Jack, I've got three of them I've got to keep up with, three tackle boxes, you know, from a controlled to the IV to the oral solids and we're trying to condense it all right here.

As you see it set up right here with this particular system, this can handle 220 medications and they get dropped into an individual bin that you see right here and you can take these dividers out and customize it any way that you want, make it as big as you want.

MR. CONRADI: You just pulled that drawer out, so you don't have -- it won't

release it when you type in the drug and all, they can pull it out at any time.

MR. BURNS: When you access the cart -- let me see if I understand the question. When you access the cart --

MR. CONRADI: Like you just went and pulled that out just right then.

MR. BURNS: Uh-huh.

MR. CONRADI: But you didn't sign in the patient's name or anything?

MR. BURNS: No, and what I did is I actually overrode this on a keyboard. There will not be a keyboard on the cart themselves. That's just for my demo to open it quickly.

MR. CONRADI: Okay. So they can't get in that drawer until they put the information in?

MR. BURNS: Correct.

MR. CONRADI: And only the one drawer that has that drug in it?

MR. BURNS: Well, when you come here and sign in and I sign in Jack Burns and I put my user name, the cart will automatically

unlock. I do have access to these. I don't have access to the control yet but I can take as many as I want up here.

MR. CONRADI: So nothing is stopping the nurse from putting in one drug and then getting whatever she needed out of it.

MR. BURNS: Absolutely. But then the next nurse that comes in that signs in or a nurse manager that's looking at the report on who got into it, they will know that there are doses missing.

MR. CONRADI: Yeah, I mean, it's no different than a tackle box.

MR. BURNS: Correct, exactly correct.

DR. MARTIN: I see that under the options and accessories you have a scanner holder.

MR. BURNS: Yes.

DR. MARTIN: So you're going to take advantage of barcodes?

MR. BURNS: Absolutely.

DR. MARTIN: Tell us a little about that.

MR. BURNS: We are talking -- our software people right now are getting close to having barcode scanning available. We think it's going to be available the end of the second quarter along with interfacing with a lot of the pharmacy softwares being Framework, QS/1. Right now this talks realtime to a sequel server back at the pharmacy. The facility would set up a VPN, so we would have the security, and eventually we're going to get to the point where we are going to have barcode scanning.

Right now the all in one has the capability to have a camera in it but we choose not to do that right now because of HIPAA. If I'm standing here signing in and I want it to take a picture of me, we don't know if it might capture a resident behind us, so right now at this time we choose not to do that.

You log in by your name and your password. We do have the ability to do that along with the -- now, barcode scanning is high on the list along with interfacing with QS/1 and Frameworks for billing purposes.

DR. MARTIN: You'd be scanning out but not necessarily scanning in.

MR. BURNS: Correct.

DR. MARTIN: Okay. When the nurse removes an item from the cart, the expectation would be that is a FIRST dose that's needed or those are used to fulfill all the patient's medication needs.

MR. BURNS: Correct, correct.

DR. MARTIN: Is it limited to first dose or all of the patient's medication needs stored in the cart.

MR. BURNS: Well, basically on a new admit if -- if the medications have not made it to the facility yet to the actual med cart.

DR. MARTIN: Yes.

DR. MARTIN: That's when they will go to the tackle box --

DR. MARTIN: Right.

MR. BURNS: -- or to our first dose.

DR. MARTIN: Right.

MR. BURNS: -- and there will be the 50 medications in here.

DR. MARTIN: Right.

MR. BURNS: And if there are some that are not in here, then it would fall to the protocol with what are they doing now with their current tackle boxes.

DR. MARTIN: I guess the question is do you envision this now or eventually replacing the med cart?

MR. BURNS: No, we do not. I've been with the company as I said 24 years this month. We are still doing the medication carts that have eMAR that do the documentation for the medication records.

DR. MARTIN: Yeah.

MR. BURNS: This is totally a separate entity for the first dose documentation.

DR. MARTIN: So you would expect the work flow to be something like the nurse enters -- gathers the information, knows the patient, knows the patient room, enters the cart, removes medication, goes immediately to the bedside to administer the medication, no interruptions in between.

MR. BURNS: (Indicating fingers crossed.)

MR. CONRADI: That's the ideal.

MR. BURNS: Yes, exactly, on the nose.

