TRUSTED TO LEAD.
INSPIRED TO SERVE.
DRIVEN TO PROTECT.
OCP's 2024-2028 Strategic Plan

Board of Directors Meeting Agenda

MONDAY MARCH 25, 2024
9:30 AM – 5:00 PM

MEETING LINK

1. **Welcome and Land Acknowledgement**
   A Land Acknowledgement will be offered.

2. **Declaration of Conflict of Interest**
   Board members will be asked to identify any items on the agenda with which they have or may appear to have a conflict of interest.

3. **Minutes of the December 11th Board Meeting – For Decision**
   The Board will consider the minutes of its last meeting for revision or approval.

4. **Chair's Report – For Information**
   The Chair, James Morrison, will report on activities, decisions, and initiatives undertaken on behalf of the OCP.

5. **Registrar's Report – For Information**
   The Registrar's Report provides information to assist the Board in exercising its oversight function of College operations and updates relevant to the regulatory environment.

   In the interest of time, the Registrar will speak briefly about this item at this meeting but will be available to answer questions.

   5.1 Registrar's Update Dec 2023 - Jan 2024
   5.2 Registrar's Update Feb - March 2024
   5.3 College Performance Scorecard – Key performance results for Q4

6. **2024 College Dashboard Targets - For Decision**
   Director, Corporate Services, Thomas Custers will present a progress update on strategic and operational activities and the Board will be asked to approve targets for the 2024 College Dashboard.

BREAK

7. **Audited Financial Statement – For Decision**
   Finance and Audit Committee Chair, Doug Brown and Tinkham LLP Chartered Professional Accountants will present the audited financial statements for 2023 for Board approval.

8. **Finance and Audit Committee: Changes to Board Policy 4.12 - Investments - For Decision**
   The Finance and Audit Committee Chair will recommend to the Board a change in the Investments Policy to expand the fixed income investment timeline options and consolidate investment categories.

9. **Time-Delayed Safes – Revised Policy – For Decision**
   The Time-Delayed Safes policies have been updated to address recent issues that came to light during implementation. Director, Policy, Engagement and Strategy Implementation, Katya Masnyk will present. The Board will be asked to consider the updated policy for approval.

10. **OCP Approved Training for Compounding Supervisors – For Decision**
    Pharmacy operational assessments indicate that compounding standards are not being fully met, in part due to insufficient training of compounding supervisors.

    Special Projects Manager, Sandra Winkelbauer will recommend the Board consider making OCP-approved training mandatory for new compounding supervisors and compounding supervisors in pharmacies where standards are not met.

11. **Discipline Committee Review Project – Phase II – For Information**
    Director, Conduct, Angela Bates, will provide an update on the Discipline Committee review project.

12. **In Camera - Motion to go in Camera pursuant to the Health Professions Procedural Code, subsections 7(2)(b) and (c)**

13. **Changes to Accreditation Committee Composition By-law – For Decision**
    The requirement to have Public Directors on the Accreditation Committee poses a barrier to forming quorum for it and other committees.

    The Registrar and CEO, Shenda Tanchak, will propose a by-law revision altering the compositional requirements of the Accreditation Committee to replace Public Directors with Lay Committee Appointees.

14. **Proposed Change to Election Eligibility Requirements – For Decision**
    The Ontario College of Pharmacists has committed to promoting equity, diversity and inclusion ("EDI") on the Board. The OCP By-law excludes from eligibility for election those who have been an employee, officer or director of a professional advocacy association within the past three years.

    Some associations exist for the promotion of historically underrepresented groups in the profession. Prohibiting those with leadership roles in such associations from serving on the OCP Board is a barrier to our EDI aims.

    Chair of the Governance Committee, Sara Ingram will present the Governance Committee's recommendation that the By-law be revised to create an exception for associations whose primary purpose is to mitigate systemic barriers.

LUNCH

15. **Executive Committee Election – For Decision**
    The Chair of the Governance Committee will call for interest from public board members in running for election to the Executive Committee.

    The Board will elect a new member to the Executive Committee.

16. **Board Composition Requirements for 2024 Elections – For Decision**
    The 2024 Skills Attributes Survey identified that the current OCP Board is generally well-balanced with strong skills present across the competencies.

    The Chair of the Governance Committee will make recommendations for the skills focus for candidates in the 2024 election.

17. **Appointment of the 2024 Screening Committee – for Approval**
    The Board Chair will present the Executive Committee's recommendations for appointments to the Screening Committee. The Screening Committee will screen for competency of individuals to run for election to the Board for 2024 – 2025.

18. **Strategic Goal Recommendations and Brainstorming**
    Strategic Goal #1 is that regardless of pharmacy setting, management and business exigencies do not compromise the health and well-being of pharmacy professionals or impede their ability to adhere to the Standards of Practice and Code of Ethics.

    Due to a recent surge in concern about issues relating to the pharmacy workplace, the following items will be considered by the Board.

    18.1 Preferred Provider Networks – For Decision
    Director, Policy, Engagement and Strategy, Katya Masnyk will be asking the board to provide direction on a proposed regulatory response to address risks of patient harm associated with Preferred Provider Networks.

BREAK

18.2 Corporate Influence on Pharmacists/Patient Safety – For Discussion – No materials
Director of Registration and Quality, Susan James, will present current activities related to Strategic Goal #1, including the recent registrant survey and Town Hall meetings. The Board will be asked to engage in brainstorming about what regulatory interventions, or other actions, the College could consider to address the issue of management and business practices that impact the well-being of pharmacy professionals and quality of patient care.

MEETING ADJOURNMENT

OCP Strategic Plan *2024-2028*

Our Values *These express who we are and how we are operate.*

- Accountability
- Fairness
- Collaboration
- Judiciousness
- Integrity
- Transparency

Our Regulatory Principles *These guide our work and decisions as a regulator.*

- **Mandate/Public Protection:** All our work is to ensure safe, competent, and ethical professional practice.
- **Risk:** We act to reduce or prevent harms. We use data to anticipate and measure risk. We measure the outcome of our actions and adapt our regulatory response to ensure the most beneficial impact.
- **Right Touch:** Our regulatory actions are proportionate to the level of risk to the public.
- **Partnerships:** We engage and collaborate with Ontario patients and other health system partners to protect the public.
- **Culture:** We believe in justice, equity, diversity and inclusion. We aim to identify, remove, and prevent inequalities.
- **Person-focused:** We will act with fairness and compassion towards all participating in our processes.
- **Transparency:** We clearly communicate our expectations, requirements, activities and performance as transparently as possible.
- **Leadership and Innovation:** We will innovate and endeavour to drive change to most effectively address identified risk.

Our Strategic Goals *These are what we intend to achieve as we fulfill our mandate.*

1. Regardless of pharmacy setting, management and business exigencies do not compromise the health and well-being of pharmacy professionals or impede their ability to adhere to the Standards of Practice and Code of Ethics.
2. The College effectively provides members of the public, registrants and other partners with clear, relevant, up-to-date information.
3. The College has the expertise and resources to address immediate demands caused by changes in the regulatory or practice environment.
4. The College uses its regulatory influence to ensure that all patients are treated with respect and without discrimination via positive changes in pharmacy practice.

Ontario College of Pharmacists

Putting patients first since 1871

MINUTES OF A
BOARD OF DIRECTORS MEETING
HELD IN TORONTO, ONTARIO
DECEMBER 11, 2023
9:30 A.M. TO 5:00 P.M.

Attendance
Jennifer Antunes

Randy Baker
Connie Beck (virtual)
Douglas Brown
Billy Cheung
Andrea Edginton
Jean-Pierre (JP) Eskander (virtual, morning)
Andrea Fernandes (virtual)
Daniel Figeys (virtual, morning)
Christine Henderson
Sara Ingram
Adrienne Katz
Elnora Magboo
James Morrison
Micheline Piquette-Miller
Siva Sivapalan
Daniel Stapleton
Wilfred Steer
Cindy Wagg
Devinder Walia

Regrets
John Vanstone
Gene Szabo

Staff
Shenda Tanchak, Registrar and CEO
Angela Bates, Director, Conduct
Susan James, Director, Quality (virtual)
Thomas Custers, Director, Corporate Services
Katya Masnyk, Director, Policy, Engagement and Strategy Implementation
Christian Guerette, General Counsel and Chief Privacy Officer
Todd Leach, Director, Communications and Government Relations
Delia Sinclair Frigault, Manager of Equity, Diversity and Inclusion
Saira Lallani, Medication Safety Lead
Sandra Winkelbauer, Special Projects Manager
Stephenie Summerhill, Executive Assistant to Registrar and CEO
Sharlene Rankin, Executive Assistant to the Directors

The meeting was called to order at 9:31 a.m. The Chair, James Morrison, welcomed all Board Directors, staff and observers. He announced the resignations of two Public Directors, John Vanstone and Gene Szabo, and thanked them for their service; recruitment of additional Public Directors was underway.

James Morrison informed the Board that beginning in March 2024, Board meetings would no longer be hybrid. While some meetings may be planned to be remote, if the meeting is in person, virtual participation will no longer be offered. The meetings will continue to be broadcast for those who wish to observe.

1. Land Acknowledgement

Delia Sinclair Frigault, Manager of Equity, Diversity and Inclusion, opened the meeting with a land acknowledgement in recognition and respect for Indigenous peoples and the land the College occupies.

2. Declaration of Conflict

The Chair called for declarations of conflict of interest. No conflicts were declared.

3. Minutes of the September 18-19, 2023, Board Meeting – For Decision

It was requested by Daniel Stapleton, that the following be added to clarify agenda item 13: The next market review for auditor services would take place in 2026.

> **MOTION**, proposed by Jennifer Antunes, seconded by Douglas Brown and **carried**: the Board approved the minutes of the September 18-19, 2023, Board Meeting with amendments.

4. Chair's Report – For Information

James Morrison provided a summary of activities undertaken since the September meeting. He highlighted the continued difficulty in constituting panels for Discipline Hearings and encouraged Board Directors to make themselves available. Discussion followed regarding the benefits of polling software that displayed the availability of other Directors within the poll.

5. Registrar's Report – For Information

Shenda Tanchak, Registrar and CEO, provided key highlights from her report including updates regarding pharmacist scope expansion, pharmacy-led clinics, nurse prescribing within family health teams, and drug lists. Clarifying questions and discussion followed regarding ongoing dialogue with other healthcare professionals around scope expansion, continuity of care for patients, changes to emergency registration, student class registration and language proficiency testing.

Shenda Tanchak led an overview of the quarterly College Performance Scorecard which provided the Board with a report on the status of the College's performance on key performance indicators. Shenda Tanchak also provided the Board with an overview of the 2023 Year End Risk Dashboard containing updates on the top organizational risks, ratings, and mitigation activities.

