Canadian Society of Hospital Pharmacists
Société canadienne des pharmaciens d'hôpitaux

November 20, 2015

Marshall Moleschi
Registrar
Ontario College of Pharmacists
483 Huron Street
Toronto, ON M5R 2R4

Re: CSHP – Ontario Branch Feedback on the proposed revisions to the Ontario College of Pharmacists (OCP) By-Law No. 3

Dear Marshall:

The Ontario Branch of the Canadian Society of Hospital Pharmacists (CSHP-OB) thanks you for the opportunity to provide feedback on the proposed revisions to the Ontario College of Pharmacists (OCP) By-Law No. 3 respecting fee changes, in particular, the implementation of fees for application and issuance of Certificates of Accreditation, and annual renewals of this Certificate. The OCP has done a great deal of work in the last two years to create a framework for, and a baseline assessment of Pharmacy Practice in the Hospital Pharmacy setting.

CSHP-OB certainly welcomes and endorses the OCP's role in this important patient safety and quality initiative. By drawing together best-practice as well as legislated standards into a single organized, justifiable and implementable format is no small endeavor. As a stakeholder in the process as well as a collection of members who have participated in the initial assessment process, we continue to support the ongoing activities of the OCP. The amount of the proposed **total** fees for the province of Ontario seems justifiable on a cost-per-value basis.

The fees and structure presented in the proposed bylaw, however, do raise numerous concerns amongst our membership. We welcome the opportunity to provide feedback on those issues.

The feedback heard most often, is that the fee itself seems excessive when placed next to fees for our colleagues practicing in a Community setting ($940), or a Drug Preparation Premises ($2500). A fee that is over five times greater than the Community annual renewal has captured the attention of most respondents.

This leads to another concern raised: Some members and leaders that responded to CSHP-OB are gravely concerned that these fees will be taken from Pharmacy Departmental or Program operating budgets. Hospitals have little flexibility in absorbing new costs – these monies may well be taken from direct patient care initiatives, or alternately at the expense of other departmental supports or activities

that support direct patient care. It would be unfortunate to see the cost of OCP's activities, aimed at increasing patient safety and quality, actually reduce a hospital's ability to support the same goal.

Smaller, amalgamated hospitals of various configurations and sizes have also raised the concern that efforts to regionalize common services, including programs and activities to standardize medication therapy management, procurement and quality assurance systems will now be compromised due to the approach of this proposed fee structures. In particular, the "per site" strategy suggested will be overwhelming for small hospitals that have used regionalization to gain the ability to provide services above what might be possible if they functioned independently.

As an organization, CSHP-OB is also concerned for the patients at hospitals, particularly smaller institutions that have limited contact with modern, team-centric pharmacy services. These institutions, focusing on how to provide the best possible care for their patients may not be as aware of the benefits to some of the 'aspirational' standards in the OCP assessment document. It would be unfortunate, but we believe possible, for these hospitals to 'opt out' of having a pharmacy department within their hospital. In the short term this could benefit the institution financially, but I cannot believe that would be the intent or goal of the OCP to have the entire pharmacy services outsourced in an effort to avoid the annual fee.

To reiterate, CSHP recognizes the value for the proposed total fees requested by the OCP. To make this financial impact less to hospitals, we submit a few possible alternatives to the proposed fee structure:

1. a flat fee across Ontario Pharmacy in its entirety (same fee for retail and hospital)
2. consideration for reduced fees or a single common fee for amalgamated hospital corporations
3. a tiered system based on number of beds, number of services (according to those defined in the OCP hospital assessment document) or a combination of both
4. a fee per hospital (as defined by the Ministry of Health and Long-Term Care) rather than per site (as defined by OCP accreditation number)
5. a reworking of current bylaw section 14.1 that considers multi-pharmacy fee structures
6. a fee based proportionally on number of beds, number of visits for ambulatory centers, total hospital budget, or Pharmacy operational budget.
7. consideration to have the total provincial fees paid directly from the MoHLTC to the OCP.
8. advocacy to the MoHLTC to increase base budgets and earmark the increase for Pharmacy fees

One particular model discussed at length at the CSHP-OB was the concept of a 'risk/activity formula'. Working on the assumption that a high-risk, high-volume hospital will utilize more of OCP's dedicated but limited resources, and presumably is in a hospital with a larger base budget, we would consider a cost formula structured in the general format of:

1. Base fee (example – congruent with community pharmacy of $940)
2. additional fees:

a. Per-activity fee – using the OCP assessment document, identifying higher risk practice areas – Radiopharmaceuticals; Aseptic Hazardous Drugs preparation; Methadone/Suboxone; high-level automation and charging a $500 “per activity” fee – full suite of this example would be an additional $2000 per year. This may also support Thiessen’s recommendation #8 to annually inspect pharmacies, focusing on risk stratification
b. Per-volume fee. Set a defined “Per Bed”, “Per visit” or combination fee to charge higher costs to those hospitals with a greater need to avail themselves of OCP assessment staff. This could be set to place a “usual” mid-to-large community hospital close to $1500
c. Per-site fee. Add $500 per pharmacy department in an amalgamated entity.

These numbers are for illustration purposes only, and would need to be considered by OCP. CSHP-OB recognizes the value to hospitals that OCP oversight and assessment brings, and wishes to balance that against a hospital’s ability to re-organize revenue and according to the OCP staff workload they would potentially generate.

Again, thank you for the opportunity to present these considerations. CSHP-OB executive is available for discussion of any of these points.

Respectfully submitted on behalf of CSHP-OB executive and council

November 20, 2015

Trent Fookes, RPh, BSP
President, Canadian Society of Hospital Pharmacists – Ontario Branch