MR. MCCONAGHY: How many more zeroes were you adding on to that tackle box?

MR. BURNS: If it's just between you and I here and nobody else in the room --

MR. MCCONAGHY: That's more like it.

MR. BURNS: This unit -- this unit -- she's still typing over here. This unit comes in at $5,500, okay, and that's all in for the all-in-one unit, the cassette exchanges, and also our implementation team flying from Portland to wherever the pharmacy is located, let's say here in Birmingham, to get the software loaded onto the pharmacy, train the pharmacy for a full day. The next day we will go out to the first facility that the pharmacy wants to install the FirstDose and we will train the nurse managers there. That is all part of that $5,500 is we make sure that the product is rolled out properly and in service properly and

then from that point on, it's going to be more like trainer train everybody else.

MR. BUNCH: Just a curiosity question: Do you have a monthly fee to maintain it?

MR. BURNS: There you go. I did not mention that. We do have a monthly IT maintenance fee that's $41 per month per cart. That would be for any upgrade on the software, like if we had barcode scanning, it would automatically be done because it is web based, cameras, any software updates. I forgot to mention that. Thank you.

MR. DARBY: What problems have you run into in the states you are already operating?

MR. BURNS: Nurses forgetting their user password and logging into the cart. If this cart -- it will be plugged in, so it's electronic and it's not -- even though it's on wheels, it's not meant to roll up and down the hallway because ideally -- and the cart is going to automatically lock itself because it's on a five-minute delay, which is something else I forgot to mention -- that if the nurses walk

away from the cart and don't click the mouse that says lock the cart, the cart automatically locks itself.

We're really finding it's a lot of -- a lot of users getting into it but once they get into the cart, it works extremely well. If the electricity goes down and we have a thunderstorm and the power goes off in the facility and the generators don't kick on immediately and they don't have it plugged in to a red plug, then this turns into a very expensive manual cart that you lock and unlock with the key and then whatever the protocol is for the pharmacy and the facility, they would document it like they're doing now until the power comes back on. So that would be lock number one. And on the back of the cart there is a way to access hidden away a key to unlock the narcotics, so that would still constitute the double lock for the security on the narcotics.

MR. CONRADI: Until everybody found out about both keys.

MR. BURNS: Yeah, and that's a good

question because people say, Jack, who has the keys? I say, who do you want to have the keys? Do you want a nurse manager? Do you want the administrator, DON? Again, I do not want to dictate the policy and procedures on how this cart is implemented. What I'd like to do is have the policies and procedures that are in place with the tackle box now but we just have a better way, I feel, of documenting.

DR. MARTIN: The time-out is adjustable?

MR. BURNS: Yes, it is, between one minute and 99 minutes. It comes in from the factory at a default of five minutes and we feel that that's long enough that if a nurse realizes that he or she didn't lock the cart, it's going to lock. A minute is pretty quick.

MR. BUNCH: You just built a better mouse trap.

MR. BURNS: That's right. I hope so.

DR. MARTIN: The picking of the dose that has the nearest expiration date is going to be a challenge, you already know that, so short

of scanning. If you scan the product and it's got an expiration date embedded, you might could force that a little bit.

MR. WARD: I want to know what you had to eat today with all of that energy.

MR. BURNS: I had three cups of coffee.

MR. CONRADI: Adderall 30.

MR. WARD: You got some stuff -- you got some stuff in that thing?

MR. BURNS: No, no energy drinks, no, sir.

MR. CONRADI: Any other questions?

DR. MARTIN: Well, I do have one, so based on what you said earlier on the other states you're working in and the installs you already have, we can expect -- in fact I think there's already been some talk of the need to increase the number in Alabama from 50 to something greater than 50.

MR. BURNS: Yes, yes, yes, I've heard that absolutely.

MR. CONRADI: Twenty-five?

DR. MARTIN: Fifty-five.

MR. BURNS: Fifty-five. It does hold up to 330. I have not heard of anybody getting close to the 330 meds. As you see it right here, it could hold 220. I've had a couple down in Florida get close to that in the high 190s but -- and that's just loaded.

DR. MARTIN: We're aware that that's an issue that needs to be dealt with.

MR. CONRADI: Susan, do you have a question?