6. 2020-2023 Strategic Plan – Presentation

Todd Leach, Director of Communications, Knowledge Translation and Government Relations, introduced a presentation outlining the College's accomplishments undertaken during the 2019-2023 Strategic Plan.

7. Equity, Diversity & Inclusion Strategy – For Decision

Delia Sinclair Frigault sought the Board's direction on whether to prioritize reconciliation and Indigenous cultural humility in pharmacy practice and regulation within the College's Equity, Diversity and Inclusion

strategy. Following clarification regarding terms and language, Delia Sinclair Frigault shared that Ontario had the largest Indigenous population in Canada and while efforts would continue in support of equitable care for all patients, this motion would allocate resources towards engagement and relationship-building to address Indigenous health disparities.

> **MOTION**, proposed by Jennifer Antunes, seconded by Micheline Piquette-Miller, and **carried**: the Ontario College of Pharmacists will continue to address all protected grounds under the Ontario Human Rights Code and emerging issues, and will include a focus on Indigenous cultural humility and reconciliation in our Equity, Diversity, and Inclusion Strategy.

8. Motion to go *in camera* pursuant to the *Health Professions Procedural Code,* subsections 7(2)(b) and (c).

The Chair explained that the Board of Directors would be meeting in camera and the Board meeting would reconvene at 3:15 p.m. following lunch and a Board Governance workshop session.

> **MOTION**, proposed by Siva Sivapalan, seconded by Billy Cheung, and **carried**: the meeting moved *in camera* at 12:02 p.m.

No actions were provided for inclusion in the minutes. The *in camera* meeting ended at 12:53 p.m.
The Board meeting resumed at 3:21 p.m.

9. Best Practices for Land Acknowledgement – For Information

This item was deferred.

10. Assurance and Improvement in Medication Safety (AIMS) Evaluation – For Information

Saira Lallani, Medication Safety Lead and Sandra Winkelbauer, Special Projects Manager provided an update regarding the status of the AIMS program, including recent accomplishments, barriers, and challenges. They also provided an outline of the plan for evaluation of the program. It was noted that an evaluation report would be brought to the Board at a future meeting.

11. OCP Disciplinary Processes – For Information

This item was deferred.

12. Ontario College of Pharmacists 2024 Budget – For Decision

Douglas Brown, Chair of the Finance and Audit Committee, introduced the annual budget which ensures funding for the College's strategic, operating and regulatory activities. Thomas Custers, Director, Corporate Services led a detailed overview of the budget schedules. He informed the Board that the 2024 deficit would be covered by the current operating surplus and the remainder would be drawn from the contingency reserve.

> **MOTION**, proposed by Jennifer Antunes, seconded by Dan Stapleton, and **carried**: the Board approved the 2024 Operating and Capital budget as proposed.

13. Proposed College Performance Scorecard 2024 – For Decision

Thomas Custers presented the draft 2024 College Performance Scorecard. The Board's feedback was requested to ensure that the indicators as presented were clear and that information and data reported on the newly designed Performance Dashboard would provide the Board with meaningful information to support its oversight role.

> **MOTION**, proposed by Siva Sivapalan, seconded by Devinder Walia, and **carried**: the Board approved the 2024 Scorecard, to be called a Dashboard, as presented.

14. By-Law Review: Article 9 and Article 14.2 – For Decision

Sara Ingram, Vice Chair of the Board and Chair of the Governance Committee, presented an overview of a proposed by-law change that would align the quorum requirements for meetings of the Drug Preparation Premises Committee with those of the Accreditation Committee. Both committees share the same membership, and a change to permit the Drug Preparation Premises Committee to sit in panels of three would help address scheduling challenges.

> **MOTION,** proposed by Jennifer Antunes, seconded by Cindy Wagg, and **carried**: the Board approved revisions to Articles 9 and 14.2 of the College By-laws as presented in the materials.

15. OCP Service Charter – For Information

This item was deferred.

16. Adjournment

The Chair thanked Micheline Piquette-Miller for her participation, as this was her last meeting as Interim Dean at the Leslie Dan Faculty of Pharmacy. There being no further business, at 4:54 p.m. the meeting ended.

Sharlene Rankin
Executive Assistant

James Morrison
Board Chair

BOARD BRIEFING NOTE

MEETING DATE: March 25, 2024

FOR INFORMATION

From: James Morrison, OCP Board Chair

Topic: Chair's Report

Background: In addition to regular meetings and phone calls with the Registrar & CEO, listed below are the meetings, conferences and presentations I attended on behalf of the College during the reporting period.

College and Other Stakeholder Meetings:

- December 20, 2023 – Discipline: Contested Hearing on Order
- January 19-20, 2024 – Rx Talks (OPA Conference)
- January 22, 2024 – Governance Committee Meeting
- January 25, 2024 – New Board Director Orientation
- March 4, 2024 – Finance & Audit Committee Meeting
- March 4, 2024 – Executive Committee Meeting
- March 6, 2024 – Governance Committee Meeting
- March 8, 2024 – Discipline: Contested Motion
- March 11, 2024 – Discipline: Contested Hearing on Order
- March 18-21, 2024 - Discipline: Contested Hearing

December Board Meeting Evaluation

Attached is the December 2023 Board Meeting Evaluation report (Attachment 4.1).

Board members are reminded that every attending individual is expected to complete the evaluation following the meeting. It is a critical component of maintaining good governance.

Updates

Between Board meetings the Chair continues to support Director's questions on emerging issues, communicate important updates to the Board, and inform College staff on matters of importance in the pharmacy environment.

Board Director Committee Activities

The following chart below provides an overview of the committee activities in which the Board Directors participated in since the December Board meeting. Information in the table below is intended to provide an overall sense of workload and may not capture every activity. Staff continue working to refine information-gathering precision in this area.

Director	Committee(s)	Meetings/Hearings
Jennifer Antunes	Discipline	Feb 22
Connie Beck	Discipline Finance and Audit Governance	Dec 19; Jan 17, 24, 30 Mar 4 Jan 22, Mar 6
Doug Brown	Discipline Finance and Audit	Jan 8, 26; Feb 26 Mar 4
Billy Cheung	Discipline	
Andrea Fernandes	Discipline Finance and Audit	 Mar 4
Sara Ingram	Discipline Executive Governance	Jan 15; Feb 29, Mar 1, Mar 15 Mar 4 Jan 22, Mar 6
James Morrison *ex-officio	Discipline Executive Finance and Audit* Governance*	Dec 20; Mar 8, 11, 14, 18, 19, 20, 21 Mar 4 Mar 4 Jan 22, Mar 6
Siva Sivapalan	Discipline Executive Governance	 Mar 4 Jan 22, Mar 6
Wilf Steer	Discipline Finance and Audit	Jan 16; Feb 5, 20, 21; Mar 13, 18, 19, 20, 21 Mar 4
Randy Baker	Discipline Fitness to Practice ICRC Registration	Jan 8, 15; Feb 29; Mar 1, Mar 13, Mar 15 Feb 13, 14; Mar 21 Dec 15, Feb 12
JP Eskander	Discipline ICRC Quality Assurance	 Dec 19, Jan 16
Christine Henderson Resignation Pending	Discipline Executive ICRC	Dec 20, 21; Jan 17, 24, 26, 30; Feb 26
Adrienne Katz	Discipline Executive Finance and Audit ICRC	Dec 19; Jan 15, 26; Feb 26 Mar 4 Mar 4 Jan 17; Feb 6
Elnora Magboo	Accred/DPP ICRC	Dec 19; Feb 20 Dec 12; Jan 30, 31; Mar 19
Stephen Molnar	Accred/DPP ICRC Quality Assurance	 Feb 13

Dan Stapleton	Discipline Finance and Audit ICRC	Dec 20; Jan 8; Feb 22; Mar 8, 11, Mar 14 Mar 4 Jan 9; Feb 1, 15, 28; Mar 12, 14
Cindy Wagg	Discipline ICRC Quality Assurance	Dec 21; Jan 17, 24; Feb 20, 21; Mar 13, Jan 18 Dec 19, Mar 19
Devinder Walia	Discipline ICRC Governance Registration	Dec 21; Jan 16, 30; Feb 5; Mar 18, 19, 20, 21 Jan 23; Feb 27; Mar 5, 13 Jan 22, Mar 6 Jan 26, Feb 23
Shari Wilson	Discipline ICRC	Feb 13; Mar 6, 21
Andrea Edginton	Registration	
Lisa Dolovich	Registration	
Daniel Figeys	Registration	

GOVERNANCE COMMITTEE BRIEFING NOTE

MEETING DATE: January 22, 2024

FOR INFORMATION

From: Shenda Tanchak, Registrar and CEO

Topic: December 2023 Board Meeting Evaluation

Background: In accordance with Board policy, following each Board meeting, Directors submit an evaluation. Following the December 2023 Board meeting all attending members completed the evaluation survey.

Results:
Overall, the meeting was well reviewed.

The following summary highlights responses that reinforce current practices or identify opportunities for improvement.

Adequacy of Board Package

- All but one Board member was confident that the reports included in the Board were sufficient. The individual whose response was exceptional felt that more operational detail would have been appropriate for inclusion.

***Proposed action: None**, providing additional detail (likely operational) would not meet the needs of the 17 other Board members.*

Board Conduct

- Two people felt that the Board was not always respectful and/or considerate.
- One person commented that it was uncomfortable asking the Registrar/CEO to leave while the Board discussed the retreat.
- One person made a positive comment about the viewpoints shared in the EDI discussion.

***Proposed action: None**.*

Focus on oversight and strategy

- There was general agreement that the Board discussions stayed at the appropriate level.
- There was one positive comment that staff and the Board are clear on public interest, and one indicated that the discussion related to one issue was confusing.

***Action:** The quality of briefing materials and presentations offers an opportunity for improvement. This will be a focus for the new Director of Policy.*

Meeting Process Details

- One or occasionally two people found specific details about the meeting process wanting. The comments related to concerns are set out below:

- "Because we went a bit overtime, I'm not sure that everyone was clear on any follow-up items. However, those were clarified subsequent to the meeting."

- "I would suggest putting budget items in the morning. It was a long day and personally I found it difficult to focus on that particular more technical discussion at the end of the day."

Action: Care *will continue to be paid to meeting agenda order and volume of materials.*

- Two people reported poor video quality for the meeting. Everyone reported high or very high audio quality.

- One person noted a desire for virtual meeting capability to be continued for those who had health or other reasons not to be able to attend.