MS. ALVERSON: Yes. Does it have a screen that shows everything in the cart because the physicians will often call and say, well, which antibiotics do you have, for example. Can I pull that up?

MR. BURNS: Well, currently right now you can only pull up what is in the cart by identifying the medication. If you want, the pharmacy can put together a master list of what is in each cart and each cell as a quick reference guide.

MS. ALVERSON: But it wouldn't -- it

will not show on the screen?

MR. BURNS: Right now it will not show on the screen. That --

MR. CONRADI: Didn't you just say you could search it?

MR. BURNS: Yeah, you can search, absolutely, but I think she was trying to get a quick overview of everything. But if you put in the medication and start typing in the characters, it will tell you immediately if it's in there and where it's located.

MS. ALVERSON: But I have -- I can only find it by one name at a time. I can't find --

MR. BURNS: Correct. Now, if that is something, since we do have the monthly maintenance fee for the IT, if that is something that we are getting more and more feedback the more units we get out into the field, I don't think that would be that difficult for our software engineers to implement. Right now if we waited for all the enhancements for the FirstDose product, we would have never launched

this product and we launched it just back in August.

MS. ALVERSON: I think federal law requires that there be a list associated with the cart showing all ingredients and all expiration dates.

MR. BURNS: Well, it is. It's just --

MS. ALVERSON: Rick may know --

MR. STEPHENS: That would be no different than what goes with the tackle box now.

MS. ALVERSON: Right.

MR. STEPHENS: It would just be on a list.

MS. ALVERSON: A separate.

MR. BURNS: Do you know what, that's a good point. You could do exactly like you're doing with the tackle box now and have it in one of the drawers like the deep drawer or some other location. Yeah, that's a good point.

MS. ALVERSON: Now, my second question was a lot of facilities have multiple tackle boxes, not the three different kinds but if it's

a four-floor facility when there's an emergency, you don't want to run from one to the other or run from wing to wing, so do your customers tend to buy multiples of this?

MR. BURNS: Yes, they do, and I like those customers.

MS. ALVERSON: I'm sure you do. And my last question was if -- if I have to take out a couple of ingredients, once I've accessed it, put in the drug name, I open the drawer and I need to get this antibiotic and some Lasix, I could grab both without having entered the name of both.

MR. BURNS: Absolutely correct, and here's a step that I'm hoping during our in-service with the facilities that they follow that protocol and procedure is as you put in Jack Burns, the medication, and I pull that dose, I've done it successfully. I've logged it. You can go right back up into the same window, go to the item locator, and type in the next medication so that there is documentation. You don't have to fill that screen out again but

you would and we would like the nurses to fill in that medication and when you do and click it, it identifies where it is and what bin so you can pull it but nurses have been known to find shortcuts --

MS. ALVERSON: I've worked in long-term care a long time and --

MR. BURNS: -- to streamline the process.

MR. CONRADI: That's no different than a tackle box though.

MR. BURNS: But it's no different than a tackle box.

MS. ALVERSON: No, it is no different than the tackle box, right, but it doesn't prevent that --

MR. CONRADI: Oh, no.

MS. ALVERSON: -- function from happening.

MR. BURNS: No, it does not. No, it does not. We're just --

MR. CONRADI: You have to get up to $25,000 to --

MR. BURNS: That's right.

MS. ALVERSON: And then something comes out and slaps your hand.

MR. CONRADI: Electric shock.

MR. BURNS: Electric shock.

MR. CONRADI: Any more questions?

MR. BURNS: I do appreciate this.

MR. CONRADI: Rick, put y'all on the spot, is this something y'all would actually consider using?

MR. STEPHENS: If you would raise that 50 number.

MR. CONRADI: That's something y'all to petition the Board to ask for. That's a rule. That's easy to -- it could be done.

MR. STEPHENS: I've already written a rule so I get the petition up next.

MR. CONRADI: Yeah.

MS. SMITH: I have a question. In a typical nursing home with these tackle boxes, if somebody opens the controlled substance part, you're supposed to immediately call the pharmacy, and sometimes it doesn't happen, and

get it traded out, so you've got at least kind of a quick view of what might have happened if they don't record it correctly.

In this case here, say you had 50 Lortab in your controlled substance little box there and the first nurse gets one for herself and one for the patient and the next nurse maybe does the same thing or maybe gets several, at what point -- you're not going to get an immediate -- be able to reconcile. It may go a period of time and then you've got to go back and backtrack. Well, these ten nurses had access. Who took -- who's been taking the extras?

MR. BURNS: That's a god point.

MS. SMITH: Is there -- is there an inventory or blind counts?

MR. BURNS: Yes, yes, there is.

COURT REPORTER: Your name, ma'am?

MS. SMITH: My name is Melanie Smith.

MR. BURNS: Great point. There's a couple of ways to access the narcotic box, okay. You put your name -- you put your name and user

passcode in. You get the regular medication. You have to put a second authorization code in to get into the narcotic box and there's three ways to get that access and authorization.

Number one, call the pharmacy for a one-time user code, okay. But again, we're hearing conflicting -- and we've got facilities using all three of these. I call the pharmacy. I get a one-time authorization code but I have to get called back because I'm waiting here for the pharmacy to give it to me but that's one way. There is a record for that one-time authorization.

Number two, go to the nurse manager at the facility to get a one-time user authorization code. Or number three, I have an authorization code tied to my name and user that's totally separate than my user code to get into the cart. So I type in Jack Burns, 1234. I get the regular meds. I want to get into the narcotics, I go 5, 6, 7, 8, so it ties it with me.

Now, at that point I have access. If

I close the drawer, I need another authorization code but let's say I have it open. I pop open that one cubey or cell, break the safety seal. There's ten tablets, one for me, one for them. Put it back in. You can either put -- some pharmacies are saying put a yellow safety seal back on that one, the rest of them are red or blue to know that it's been opened. Close the drawer. What is the policy and procedure now on the tackle boxes for the narcotics? Is there a blind count at the end of every shift like a regular med cart? Whatever the protocol that the facility and pharmacy want to set up, they will be able to do that.

Now, as I take that one dose out, it's going to tell me, Jack, what did you take out? I took out one -- took out one Ambien. How many are left? There's a little window right there that I could put in whatever number I want but then the next nurse that comes back will be able to check and that time period could be a matter of hours or what is the policy and procedure now for the pharmacy? Do they come every 24 hours?

Do they come as soon as that seal is broken? Some pharmacies as soon as this cart is gotten into, they get an email immediately who got into it, what they took out, when they took it out.

So there is a way for the nurses to catch it but yes, to answer your question, one for me, one for them, you could still do it. But we hope that that time period won't be as long as it is now with the tackle boxes.

MS. SMITH: So you've got that -- you say you put the yellow seal on there. Is that for the pharmacy -- when they come to notice that or what if the next nurse notices, she'll have to cut it to get that second drug out?

MR. BURNS: Correct, some pharmacies are doing that. Some pharmacies, that is their procedure that when that safety seal is broken, you put a different safety seal on that that is numbered and identified. Again, you can -- you can customize how you swap out meds, how you load the cart, and the policies and procedures to retrieve medications from the narcotics. I think it's very important and that's where I try

to totally stay out of it because I'm not a pharmacist but I do know that I've got, you know, we have over 60 units out in the field and people are using it different ways so I have a lot of referrals for people to call and get feedback.

MR. BEAR: I'd like to make a comment if I could. My name is Mark Bear.

I'm glad to hear that you have a one-time passcode. It's very important to know -- the pharmacy to know that they have a valid prescription before they authorize dispensing from an automated dispensing system like that, so I'm glad to hear that. That would solve our problem.

MR. BURNS: Appreciate it.

MR. CONRADI: Thank you, Jack.

MR. BURNS: Thank you all very much. Thank you for your time.

MR. CONRADI: If you'll move that.

MR. BURNS: Now they get to see you all.

MR. CONRADI: Thank you.

DR. MARTIN: Thank you.

MR. CONRADI: The next thing on the agenda, Dan, do you have your treasurer's report?

MR. MCCONAGHY: Maybe.

MR. CONRADI: Okay. Or do you want us to do the minutes first?

MR. MCCONAGHY: No, I can go ahead.

MR. CONRADI: Okay.

MR. MCCONAGHY: If y'all have looked at it in the Dropbox there, I'll remind you that we're on pretty much like a two-year cycle and as far as the budget goes, we have already run out of money for this year as far as the income that came in this year but at the six-month mark, I think probably the important thing to look at is where we stand on expenses and we're pretty much in line there.