Action: The *Chair has indicated that future meetings will not follow the hybrid model. He, and others, have observed that it is not possible to ensure best quality participation for those who are not in the room when the meeting is held in person. The College will, however, arrange for participation by those who qualify for accommodation under the Human Rights Code.*

Governance Workshop

- Four people thought the workshop was a good use of their time. Eight people said it was not.
- The concerns expressed by Board members were that the hybrid approach was not conducive to a good discussion; and the workshop's purpose was unclear.

Action*: It appears that overall, the Board is comfortable with its working relationships and there is an opportunity to build on these through additional governance training.*

Opportunities for Change in How the Board Works (Question 13)

- 11 responses were received. They focused on the desire for additional governance training and clarity about governance policy, and ongoing focus on inter-Board communications

Potential action*: Discussion at the March Board retreat.*

REGISTRAR'S UPDATE

From: Shenda Tanchak, Registrar and CEO

Topic: Registrar's Update, December to January 2024

GOVERNANCE

Board Membership Update

Sadly, Christine Henderson has let us know that she will be leaving the College at the end of this month. I know that you share my regret about this news. Christine is irreplaceable. We will find an opportunity to properly thank her for her contributions in the coming months.

In good news, we have two new publicly appointed Board members: Stephen Molnar and Shari Wilson.

Stephen is the retired mayor of Tillsonburg, where he served for 15 years. He has significant additional public service experience in health and other sectors.

Shari served as a member of the Council of the College of Audiologists and Speech Language Pathologists for 11 years and served as chair for three of those years, and has significant training and practice in mediation and marketing.

Stephen has been appointed to the Accreditation and Drug Preparation Premises and Quality Assurance Committees. Shari has been appointed to the ICRC and Discipline Committees.

As you may recall, Micheline Piquette-Miller has completed her time with the Board and Lisa Dolovich is returning as of the March meeting.

Committees Governance Review Project

Policy analyst, Sandra Brazel, presented the project plan to bring committee governance into alignment with best practices and OCP Board governance principles at the Governance Committee meeting on January 23.

The problem statements she presented to the Committee are as follows:

- Separating the Board and committees may affect the flow of information between them.
- It can be more difficult to form committees and panels when the size of the Board is smaller.
- Committees assuming too much autonomy usurps the Board's authority for decision-making and oversight.
- Committees too involved in operations impedes the Board's ability to effectively oversee performance and the budget.

Sandra will be working with the Committee to recommend Terms of Reference for each Committee and make recommendations for changes to legislation, by-laws and policy.

The Board can expect to receive reports about the progress of this project in March and, barring intervening events, recommendations or options for governance change in June. The target is to be in a position to implement any changes in September at the time of committee appointments.

Regulatory Activity

Emergency Assignment (EA) Registration

As you are aware, the EA Registration category fast-tracks registration for Pharmacy Technicians and Pharmacists in times of emergency. Certificates of registration in this category are time-limited and these registrants must practice under supervision. The expectation is that when the emergency ends, the certificates are no longer renewed or issued and these registrants, many of whom will have been working towards fulfilling their regular registration requirements in the interim, will transition to full registration, or another class of registration as applicable, such as intern.

Staff are drafting a policy for Board consideration establishing the criteria to declare or end states of emergency.

In the meantime, the Registrar has extended access to existing EA registration certificate holders until March 23, 2024, and continues to accept new applications for EA registration for pharmacists and pharmacy technicians to support workforce challenges that remain in some practice locations.

As of January 15, 2024, there are 377 active EA registrants, which is composed of 272 EA pharmacists and 105 EA pharmacy technicians.

Working with Partners: December 12, 2023 to Date

Health Professional Regulators of Ontario (HPRO)

The Registrars from all 26 regulated Ontario health colleges form the Board of HPRO. HPRO brings us together to advocate for ongoing regulatory improvement that supports the public interest.

I am a member of the Management Committee and the Treasurer for HPRO. In that capacity I have attended, or someone has attended on my behalf the following meetings:

- Bi-Weekly Information-Sharing Session – December 12, 2023, January 9 and January 23, 2024
- Board of Directors Meeting – December 13, 2023
- Management Committee Meeting – January 22, 2024

NAPRA (National Association of Pharmacy Regulatory Authorities)[1]

The Registrars of all Pharmacy Regulators in Canada, together with three appointed external representatives and a representative from the Canadian Armed Forces are members of the NAPRA Board.

Our meetings keep us aware of events, trends, changes in legislation that affect the practice of pharmacy across Canada. We work together to identify risk and best practices.

I am a member of the NAPRA Governance Committee. I have attended the following NAPRA meetings since my last report.

- PRA Roundtable & Emerging Issues – January 16, 2024
- Board Meeting – January 23, 2024

[1] *Founded in 1995, the National Association of Pharmacy Regulatory Authorities (NAPRA) is an alliance of the provincial and territorial pharmacy regulatory authorities across Canada as well as the Pharmacy Services Division of the Canadian Armed Forces. NAPRA provides a platform for its members to discuss and take a national approach in addressing common issues in the practice of pharmacy in Canada.*
the practice of pharmacy in Canada

Other partner meetings/presentations

- Ontario Pharmacists Association (OPA) Meeting – January 10, 2024
- Prescribing Authority Discussion Meeting – January 11, 2024
- OCP and Professionalism Presentation for the first-year pharmacy students - University of Waterloo – January 11, 2024
- OPA Rx Talks Conference – January 19-20, 2024

Horizon Scan

Ontario Pharmacists Association (OPA): Ontario Pharmacy Clinic Proposal

The OPA is asking the government to support a phased roll-out of 150 pharmacist-led "health hubs" over the next year.

They have shared their proposal with us on a confidential basis and we will engage with them and government to help shape next steps in a way that ensures appropriate regulatory oversight. The Board can expect to hear more details about this proposal, at or before the March meeting.

If the proposal were to move forward, it is likely to require significant OCP work. This may have an impact on some of the plans that we had in place for 2024. This will be part of the report and/or request for direction at the Board meeting.

Pharmacy Examining Board of Canada (PEBC)[2]

The Pharmacy Examining Board of Canada (PEBC) is a critical partner in the College's ability to evaluate pharmacy applicants.

It is the national certification body for the pharmacy profession in Canada, with the purpose of assessing qualifications of pharmacy professionals on behalf of participating provincial regulatory authorities. The Board evaluates qualifications, develops and administers examinations including a national Qualifying Examination, and issues Certificates of Qualification. As set out in the PEBC by-laws, the Board is comprised of members of the profession, including representatives from pharmacy regulatory bodies that rely on PEBC certification for registration purposes.

Over the last six years, Karen Riley, current chair of the Quality Assurance Committee and past Board Director, has served as OCP's representative on the PEBC Board. Karen's appointment will conclude following PEBC's March Board meeting, at which time a new representative, Jane Hilliard, will begin her first term through March 2027. Jane understands our entry-to-practice requirements well as a former member of the Registration Committee and preceptor for pharmacist and pharmacy technician students. The College thanks Karen and Jane for their ongoing commitment and contribution to the College's work.

Judicial Review Application – Mr. Michael El Raheb

Mr. El Raheb applied for judicial review of a caution directed by the ICRC following an investigation into pricing and billing issues. He argued that cautions are intended to be remedial and not punitive in nature, and he had already been the subject of disciplinary action involving similar conduct. The Divisional Court dismissed the application and confirmed the ICRC decision, noting that cautions are a step toward public protection by ensuring similar conduct does not occur again. Also, in this case, the conduct differed from the conduct before the Discipline Committee in significant ways.

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[2] *The purpose of the Pharmacy Examining Board is to assess qualifications for pharmacists and pharmacy technicians on behalf of participating provincial regulatory authorities. The Board evaluates qualifications, develops and administers examinations including a national Qualifying Examination, and issues Certificates of Qualification.*

OPERATIONS

People/Culture

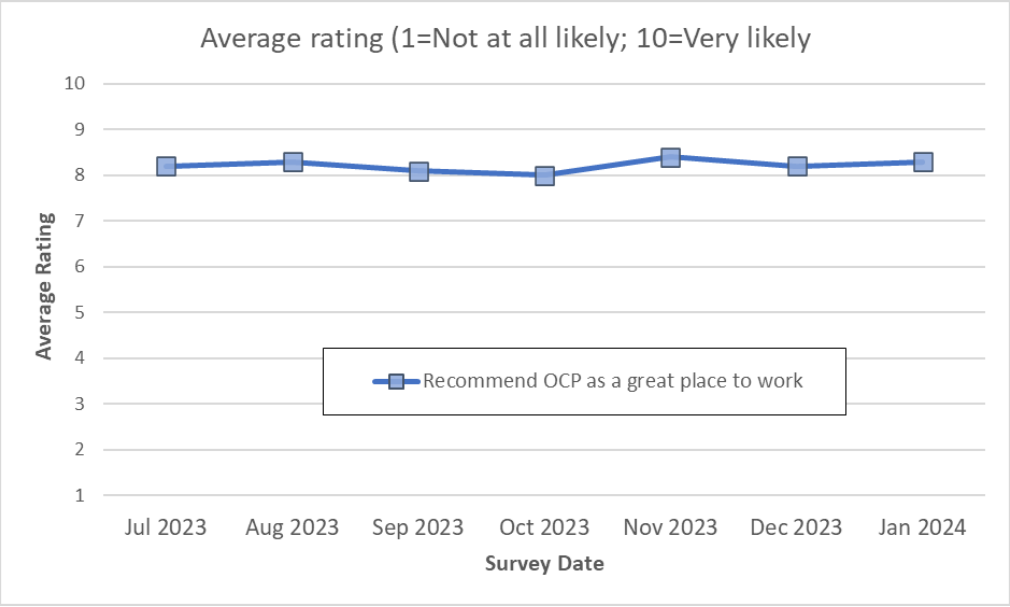
Staff are important to the OCP Board: “OCP is committed to recruiting and retaining staff that meet the high-quality standards of the organization and will provide an environment that fosters engagement and ongoing development to ensure that all staff reach their full potential. We are cautious with risks to this aim and will only accept them if they are necessary to ensure our ability to protect the public.”[3]

While not losing sight of our ongoing efforts regarding the culture, a key focus in 2024 will be on staff development and growth to ensure they possess the necessary skills and confidence to be effective in their role and to help further improve staff engagement and retention. To that end, we included the following new statement to our monthly all-staff ‘pulse’ survey: “OCP is supporting me in having the right skills to succeed in my current role.”

Combined with measuring and reporting on "how likely staff would recommend this organization to a qualified friend or family member as a great place to work," an employee engagement and loyalty towards the organization measure that will help us monitor the impact of our efforts and make adjustments if concerns arise.

In January, 54% of the staff who responded "agree/strongly agree" that the College supports them in succeeding in their role. This is similar to the December results (53%), the first time this statement was measured.

The College has been measuring the statement "how likely staff would recommend this organization to a qualified friend or family member as a great place to work" for a longer period of time. The most recent results are captured in the graphic below.



As you can see, with an average rating of around eight points, the scores have remained stable over the past few months. Breaking down the score, 48% of the staff who responded scored either a nine or a ten.

These measures are part of the 2024 College Dashboard, and the results will be discussed in more at the March Board meeting.

[3] *OCP Risk Appetite Statements approved September 2022*

Lastly, we are very excited to share the news that OCP's Melanie Sebastianelli, Registration Advisor, was recognized as OPA's Pharmacy Technician of the Year at the RxTalks conference on January 19, 2024. We are thrilled for her, but not surprised as we know how hard she works, she has tremendous expertise and is extremely dedicated to the public interest. We are proud to be her colleagues.

BOARD BRIEFING NOTE

MEETING DATE: March 25, 2024

FOR INFORMATION

From: Shenda Tanchak, Registrar and CEO

Topic: Registrar's Update, February to March 2024

GOVERNANCE

Board Membership Update

In addition to the two new Board members announced in my last update, I am pleased to announce the appointment of Nadirah Nazeer to the OCP Board.

Nadirah has a background in business, having worked as the Global Business Development manager for HP Inc.. She currently hosts a television show called "Healthy Minds and Healthy Lives" on Cogeco Cable TV.

Nadirah's committee appointments have not been determined at the time of writing and will be announced at the Board meeting.

Regulatory Activity

Regulations Update

As usual, you will find a table summarizing the status of submissions to the Ministry of Health, including outstanding and recently approved amendments to regulations. We are anticipating within the next few months approval of the regulation that will introduce the pharmacy intern class of registration and make participation in our quality assurance program for pharmacy technicians. We are ensuring that the Registrant Records System presently under development (see more details below) will accommodate these changes to operations, which we anticipate would take effect in the fall. (Attachment 5.2a).

Equity, Diversity, and Inclusion (EDI) strategy

The College does not collect demographic data from registrants or complainants, making it difficult to understand the diversity of these populations and investigate the potential barriers they may be experiencing in our processes or practice. We are capitalizing on the development of the Registrant Records System to be able to capture and analyze such data effectively in future. Defining the scope of the information we will collect and developing policy to govern the management of this data is a prioritized activity within the EDI Strategy in 2024.

Work is also underway to support registrants in meeting their obligations under the *Ontario Human Rights Code*, 1990 and the *Accessibility for Ontarians with Disabilities Act,* 2005: developing practice tools and communications for registrants on how they can meet human rights and accessibility obligations in practice, as well as working to define policy expectations for accommodations throughout our regulatory processes, is a prioritized activity within the EDI strategy. The College will work to balance meeting these immediate actions with the longer-term approach required for making progress on Indigenous Cultural Humility and Truth & Reconciliation in pharmacy practice and regulation.

Emergency Assignment (EA) Registration

I have extended access to existing EA registration certificate holders until March 23, 2024 and continue to accept new applications for EA registration for pharmacists and pharmacy technicians to support workforce challenges that remain in some practice locations. Staff are in the process of gathering information to draft a policy for Board consideration establishing the criteria to declare or end states of emergency.

As of February 21, 2024, there are 409 active EA registrants, which is comprised of 293 EA pharmacists and 105 EA pharmacy technicians.

Office of the Fairness Commissioner

The Office of the Fairness Commissioner (OFC) assesses registration practices of regulated professions and trades in Ontario and assigns a risk rating to each regulator according to a risk-informed compliance framework. The College has recently been informed that the OFC has determined that the College should be placed in the low-risk category for the period April 1, 2024 to March 31, 2026. A copy of the report is available on request.

Compounding Standards Revisions

NAPRA[1] is beginning work on updating its suite of compounding standards. A project overview is attached which includes more details about the project.

OCP has seconded Judy Chong, Manager, Hospital Practice to NAPRA on a part-time basis to lend her expertise to this project.

System Partner Engagement: February 1, 2024, to date

Registrar's Activity

Health Professional Regulators of Ontario (HPRO)

The Registrars from all 26 regulated Ontario health colleges form the Board of HPRO. HPRO brings us together to advocate for ongoing regulatory improvement that supports the public interest.

I am a member of the Management Committee and the Treasurer for HPRO. In that capacity I have attended, or someone has attended on my behalf the following meetings:

- Management Committee Meeting – February 14 and March 5, 2024
- Bi-Weekly Information-Sharing Sessions – February 20, March 5 and March 19, 2024
- Treasurer and Executive Director Meeting – February 21 and March 21, 2024
- Board of Directors Meeting – March 7, 2024

NAPRA (National Association of Pharmacy Regulatory Authorities)

The Registrars of all Pharmacy Regulators in Canada, together with three appointed external representatives and a representative from the Canadian Armed Forces, are members of the NAPRA Board. I am also a member of the NAPRA Governance Committee. I have attended, or someone has attended on my behalf, the following NAPRA meetings since my last report.

- PRA Roundtable & Emerging Issues – February 13, and March 12, 2024
- Registrars' Meeting on Outsourced Drug Preparation – February 26, 2024 (Katya Masnyk)
- Governance and Nominating Committee Meeting – March 5, 2024

[1] Founded in 1995, the National Association of Pharmacy Regulatory Authorities (NAPRA) is an alliance of the provincial and territorial pharmacy regulatory authorities across Canada as well as the Pharmacy Services Division of the Canadian Armed Forces. NAPRA's members regulate the practice of pharmacy in their respective jurisdictions in Canada and their primary mandate is to protect and serve the public interest. NAPRA provides a platform for its members to discuss and take a national approach in addressing common issues in the practice of pharmacy in Canada.

Other

- CNAR Effective Risk Management Workshop – February 28, 2024
- Ministry of Health Quarterly Meeting – March 18, 2024
- Ontario Pharmacists Association Quarterly Meeting – March 21, 2024

Other Staff Activity

- Ontario Regulators for Access Consortium (ORAC) meeting – February 28, 2024 (Greg Purchase)
    - To discuss common registration issues amongst Ontario regulators (health and non-health) and strategize ways to share information and resources amongst regulators in the future.
- Comprehensive Medication Record for Ontarians (CMRO) Pharmacy Sector Working Group – March 6, 2024 (Judy Chong, Melanie Zabawa)
    - Working Group is led by Ontario Health and is attended by a number of health system leaders including associations, practicing pharmacy professionals, and the Ministry of Health.
    - The CMRO project is working towards adding drugs and medication data to the Electronic Health Record by adding additional clinically relevant data elements and data from pharmacies regardless of coverage.
- RN Prescribing meeting with the College of Nurses of Ontario - January 18, 2024 (Vivian Ng, Melanie Zabawa and Jennifer Leung)
    - The purpose is to share up-to-date information on RN prescribing to ensure registrants are aware of changes in nursing scope of practice and share questions being raised about RNs as new prescribers.
- Evaluation of Minor Ailments with Ontario Drug Policy Research Network (ODPRN) – February 9, 2024 (Katya Masnyk and Vivian Ng)
    - The purpose is to share OCP's research needs in minor ailments evaluation, which focuses on identifying risk of harm to patients from pharmacists prescribing minor ailments.
    - An evaluation plan with associated funding is being developed and planned for implementation in 2025.
- NAPRA Competencies Working Group – February 1, 2024 (Sandra Winkelbauer)
    - The purpose is to update the professional competencies for Canadian pharmacists and pharmacy technicians at entry to practice
- Project Advisory Committee – Workforce Planning for Ontario Pharmacists and Pharmacy Technicians – February 7, 2024 (Sandra Winkelbauer)
    - The purpose is to develop an evidence-based workforce planning tool for pharmacists and pharmacy technicians in Ontario that is evidence-based, sustainable, equitable, and detailed.
    - The project is led by OPA.
    - Workforce projections and a draft report were reviewed by advisory committee members
- Health Profession Regulators of Ontario
    - EDI Project Steering Committee & EDI Network - Jan 12, Feb 2, Mar 1
        - The purpose is to monitor the implementation of the HPRO EDI toolkit across member colleges and support staff with EDI responsibilities across HPRO
        - Jacq Hixson-Vulpe is OCP's representative
    - Citizen's Advisory Group (CAG) Partnership – Transition from CPSO to HPRO
        - January 22 presentation to HPRO Management Committee (Delia Sinclair Frigault)
        - March 7 presentation to HPRO Board (same as above)
        - The purpose is to submit a proposal to HPRO Management Committee and Board for administrative and operational structures of the CAG be assumed by HPRO by establishing a Citizen's Advisory Committee

OCP Presentations

- Hospital Oversight to third year PHM371 Hospital Management course students at the Leslie Dan Faculty of Pharmacy at the University of Toronto – January 9, 2024 (Judy Chong)
- Professional Practice to first year students at the School of Pharmacy at the University of Waterloo – January

11, 2024 (Shenda Tanchak)
- Student Registration to first year students at the University of Ottawa – January 11, 2024 (Jillian Polson, Kelly Crotty & Julie Koehne)
- Developing an Ontario Community Pharmacy-Based Minor Ailment Service Evaluation Framework to pharmacy sector stakeholders, OPA, Association, Ministry, other health system guests, ICES, ODPRN – January 16, 2024 (Thomas Custers & Vivian Ng)
- Canadian Council on Continuing Education Q&A to Sheridan College students – January 26, 2024 (Melanie Sebastianelli & Travis Spencer)
- Canadian Council on Continuing Education Q&A to 1st Semester students at Centennial College – January 30, 2024 (Melanie Sebastianelli & Travis Spencer)
- Canadian Council on Continuing Education Q&A to 4th semester students at Centennial College – February 6, 2024 (Melanie Sebastianelli)
- Canadian Council on Continuing Education Q&A to Anderson College Students – February 12, 2024 (Melanie Sebastianelli & Travis Spencer)
- PACE for Pharmacy Technician Applicants- information session for hospital pharmacy staff – February 14, 2024 (Melanie Sebastianelli, Debra Moy, & Julie Koehne)
- PACE For Pharmacy Technician Applicants- information session for hospital pharmacy staff – February 21, 2024 (Melanie Sebastianelli, Debra Moy, & Julie Koehne)
- Current Topics in Practice to international pharmacy graduate program students at the Leslie Dan Faculty of Pharmacy at the University of Toronto – February 22, 2024 (Anita Arzoomanian)
- Canadian Council on Continuing Education Q&A to Niagara College Students – March 4, 2024 (Melanie Sebastianelli & Jessie Reid)
- Canadian Council on Continuing Education Q&A to Lambton Students – March 5, 2024 (Melanie Sebastianelli)
- Canadian Council on Continuing Education Q&A to Georgian College Students – March 13, 2024 (Julie Koehne & Travis Spencer)