The personnel expenses are at 51 percent, in-state travel is 51, out-of-state is a little high at 64 but that will smooth out over a couple of months where there's not a whole lot of travel going on. The repair and

the maintenance is at 50 percent, operational is at 45, supplies 42, and your overall expenses are -- you'd thought I'd wrote it up this way -- 49.91 percent at the 50-percent mark, so we're -- we're right on track on expense wise but if you look at the overall numbers, we're -- David, we're losing 200,000 out of the checkbook right now.

MR. DARBY: I noticed that.

MR. MCCONAGHY: That's pretty much right on track and by the end of this fiscal year, we will still have enough money in the checkbook to pay the bills. That's it. Unless you've got questions.

MR. CONRADI: Anybody have any questions?

MR. BUNCH: No questions.

DR. MARTIN: I move we accept the report of the treasurer.

MR. DARBY: I second that.

MR. CONRADI: All in favor?

DR. MARTIN: Aye.

MR. DARBY: Aye.

MR. MCCONAGHY: Aye.
MR. CONRADI: Aye.
MR. BUNCH: Aye.
MR. CONRADI: We've got to approve the minutes from last meeting. Do I have a motion to approve the March 19 board minutes?
MR. BUNCH: I make a motion we approve the March 19 minutes.
MR. DARBY: Second.
MR. CONRADI: All in favor?
DR. MARTIN: Aye.
MR. MCCONAGHY: Aye.
MR. DARBY: Aye.
MR. BUNCH: Aye.
MR. CONRADI: How about the March 19 board work session? Did we have a work session?
MR. DARBY: No, just interview.
MR. CONRADI: And then March 19 interviews.
MR. BUNCH: I make a motion we approve the March 19 interviews.
MR. DARBY: Second.
MR. CONRADI: All in favor?

DR. MARTIN: Aye.

MR. BUNCH: Aye.

MR. CONRADI: Have I got one more aye down there?

MR. DARBY: Aye.

MR. MCCONAGHY: Aye.

MR. CONRADI: Henry, have you got a report for us?

MR. BURKS: Yes, sir, this will just take a second. The monthly enforcement report for March of 2014, there were 86 inspections completed for a total of 310 from the beginning of the year. We have received 26 -- I mean, excuse me, six complaints in the month of March, completed seven in the month of March. We've received a total of 38 complaints from January 1 until March 31 and 27 were completed but some of those 27 were from 2013 and then I have some things to discuss in executive session.

MR. CONRADI: Anybody have any questions for Henry?

DR. MARTIN: No questions.

MR. WARD: No.

MR. CONRADI: Secretary report, Ms. Alverson?

MS. ALVERSON: All right. We have now completed all online renewals for all permits in the state. We will be testing those over the next couple of months but come this fall, we plan on renewing all pharmacists and all facilities online. Right now we're talking about staggering that because you know and I know no matter how perfect we claim any system is, there's going to be a glitch once it's -- we implement it, no matter how much planning we do.

And so we're thinking about having pharmacists begin renewal -- maybe pharmacies begin renewal a few weeks later so we don't have every glitch show up the same week the staff quits, so we'd rather stagger our glitches. So we will probably begin some renewals September 1 and we will most certainly be letting you know when we put that schedule out there.

We have a meeting this week in finalizing the new website. We're hoping to have a new website up within the next few months

that we hope will be user friendly. We will still be rewriting some of the individual pieces but we hope things will be easy to find and easy to use. We are always open to suggestions. If you have any issues, please call us. We'd rather hear you here than have you sitting in Opp, Alabama, calling us bad names or any other place. That was just the shortest word that came to mind.

For the next newsletter it seems we have a lot of questions about e-prescribing. It's very common questions we get, so we plan to publish something in the next newsletter about e-prescribing.

The Board yesterday talked with us about CE hours. That always seems to be a question, what if this, what if that, and so that has been finalized, rewritten. Mr. Ward is preparing that and that's the other thing I have -- well, will go out in the next newsletter so that everybody can say, this is it, it's in black and white, and this is where the Board stands.