Horizon Scan

Health and Supportive Care Providers Oversight Authority

- From Dec 1, 2023 – Jan 15, 2024, the Ministry of Health (MOH) accepted feedback through open consultation on regulations pertaining to the establishment of the Health and Supportive Care Providers Oversight Authority (the Authority) through Ontario's Regulatory Registry. A number of webinars in Dec and Jan were hosted by the MOH to provide system partners information about the regulations and the Authority.
- In 2021, the *Health and Supportive Care Providers Oversight Authority Act* (HSCPOA Act) was enacted, which allows for oversight and registration under the Authority.
- Primary oversight focus of the Authority is Personal Support Workers (PSWs) but other unregulated health professionals can be added in the future.
- The consultation included information about the governance, administration, the creation of an Advisory Committee, proposed bylaws and policies, approach to registration, expectations on fees, expectations on data collection from registrants, potential future competency assessment framework, registration renewal and quality improvement, information proposed on a PSW public register, proposed code of ethics, complaints process, and proposed composition of committees (including discipline and appeals committees).
- Registrants will receive a distinct visual mark denoting their specific registrant class. This will provide official identification of the registrant under the Authority's oversight for patients, clients and employers.
- At this time, the MOH proposes registration will be voluntary, but this may change based on future employer or client expectations (e.g. employers may require registration under the Authority as part of role qualifications).

OPERATIONS

College Performance Measurement Framework

- The College Performance Management Framework (CPMF) is an annual reporting tool developed by the Ministry of Health (Ministry) in collaboration with the regulatory colleges, the public and experts. The CPMF was introduced in 2020. The purpose of the CPMF is to improve accountability and Ministry of Health oversight of Ontario's health regulatory colleges, strengthen the public trust that the Colleges act in their interest and provide benchmark information to help Colleges improve their performance. Performance under the CPMF is defined as how well a college is meeting a set of standards, or best practices across seven domains that relate to colleges' key statutory functions, governance, and operations.
- Colleges are required to post their completed CPMF on their website by March 31st and provide a copy to the Ministry. Each year, a CPMF Working Group is convened to help identify commendable practices from the colleges' reports that other colleges could consider adopting and review the CPMF to make any changes to what colleges should or should no longer report on.
- The CPMF reports on 14 Standards. For 12 of those Standards, colleges must respond as either 'having met,' 'partially met,' 'or not met,' for a total of 49 responses. For the other two Standards, colleges are being asked to describe how they have engaged or collaborated with system partners in executing their mandate and ensuring alignment with other health regulatory colleges, where appropriate, and building and maintaining relationships to respond in a timely way to changing public expectations.
- The goal of the CPMF is not necessarily for health regulatory colleges to meet all the Standards. Colleges might have different ways to meet or even exceed the Standards mentioned in the CPMF. This allows both the Ministry and colleges to keep thinking about whether the processes and activities listed in the CPMF are the most efficient or effective in serving and protecting the public interest, and what the actual best practices are. The OCP met six of the 12 Standards.
- In reflecting upon the 2023 results, the College is planning to improve its performance on four Standards in 2024 (data sharing with external parties, strengthening documenting the criteria for determining whether an applicant meets its registration requirements, further improving timely response to inquiries from the public, and disclosing information about registrants to other health regulatory colleges and other partners).
- The CPMF also includes a section that provides statistical data that may offer helpful context information about a College's performance related to the Standards.
- See Appendix 5.2b for the 2023 CPMF Report.

Time-Delayed Safes Compliance Blitz

- In March 2023, the OCP announced a requirement for pharmacies to install time-delayed safes to store narcotics, and to post associated signage. The policy related to this requirement is being returned to the March 2024 Board meeting for updates.
- Following identification of concerns about compliance rates and ongoing reports of pharmacy robberies, in early February 2024 more than 50 staff from across the OCP volunteered to participate in an initiative aimed at increasing the number of pharmacies attesting to compliance with these requirements by making calls to designated managers of pharmacies that had not yet declared compliance. The effort was successful, in that by March, almost 100% of pharmacies across Ontario have attested to having installed a time-delayed safe or have a safe on order.
- This initiative required considerable effort and coordination on short notice. Special thanks to Angela Bates for leading the work, to the volunteers making the calls, to Lisa Simpson, Melanie Zabawa, Shelina Manji and Jovenice Santiago for leading the follow-up effort, and to many others including Todd Leach, Barb Church, Sharlene Rankin, Stephenie Summerhill and Rob van Doorn for supporting the initiative.
- We are now discussing next steps in this compliance initiative.

Service Charter

- In January, in conjunction with the strategic plan, OCP launched a Service Charter. The purpose of the Charter is to quantify the regulatory principles and values approved by the Board last March, so that registrants, members of the public and other partners know what to expect from the College and can hold us accountable for the promises we make in the Charter.
- As far as we know, we are the first Canadian regulator to develop a service charter.
- The Service Charter is a small first step towards strategic goal 2: "The College effectively provides members of the public, registrants, and other partners with clear, relevant, up-to-date information."
- Starting with the next Board meeting, we will begin reporting on our service charter performance.
- You can find a video introduction to the Service Charter here.

Ontario College of Pharmacists

Putting patients first since 1871

OUR PROMISE TO YOU

OCP SERVICE CHARTER

We're serious about our values and principles and we are committed to living by them as a regulator.

The service commitments naturally build off the Board-defined regulatory principles that guide what it is we do and how we work. They ultimately reflect operational practices and are an expression of what you can expect when you interact with the College.

Let us know how we're doing.

ocpinfo.com/servicecharter

PARTNERSHIPS

We engage and collaborate with Ontario patients and other health system partners to protect the public.

We work with partners, including patients, government, educators, other regulators, professional associations and others.

We consult with registrants and the Ontario public on proposed regulations, standards and policies.

Whenever we can, we share our documents and experiences with others in Canada and internationally to amplify benefit to patients.

We strive to be efficient by learning from other leading regulators nationally and internationally.

We provide input into relevant government and health system consultations.

We share data with external researchers in keeping with our research policy.

We respond to data requests within 10 business days and provide data within 30 business days.

CULTURE

We believe in justice, equity, diversity and inclusion. We aim to identify, remove, and prevent inequalities.

We do not discriminate. We treat everyone fairly, regardless of who they are (e.g., race, age, sex, gender, disability, religion, sexual orientation).

We commit to promoting equity, diversity and inclusion (EDI) in all work with the profession, with pharmacy patients and internally.

We aim to enhance cultural safety, including Indigenous cultural humility, to minimize systemic inequities.

All staff, Board and Committee members complete EDI training.

We review our policy and program decisions using an EDI lens and explicitly consider identity data where available.

We avoid language in our work that condones or reinforces longstanding power imbalances.

LEADERSHIP & INNOVATION

We will innovate and endeavour to drive change to most effectively address identified risk.

We are committed to innovation and regulatory best practices.

We dare to depart from convention and seek new approaches to reduce risk whenever the evidence or opportunity presents options.

We actively participate in provincial and national initiatives focused on best practices and innovative ways of doing things.

We present our work at regulatory conferences to foster the active exchange of ideas and regulatory developments.

PUBLIC PROTECTION

All our work is to ensure safe, competent and ethical professional practice.

We explicitly link the decisions we make to why they will be good for Ontario patients.

RIGHT-TOUCH

Our regulatory actions are proportionate to the level of risk to the public.

We strive to eliminate requirements that do not clearly benefit patients or serve their needs.

Our Board specifically considers risk to patients in its decision making.

We define "risk of harm" broadly to encompass physical, mental/emotional or societal harm.

PERSON-FOCUSED

We act with fairness and compassion toward all participating in our processes.

We treat you fairly and with sensitivity. You are not a problem to be solved.

We communicate and interact with you with respect, taking the time to listen and providing you with the opportunity to voice your concerns.

Everyone we interact with will have the opportunity to provide feedback. We will learn from your feedback on how we can improve our processes.

RISK-BASED

We act to reduce or prevent harms. We use data to anticipate and measure risk. We measure the outcome of our actions and adapt our regulatory response to ensure the most beneficial impact.

We make decisions based on the available evidence.

We prioritize regulatory commitments in areas where data or other evidence indicates the greatest risk of harm to the public.

We collect the data needed to understand risk and we show the evidence we use in making decisions.

We evaluate the impact of our regulatory programs and initiatives, taking into consideration multiple dimensions and points of view.

TRANSPARENCY

We clearly communicate our expectations, requirements, activities and performance as transparently as possible.

We are clear regarding regulatory requirements.

We help you navigate regulatory procedures, like registration or making a complaint, and let you know how you can get more information if you need it.

Through our annual report, we show how registrant dues are used.

Our annual report provides clear and easily understandable information about our regulatory programs.

Information on the College's performance as a regulator is posted publicly on our website in an easily identifiable location.

We keep you informed about what is going on, what to expect and when.

- We respond to your inquiries by phone or email within 3 business days.
- We provide your PACE assessment results within 10 business days. We provide your Jurisprudence, Ethics and Professionalism exam results within 5 weeks.
- We complete new registrations in 30 calendar days from the time all required documents have been submitted.
- We communicate assessment results and accreditation outcomes as quickly as we can. You can expect results of practice assessments of individual pharmacists or pharmacy technicians within 3 business days and results of pharmacy operational assessments within 10 business days. If we can't meet these targets, we will let you know about our progress and next steps.
- We complete investigations into complaints within 150 calendar days or let you know why we cannot do so.
- We post all Board materials at least 7 calendar days before Board meetings. We post Board decisions within 5 business days after Board meetings.

Accountability **Fairness** **Collaboration** **Judiciousness** **Integrity** **Transparency**

Status Report of Regulatory Submissions to the Ministry of Health (MOH)

This table identifies the status of new, outstanding or recently approved regulation amendment submissions by the College to the MOH. All proposed amendments to Acts or their regulations must be approved by the Board prior to submission to the MOH. Once submitted, the government must complete their policy review and legislative drafting. Regulations are sealed once the College and Ministry agree with the legislative draft. Once sealed, the Ministry seeks final government approval.

This report is updated prior to each Board meeting.

(Updated March 6, 2024)

Act/Regulation	Primary purpose for the proposed amendment	Date of Submission to MOH	Current Status	Next Steps	Other Comments
Outstanding Submissions					
Pharmacy Act, General Regulation (202/94) Expanded Scope	Minister of Health sent a letter (March 10, 2023) requesting the College make recommendations regarding further minor ailments, including those that require additional scope recommendations	October 30, 2023 Board recommendations (approved at Sept Board meeting) were provided to the Minister.	Response under review by the Minister/ Ministry	Awaiting further direction from the Minister or Ministry regarding drafting of regulatory changes to support the recommendations.	
Pharmacy Act, General regulation (202/94) - Registration and Quality Assurance sections	**Registration** – to add a pharmacy technician intern class and eliminate the student pharmacist class and language revisions to reflect modernization of regulatory approach. **Quality Assurance** – to include pharmacy technicians and align QA program with new Mode,	February 2018	Posting on Regulatory Registry complete – feedback did not result in need for substantive changes. Ministry is working on drafting of the amending regulation, with College consultation as required.	Ministry to prepare final draft of the amending regulation, for College review and approval (sealing). Once sealed, Ministry to proceed with submission for government approval and filing of regulation.	OCP has advised MOH of the need for pharmacy technician intern class to address workforce challenges/shortages - particularly in hospital. Corresponding changes for class of certificates are approved in the *Drug and Pharmacies Regulation Act*

	including shift from declaration of practice hours to maintenance of competency to practice to standards.				(Section 149 (1)) pending approval of these *Pharmacy Act* changes.
Recently Approved					
Pharmacy Act, General regulation (202)94 – Controlled Acts	Expand scope to support the 2023-24 respiratory illness session by allowing: - administration of respiratory syncytial virus (RSV)vaccine, - pharmacy technicians to administer Schedule 3 vaccines, - pharmacists to prescribe Tamiflu, - removal of specific age restrictions for administration of vaccines, -Transition of authority for COVID-19 vaccine Paxlovid prescribing from the *Regulated Health Professions Act* (*RHPA), Controlled Acts Regulation* (107/96) to the *Pharmacy Act, General Regulation* (202/94).	August 31, 2023	Approved December 12, 2023	Effective as of December 12, 2023: - Part A pharmacists, registered pharmacy students, interns and pharmacy technicians are authorized to administer the RSV vaccine to patients five years of age and older. - Part A pharmacists are authorized to prescribe Oseltamivir (Tamiflu). - the current authority for pharmacists to prescribe Paxlovid transitioned from the *Regulated Health Professions Act* (*RHPA), Controlled Acts Regulation* (107/96) to the *Pharmacy Act, General Regulation* (202/94).	The Ministry did not include the proposed changes to remove age restrictions for vaccine administration or to allow pharmacy technicians to administer Schedule 3 drugs in the final version of the regulation. No rationale for removal was provided.

				- The authority for pharmacists and pharmacy technicians to administer the COVID-19 vaccine will transition on April 1, 2024.	
Pharmacy Act, General regulation (202/94) Registration - Emergency Assignment Certificates	To achieve alignment of the emergency assignment certificate criteria with regulation 508/22 under the RHPA	June 15, 2023	Amending regulation (295/23) approved by government and filed on Aug 21, 2023	Implementation August 31, 2023	
Pharmacy Act, General regulation 202/94 – Controlled Acts (additional minor ailment prescribing)	To add six additional minor ailments to the pharmacy scope of practice.	April 14, 2023	Approved August 21st	Implementation October 1st, 2023	The OCP submission used lists of drugs for identification of prescribing authority parameters. This was a change from the previous approach which referred to categories of drugs identified by an American entity (the AHFS clinical drug information). The change was a result of intellectual property -

					based impediments to access to the AHFS information.
Pharmacy Act, General regulation 202/94 – Controlled Acts (Administration by injection and inhalation)	Enable administration of drugs for purposes beyond education and demonstration	November 2019	Approved May 15, 2023	Implementation July 1, 2023	College guidelines updated
Other					
Pharmacy Act (and all other Acts referencing the College)	Request to change the College name to "College of Pharmacy"	February 2019, Letter to the Minister of Health and June 2021 as part of response to governance consultation.	Minister responded that evidence and support that patients would benefit is required		
Regulated Health Professions Act and Pharmacy Act – government consultation on governance reform	Board supported: Reduction in Board size, separate Board and Statutory Committees, Competency Based elections, flexibility to investigate, continue 50/50 balance of professional and public directors, and eliminating academic directors	June 30, 2021 Response to government consultation through letter to Ministry	No further action from government to date	Dependent on government direction	

N/A - Advice to Government re - closed Preferred Provider networks	Board recommendation to government to consider negative impact of closed preferred provider networks: impact on patient choice and continuity of care.	January 2019 Letter to Minister of Health	N/A – no response expected, letter provided advice only	Closed Provider Networks continue to be in existence	

Ontario College of Pharmacists

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COLLEGE PERFORMANCE MEASUREMENT FRAMEWORK (CPMF)

2023 Report Submission

March 30, 2024

Table of Contents

Introduction

The College Performance Measurement Framework (CPMF)

The CPMF has been developed by the Ontario Ministry of Health (the Ministry) in close collaboration with Ontario's health regulatory Colleges (Colleges), subject matter experts and the public with the aim of answering the question "how well are Colleges executing their mandate which is to act in the public interest?" This information will:

1. Strengthen accountability and oversight of Ontario's health regulatory Colleges;
2. Help Colleges improve their performance;

Each College will report on seven Domains with the support of six components, as illustrated in Table 1.

Table 1: CPMF Measurement Domains and Components

1	**Measurement domains**	→	Critical attributes of an excellent health regulator in Ontario that should be measured for the purpose of the CPMF.
2	**Standards**	→	Performance-based activities that a College is expected to achieve and against which a College will be measured.
3	**Measures**	→	More specific requirements to demonstrate and enable the assessment of how a College achieves a Standard.
4	**Evidence**	→	Decisions, activities, processes, or the quantifiable results that are being used to demonstrate and assess a College's achievement of a standard.
5	**Context measures**	→	Statistical data Colleges report that will provide helpful context about a College's performance related to a standard.
6	**Planned improvement actions**	→	Initiatives a College commits to implement over the next reporting period to improve its performance on one or more standards, where appropriate.

CPMF Model

The seven measurement domains shown in Figure 1 are the critical attributes that contribute to a College effectively serving and protecting the public interest. They relate to key statutory functions and organizational aspects that enable a College to carry out its functions well. The seven domains are interdependent and together lead to the outcomes that a College is expected to achieve as an excellent regulator. The fourteen Standards within the seven measurement domains are listed in Figure 2.

Figure 1: CPMF Model for Measuring Regulatory Excellence

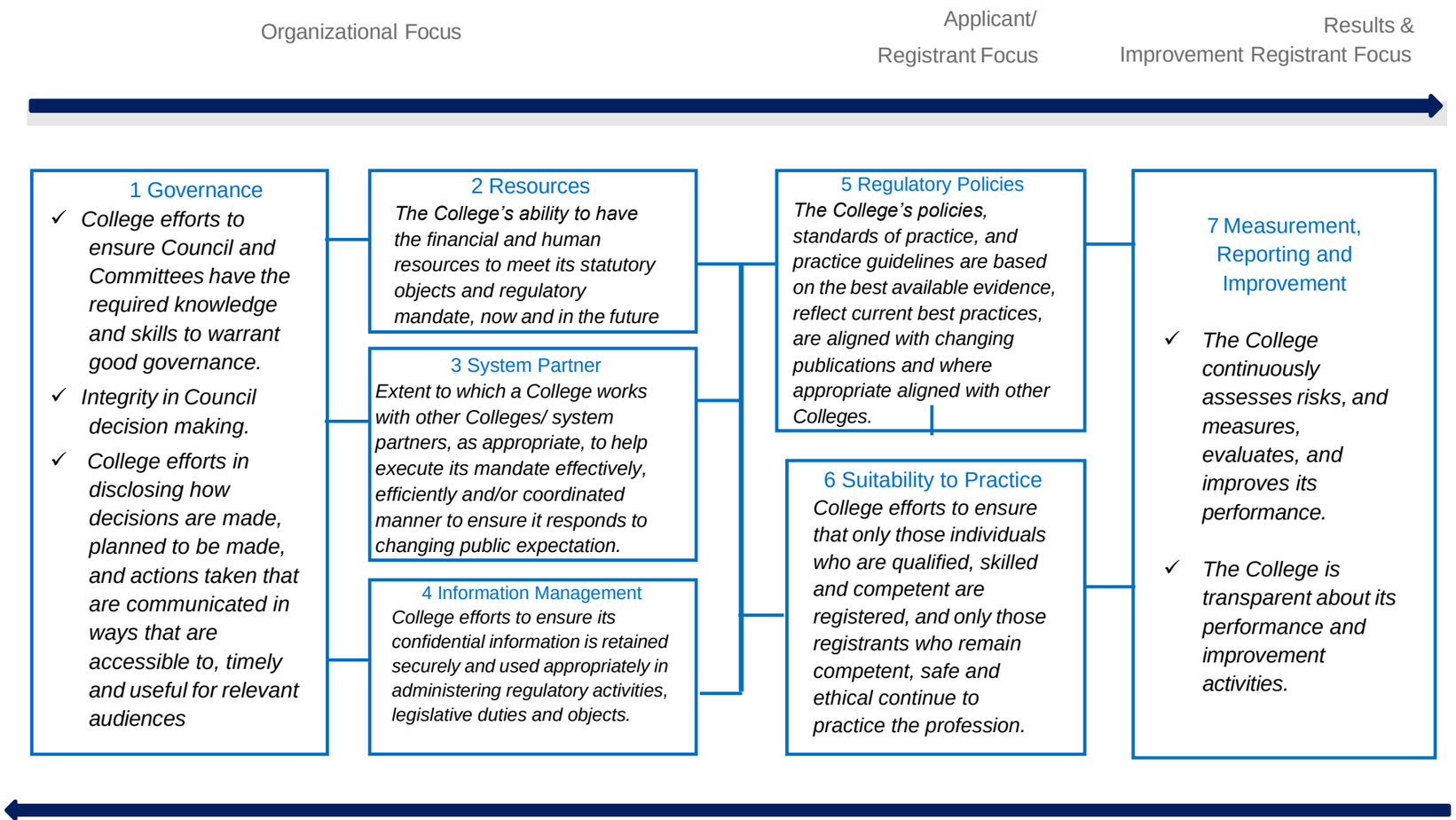


Figure 2: CPMF Domains and Standards

Domains	Standards
Governance	1. Council and statutory committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.
	2. Council decisions are made in the public interest.
	3. The College acts to foster public trust through transparency about decisions made and actions taken.
Resources	4. The College is a responsible steward of its (financial and human) resources.
System Partner	5. The College actively engages with other health regulatory Colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.
	6. The College maintains cooperative and collaborative relationships responds in a timely and effective manner to changing public expectations.
Information Management	7. Information collected by the College is protected from unauthorized disclosure.
Regulatory Policies	8. Policies, standards of practice, and practice guidelines are based in the best available evidence, reflect current best practices, are aligned with changing public expectations, and where appropriate aligned with other Colleges.
Suitability to Practice	9. The College has processes and procedures in place to assess the competency, safety, and ethics of the people it registers.
	10. The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.
	11. The complaints process is accessible and supportive.
	12. All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.
	13. The College complaints process is coordinated and integrated.
Measurement, Reporting and Improvement	14. The College monitors, reports on, and improves its performance.