I mentioned VPP. I was going to give this to the Board. I know they've seen this. Just so you know what's happening -- I'm trying to be you, Jim.

MR. WARD: I don't know why. Oh, yeah, like the hearings.

MS. ALVERSON: Doing the Vanna thing here.

NABP has initiated, as you probably all know, an inspection program for community pharmacy and are moving toward a time that they will -- would like to be inspecting all pharmacies -- all community pharmacies in the United States. But what's happening right now is this particular article I've distributed to the Board, Virginia is one of the first states to use -- utilize this service and so any company that wants to as an out-of-state company ship products into the State of Virginia, that company must have an inspection from their home state and that must have been completed within the last six months and it must meet Virginia standards.

And so our compounding pharmacies in particular have said, we need an inspection and we need it quickly to meet this deadline in Virginia and some of you have been in that situation. Fortunately our inspection forms for compounding meet Virginia's requirement, so our pharmacies in this State have not had to go to NABP to have an inspection in their pharmacy to be able to ship into Virginia but we foresee more and more of that happening.

From our perspective within the office, we would like to keep our inspections of a high-enough quality that you're not going to have to go out and buy an inspection from an outside source unless that is just your -- your choice to do. We are in the process of upgrading just our general inspections for retail pharmacies, nothing that we're planning to spring on you but just maybe to cover a few more bases. All right.

We are in the process of having our computers -- software be able to take technician applications online, so this past fall we did

technician renewals online. The permit that we do most frequently is technicians, as you can well imagine, and we would like to automate that process. We haven't quite figured out how we're going to automate pictures. We know those under 25 would put a picture I think on the moon if they wanted to. People my age still are having trouble with cameras. The gentleman previously mentioned the big screen, I'm going that's me. Anyway, so we will have to work with how we will handle submission or capturing pictures but other than that, we're hoping to have technician applications done online. All right.

As you've noticed, we have office staff at every meeting now. Our inspectors are invited to the meetings that we have and we would like you to feel comfortable talking to the office staff. We'd like you to feel comfortable talking to any inspectors that are here for meetings.

The building is somewhat locked down. I know as you walk in you -- there's a sense of we -- of security and there are meetings that we

have and days that we have that we need to do that but personally, I feel Wednesdays are our regulars. They're kind of our friends that are here on Wednesdays and so if you feel you need to do work here with the Board staff or the inspectors, I mean, please feel free to do that. If that means walking back to someone's office with someone to get work done, I just don't want you to feel and I -- I haven't checked this with the Board -- I would hope they would feel the same way.

We are here to serve you. We want you to feel comfortable here with all of us. We want you to feel comfortable in this building and so we -- we're trying to move in that direction. If you've got work here to do on Wednesday, please feel free to do that work here and feel we're welcoming to you while you're here.

I have one last thing. I hold in my hand an item that I've been working for one year to get my hands on. You've heard about it in meetings. There have been complaints. Louise,

I have in my hand a database --

MS. JONES: Don't tease me.

MS. ALVERSON: -- for your CE of names and addresses and emails and I bequeath this to you, sorted by active, nonactive, whatever.

MS. JONES: Does it have deceased?

MS. ALVERSON: No.

MS. JONES: Okay, good.

MS. ALVERSON: Well, it has others.

MS. JONES: I see dead people, yeah.

MS. ALVERSON: If this doesn't work, would you wait until tomorrow to call me? I'd like 24 hours of thinking it's good. You're welcome.

MS. JONES: Thank you. And don't call you later and tell you I lost it.

MS. ALVERSON: You can call Terry and tell him you lost it but don't call me.

MR. MCCONAGHY: I thank you too, Susan.

MS. ALVERSON: Is there anything else?

DR. MARTIN: Thank you, very good.

MR. CONRADI: I just say I'd like to

see -- use the VPP at least on virtual wholesalers, things that we have a hard time putting our hands around and seeing if they're legal, so if they do that. I don't know if they -- I know they do facilities and pharmacies.

MS. ALVERSON: We have tightened what we expect for out-of-state facilities. It used to be -- and I'm sure for every state this has been the case -- do you have a license, send us your information. The more and more we read with what's happening out of state in places we can't control so we now require -- are beginning to -- well, we are going to require an inspection and it's up to them to come up with an inspection that will meet our standards that's -- that's current and if that means they have to go to NABP, so be it, because some states don't inspect.

We are requiring that they -- if they're compounders that they fill out our inspection forms, 797 and 795, which would be self-reporting. We're requiring their actual

data on particle counts and viable particle counts so we can review those kinds of things, so it's going to become -- we're expecting more information before we're going to give someone the ALBOP stamp of approval to ship into this state.

And I've spent hours searching for information from the FDA looking at reports from Iowa. We are really trying to track down and know who we are approving before they come into this state.

DR. MARTIN: Thank you, Susan.

MR. CONRADI: Thank you, Susan. Mr. Ward, do you have any report?

MR. WARD: No, I do not.

MR. CONRADI: Old business, have we got any old, unfinished business? I wasn't here last month to know.

MR. WARD: Is Kristen here?

MS. LARREMORE: Yes.

MR. WARD: Do you want to come up here for a minute?

MS. LARREMORE: Sure. Hi.

MR. WARD: Come here for a second.

(Whereupon, a conversation occurred between Ms. Larremore and Mr. Ward outside the hearing of the court reporter.)

MR. CONRADI: Any new business? Louise.

MS. JONES: I just wanted to make the Board aware that based upon the compounding meeting that was held here, was that last week, a week ago, whenever that was, APA has scheduled a compounding meeting at our annual convention when we felt like a large majority of compounding pharmacists would be present. I have notified Susan of that meeting and anyone is welcome to attend and we will send out notice to all of the attendees at the last meeting at the State board to let them know as well where we hope to hold some discussion on what action items the compounding pharmacists of this State would request of the State board on those issues

so.

MR. CONRADI: All right, thank you. We've got to go into executive session to talk about individuals and their ability to practice pharmacy safely. We'll go into it at 10:20, expect to come out at 10:40, and when we come out, we will just have just that -- we will vote on just that meeting -- just those items discussed in that meeting and no more business after that, so you're welcome to stay and come back at 10:40, but the meeting, we'll adjourn it then. So appreciate y'all coming.

MR. WARD: Need a vote.

MR. CONRADI: I'm sorry.

MR. MCCONAGHY: Aye.

MR. CONRADI: All in favor of --

MR. WARD: You can't do it that way.

DR. MARTIN: Person -- voice vote.

MR. CONRADI: Voice vote.

MR. WARD: First of all it needs to be seconded.

MR. DARBY: I'll second it.

MR. WARD: Okay.

MR. CONRADI: Dan, how do you vote?
MR. MCCONAGHY: Aye.
MR. CONRADI: David?
MR. MCCONAGHY: Aye.
MR. CONRADI: Tim?
DR. MARTIN: Aye.
MR. BUNCH: Aye.
MR. CONRADI: Aye.

(Whereupon, a brief recess was taken from 10:10 a.m. to 10:19 p.m.)

MR. CONRADI: We're out of executive session.

Complaint number 13-0621, recommendation, no merit. Do y'all agree? All in favor?

MR. DARBY: Agree.
MR. MCCONAGHY: Agree.
DR. MARTIN: Agree.
MR. BUNCH: Agree.
MR. CONRADI: 13-0639, nondisciplinary letter of concern, and I think that's it, isn't it?

MR. DARBY: Agree.
MR. CONRADI: How do y'all -- agree to that?
MR. MCCONAGHY: Yeah.
MR. DARBY: Yes.
MR. BUNCH: Yes, sir.
MR. CONRADI: 14-0031, no evidence to substantiate and 14-0034, no evidence to substantiate. How do y'all vote?
MR. MCCONAGHY: Aye.
MR. DARBY: Aye.
MR. BUNCH: Aye.
DR. MARTIN: Aye.
MR. CONRADI: Aye.
And 14-0012, accept permanent surrender from the tech and bring statement of charges against supervising pharmacist and permit holder. How do y'all vote?
MR. DARBY: Aye.
MR. BUNCH: Aye.
DR. MARTIN: Aye.
MR. MCCONAGHY: Aye.
(Meeting concluded at 10:40 a.m.)

CERTIFICATE

STATE OF ALABAMA
SHELBY COUNTY

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

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

/s/ Sheri G. Connelly
SHERI G. CONNELLY, RPR
ACCR No. 439, Expires 9/30/2014