The CPMF Reporting Tool

The College Performance Measurement Framework (CPMF) continues to serve as a cornerstone for regulatory transparency and excellence. In the fourth iteration, the CPMF will help provide the public, the Ministry of Health, and other stakeholders with critical insights into the activities and processes of health regulatory Colleges.

For the 2023 reporting cycle, the focus remains on fostering an environment of continuous improvement. The information gathered through the CPMF Reporting Tool is intended to spotlight areas for enhancement, prompting closer attention and potential follow-up actions. As in the past, the Ministry will not assess whether Colleges meet or do not meet the Standards in the CPMF. The outcomes of the reporting will continue to facilitate meaningful dialogue on performance improvement among College staff and Council members and between Colleges and their broader communities, including the public, the Ministry, members, and other stakeholders.

In alignment with its commitment to transparency and collective advancement, the Ministry will develop a Summary Report which will underscore the commendable practices already established by Colleges, collective strengths, and areas for improvement. The Summary Report will emphasize the overall performance of the health regulatory system rather than individual Colleges, highlighting opportunities for mutual learning and growth.

The Ministry's Summary Report will be posted in English and French and weblinks to the report will be shared with the Colleges once it is published.

Completing the CPMF Reporting Tool

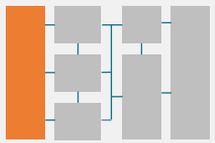
While the CPMF Reporting Tool seeks to clarify the information requested, it is not intended to direct College activities and processes or restrict the way a College fulfills its fiduciary duties. Where a term or concept is not explicitly defined in the CPMF Reporting Tool, the Ministry relies on individual Colleges, as subject matter experts, to determine how a term should be appropriately interpreted given the uniqueness of the profession each College oversees.

In the spirit of continuous improvement, if the College plans to improve its actions or processes related to a respective Measure or Evidence, it is encouraged to highlight these planned activities and progress made on commitments from previous years.

There are eight pieces of Evidence highlighted within Part 1 of the Reporting Tool as 'Benchmarked Evidence'. These pieces of evidence were identified as attributes of an excellent regulator, and Colleges should meet, or work towards meeting these benchmarks. If a College does not meet, or partially meets expectations on a benchmark, it is required to provide an improvement plan that includes the steps it will follow, timelines and any barriers to implementing that benchmark. This year Colleges should report on their progress in meeting the benchmarked Evidence.

Where a College fully met Evidence in 2022 and 2023, the College may opt to respond with 'Met in 2022 and Continues to Meet in 2023'. In the instances where this is appropriate, this option appears in the dropdown menu. If that option is not there, Colleges are asked to fully respond to the Evidence or Standard. Colleges are also asked to provide additional detail (e.g., page numbers), when linking to or referencing College documents.

Part 1: Measurement Domains



Measure:
1.1 Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.

DOMAIN 1: GOVERNANCE | **STANDARD 1**

Required Evidence	College Response	
a. Professional members are eligible to stand for election to Council only after: i. meeting pre-defined competency and suitability criteria; and *Benchmarked Evidence*	The College fulfills this requirement:	Yes
	• The competency and suitability criteria are public: Yes 1) Eligibility criteria for election to the Board can be found in the College's By-Laws (Section 5.7 "Eligibility for Election", page 7). 2) In addition, the College screens potential candidates for election against a list of competencies/qualities targeting specific competency gaps identified by Board survey ○ See By-Law section 5. 9 "Director Competencies", page 9. ○ The College attempts to recruit electoral candidates who demonstrate the specific competencies the Board is seeking through its election support materials.	
	If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation.	

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		ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	The College fulfills this requirement:	No
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	No
			Additional comments for clarification (optional): The College's application and screening process makes holding pre-election orientation sessions redundant. Applicants must: • Review documents that outline the College's mandate, Governance Framework, role, responsibilities and expectations of the Board, the individual Directors, and Board Committees. (See website for more details). • Provide written answers to questions about serving in the public interest. Applicant responses are screened by two levels of independent screening to assess their understanding of the role of a Board of Director and the required competencies.	
		b. Statutory Committee candidates have: i. Met pre-defined competency and suitability criteria; and *Benchmarked Evidence*	The College fulfills this requirement:	Yes
			• The competency and suitability criteria are public: No • *If yes, please insert a link and indicate the page number where they can be found; if not, please list criteria.* 1. ***Eligibility Criteria*** (for professional applicants) include having a valid Certificate of Registration, practicing or residing in Ontario, being subject of any discipline or incapacity proceeding, being found to have committed an act of professional misconduct or to be incompetent by a panel of the Discipline Committee, being disqualified from serving on the Board or a committee within the last six year. 2. ***Core Competencies*** are: 1) Interest in serving on a Committee; 2) Analytical; 3) Currency / Awareness of societal values; 4) Understanding of the public interest; 5) Open-mindedness/Willingness to learn; 6) Integrity/Transparency; 7) Recognition of limitations; 8) Reflective/Self-Aware; 9) Respectful/Personable (high EQ); 10) Effective Communicator; 11) Diligence/ Preparedness/Adherence to commitment; 12) Technical knowledge/Computer literacy; 13) Participatory; 14) Collaboration/Cooperation; 15) Judgement/ Decision making.	

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			If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation.	
		ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities.	The College fulfills this requirement:	No
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	No
			Additional comments for clarification (optional): The College is not intending to provide orientation training prior to appointment to a Committee as the College is confident that: 1. Its application and screening process for Committee members ensures that those who wish to serve on a committee are well-oriented to the mandate of the respective committee and the role expectations. 2. Its comprehensive Committee orientation program for members, once appointed, will provide them with the information they need to perform their duties as Committee appointees effectively, including: ○ New appointees receive training from the Board Chair and CEO and Registrar at the beginning of the Board year. ○ All appointees (new and returning) are sent a confirmation package which contains the Board policy booklet as well as an attestation and instruction to review the policies, paying particular attention to sections regarding role, duty of care and loyalty, conflict of interest (COI), privacy and confidentiality. This includes a requirement to view a video on "Managing Cultural Differences". ○ New appointees also participate in Committee-specific orientation prior to, or at the same time as, their first Committee meeting. This applies to Professional and Lay Committee Appointees as well as Board Directors appointed to serve on Committees.	

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		c. Prior to attending their first meeting, public appointments to Council undertake an orientation training course provided by the College about the College's mandate and expectations pertaining to the appointee's role and responsibilities.	The College fulfills this requirement:	Met in 2022, continues to meet in 2023

			• Duration of orientation training:
			  ○ A one-hour orientation training with the Board Chair, the CEO and Registrar and a designated mentor (a current public Board member who provides guidance and support in onboarding a new public Director).
			  ○ A one-hour online orientation module.
			• Please briefly describe the format of orientation training: The one-hour orientation training with the Board Chair, the CEO and Registrar and the mentor is virtual.
			• Please insert a link and indicate the page number if training topics are public ***OR*** list orientation training topics.
			1. Role of the College (who we are, what we regulate, how we regulate).
			2. Governance & Operations of the OCP.
			3. Board oversight (OCP risk appetite statement, oversight tools).
			4. Board duties (duties of Board of Directors, conflict of interest, privacy and confidentiality, equity, diversity, and inclusion).
			5. Committees Statutory and Standing Committees.
			See for more detail: Board Policy 3.1 – Orientation of Board Directors and Committee Appointees (Pages 26-27)	

			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional): Starting in 2024, the Colleges further enhanced the orientation for public Board members by providing them with the opportunity to shadow a virtual routine pharmacist practice assessment to help them gain knowledge about the pharmacy profession.	

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DOMAIN 1: GOVERNANCE	STANDARD 1	**Measure:** **1.2 Council regularly assesses its effectiveness and addresses identified opportunities for improvement through ongoing education.**		
		Required Evidence	**College Response**	
		a. Council has developed and implemented a framework to regularly evaluate the effectiveness of: i. Council meetings; and ii. Council.	The College fulfills this requirement:	Met in 2022, continues to meet in 2023
			• Please provide the year when Framework was developed ***OR*** last updated: 2021 • Please insert a link to Framework ***OR*** link to Council meeting materials and indicate the page number where the Framework is found and was approved: Framework: Policy 3.2 Board Meeting Effectiveness Assessment Policy (page 28). • Evaluation and assessment results are discussed at public Council meeting: Yes • *If yes, please insert a link to the last Council meeting and indicate the page number where the most recent evaluation results have been presented and discussed:* December 11, 2023, Council (Board) meeting (Page 34).	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

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		b. The framework includes a third-party assessment of Council effectiveness at a minimum every three years.	The College fulfills this requirement:	Yes
			• Has a third party been engaged by the College for evaluation of Council effectiveness? Yes ○ An independent third party evaluated the performance of the College's Board based on observation, interactions, and Board self-report on December 11, 2023. ○ Overall, the evaluation concluded that: - There is a high level of active participation among both the public and elected members of the Board, which ensures diverse perspectives are considered in decision-making. - Members are confident in their ability to make informed and effective decisions. An indication of the Board's competency and the members' understanding of their roles and responsibilities.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

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		c. Ongoing training provided to Council and Committee members has been informed by: i. the outcome of relevant evaluation(s); ii. the needs identified by Council and Committee members; and/or iii. evolving public expectations including risk management and Diversity, Equity, and Inclusion. Further clarification: Colleges are encouraged to define public expectations based on input from the public, their members, and stakeholders. Risk management is essential to effective oversight since internal and external risks may impact the ability of Council to fulfill its mandate.	The College fulfills this requirement:	Yes
			• Please insert a link to documents outlining how outcome evaluations have informed Council and Committee training and indicate the page numbers. • Please insert a link to Council meeting materials and indicate the page number where this information is found ***OR*** briefly describe how this has been done for the training provided over the last calendar year. ○ Informed by, for example, Board evaluations, the Board Chair and Board Vice-Chair may meet to discuss opportunities for Board development and may also elect to meet with any number of Directors to discuss opportunities for Board Director development. ○ The Governance Committee may consider and recommend training or development based on the feedback for the Board as a whole or for any individual Director of the Board. ○ 2023 Training included, for example, the following: - Risk appetite statements and enterprise risk management education (Board) September 2023 Board meeting (page 53) - Inclusive Language training and continued to evolve the way Directors develop and deliver meaningful land acknowledgements (Board, Discipline Committee and Registration Committee) June 2023 Board meeting (page 2)	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes
			Additional comments for clarification (optional): • As the College continues to engage in CQI, we look forward to more precisely aligning training needs with data that identifies knowledge gaps. To date: ○ The Board Chair and Board Vice-Chair may meet to discuss opportunities for Board development and may also elect to meet with any number of Directors to discuss opportunities for Board Director development. ○ The Governance Committee may consider and recommend training or development based on the feedback for the Board as a whole or for any individual Director of the Board. • 2023 training included the following: ○ Risk appetite statements and enterprise risk management education (Board) September 2023 Board meeting (page 53) ○ Inclusive Language training and continued to evolve the way Directors develop and deliver meaningful land acknowledgements (Board, Discipline Committee and Registration Committee) June 2023 Board meeting (page 2)	

		Measure: **2.1 All decisions related to a Council's strategic objectives, regulatory processes, and activities are impartial, evidence-informed, and advance the public interest**	
		Required Evidence	**College Response**
		a. The College Council has a Code of Conduct and 'Conflict-of-Interest' policy that is: i. Reviewed at least every three years to ensure it reflects current legislation, practices, public expectations, issues, and emerging initiatives (e.g., Diversity, Equity, and Inclusion); and Further clarification: Colleges are best placed to determine the public expectations, issues and emerging initiatives based on input from their members, stakeholders, and the public. While there will be similarities across Colleges such as Diversity, Equity, and Inclusion, this is also an opportunity to reflect additional issues, expectations, and emerging initiatives unique to a College or profession.	The College fulfills the 3-year review requirement: — Yes • Please provide the year when the Council Code of Conduct and 'Conflict-of-Interest' policy was last evaluated/updated: ○ The Conduct of Directors and Committee Appointees and Sanctions Process (Board Policy 3.7) was last updated in 2021. ○ The Board Code of Conduct (Appendix to Board Policy 3.7) was last updated in 2021. ○ The Conflict-of-Interest Policy (Board Policy 3.9) was last updated in 2022. • Please briefly describe any changes made to the Council Code of Conduct and Conflict-of-Interest policy resulting from the last review. ○ Changes to the Conflict-of-Interest Policy can be found here (Pages 33-34). *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* — Choose an item. *Additional comments for clarification (optional)* The College is embarking on a strategy that will include reviewing various policies and procedures to assess for unintended systemic barriers and inequitable effects

			across people and groups. It is expected that the Board Code of Conduct and Conflict-of-Interest policies will be part of this review.	
		ii. accessible to the public.	The College fulfills this requirement:	Met in 2022, continues to meet in 2023
			Please insert a link to the Council Code of Conduct and 'Conflict of Interest' Policy ***OR*** Council meeting materials where the policy is found and was last discussed and approved and indicate the page number: See links above.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period	Choose an item.
			Additional comments for clarification (optional)	
		b. The College enforces a minimum time before an individual can be elected to Council after holding a position that could create an actual or perceived conflict of interest with respect to their Council duties (i.e., cooling off periods). <u>Further clarification:</u> Colleges may provide additional methods not listed here by which they meet the evidence.	The College fulfills this requirement:	Met in 2022, continues to meet in 2023
			• Cooling off period is enforced through: By-law • Please provide the year that the cooling off period policy was developed ***OR*** last evaluated/updated: 2020 • Please provide the length of the cooling off period: Three (3) years • How does the College define the cooling off period? o The Registrant is not and has not within the three (3) years immediately preceding the election been an employee, officer, or director of a Professional Advocacy Association. o Where the Registrant was formerly a Director but is not as of the date of the election, it has been at least three (3) years since they were a Director. o The Registrant is not the Owner or Designated Manager of a pharmacy that, within the six (6) years immediately preceding the election, has undergone a re-inspection, as a result of deficiencies noted in an initial inspection, for a third time or more after the initial inspection. • Insert a link to Council meeting where cooling off period has been discussed and decided upon and indicate the page number; ***OR*** Where not publicly available, please briefly describe the cooling off policy: See College By-Law No 6 Section 5.7.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

		c. The College has a conflict-of-interest questionnaire that all Council members must complete annually. Additionally: i. The completed questionnaires are included as an appendix to each Council meeting package; ii. Questionnaires include definitions of conflict of interest; iii. Questionnaires include questions based on areas of risk for conflict of interest identified by Council that are specific to the profession and/or College; and at the beginning of each Council meeting, members must declare any updates to their responses and any conflict of interest specific to the meeting agenda.	The College fulfills this requirement:	Met in 2022, continues to meet in 2023
			• Please provide the year when conflict of interest the questionnaire was implemented ***OR*** last evaluated/updated: 2022 • Member(s) note whether their questionnaire requires amendments at each Council meeting and whether they have any conflicts of interest based on Council agenda items: Yes • Please insert a link to the most recent Council meeting materials that includes the questionnaire and indicate the page number: N/A	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	No
			Additional comments for clarification (optional) The College believes that its current approach meets the intent of this Measure, including: • The requirement that all Board Directors complete an attestation of conflict of interest (COI) at the beginning of each Board year stating that they are aware they must declare any real or perceived conflicts of interest to mitigate any risk to myself, the College, or the Board/Committee. • At the beginning of each meeting, Board Directors are being asked whether there is a conflict of interest with one or more of the agenda items. • Education regarding expectations as it relates to conflict of interest is part of the annual Board and Committee orientation. • The Governance Committee developed a table of Conflict-of-Interest considerations and precedents to assist in resolving these issues for Committee and Board Directors. See Board Policy 3.9 – Conflicts of Interest for more details (Page 53). • At the beginning of each meeting, Board Directors are asked to declare conflict with any of the items on the agenda. In the rare event where the Chair believes there may be a conflict, they will contact the Board Director in advance to ensure an understanding of the potential issue.	

		d. Meeting materials for Council enable the public to clearly identify the public interest rationale and the evidence supporting a decision related to the College's strategic direction or regulatory processes and actions (e.g., the minutes include a link to a publicly available briefing note).	The College fulfills this requirement:	Met in 2022, continues to meet in 2023

			• Please briefly describe how the College makes public interest rationale for Council decisions accessible for the public:
			  ○ Matters that come before the Board for approval or decision are accompanied by a supporting briefing note which includes a section that defines the public interest rationale for the item coming forward to the Board. The content of each briefing note reinforces the connection of the matter to the College's mandate and Board's role. This includes providing the necessary context and background to support the Board's decision-making and understanding and any key considerations that must be included to demonstrate the item as a matter of public interest. Briefing notes are supplemented by presentations, which are used to further emphasize the content of the matter before the Board as well as the public interest rationale.
			• Please insert a link to Council meeting materials that include an example of how the College references a public interest rationale and indicate the page number:
			  ○ Board meeting materials can be found here.
			  Example of how the College references a public interest rationale in its briefing notes: Expansion of Scope – Minor Ailments and Other Therapies – September 19, 2023, Board meeting (Page 91).	

			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	
		e. The College has and regularly reviews a formal approach to identify, assess, and manage internal and external risks. This approach is integrated into the College's strategic planning and operations. <u>Further clarification:</u> Formal approach refers to the documented method which a College undertakes to identify, assess, and manage risk. This method or process should be regularly reviewed and appropriate. Risk management planning activities	The College fulfills this requirement:	Met in 2022, continues to meet in 2023

			• Please provide the year that the formal approach was last reviewed: 2020 (and continues to be refined).
			• Please insert a link to the internal and external risks identified by the College **OR** Council meeting materials where the risks were discussed and integrated into the College's strategic planning activities and indicate page number:
			  ○ The College's Risk Appetite Statements, which outline the degree of risk OCP is willing to accept to achieve its objectives, can be found here (Page 53).
			  ○ An example of the College's Risk Reporting can be found here (Page 64).	

		should be tied to strategic objectives of Council since internal and external risks may impact the ability of Council to fulfill its mandate, especially in the absence of mitigations. Internal risks are related to operations of the College and may impact its ability to meet its strategic objectives. External risks are economic, political and/or natural factors that happen outside of the organization.	*If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?*	Choose an item.
			Additional comments for clarification (optional)	

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DOMAIN 1: GOVERNANCE	STANDARD 3	**Measure:** **3.1 Council decisions are transparent**	
		Required Evidence	**College Response**
		a. Council minutes (once approved) and status updates on the implementation of Council decisions to date are accessible on the College's website, or a process for requesting materials is clearly outlined.	The College fulfills this requirement: — Met in 2022, continues to meet in 2023 • Please insert a link to the webpage where Council minutes are posted: o College's Board (Council) Meetings & Reports. o In addition, the College: - Drafts and posts Council Summary reports about one week after the meeting on the College's website. - Highlights of the Board meetings are also shared via X (formerly Twitter) • Please insert a link to where the status updates on the implementation of Council decisions to date are posted **OR** where the process for requesting these materials is posted: o Status updates on Council decisions are not posted separately on the College's website. Updates are provided in subsequent Board meeting packages, which are available on the College's website. *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* — Choose an item. *Additional comments for clarification (optional)*
		b. The following information about Executive Committee meetings is clearly posted on the College's website. Alternatively, the College can post the approved minutes if it includes the following information: i. the meeting date; ii. the rationale for the meeting; iii. a report on discussions and decisions when Executive	The College fulfills this requirement: — Met in 2022, continues to meet in 2023 • Please insert a link to the webpage where Executive Committee minutes/meeting information are posted: College's Board (Council) Meetings & Reports. *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* — Choose an item. *Additional comments for clarification (optional)*

		Committee acts as Council or discusses/deliberates on matters or materials that will be brought forward to or affect Council; and iv. if decisions will be ratified by Council.	

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		Measure: **3.2 Information provided by the College is accessible and timely.**	
		Required Evidence	**College Response**
		c) With respect to Council meetings: i. Notice of Council meeting and relevant materials are posted at least one week in advance; and ii. Council meeting materials remain accessible on the College's website for a minimum of 3 years, or a process for requesting materials is clearly outlined.	The College fulfills this requirement: — Met in 2022, continues to meet in 2023 • Please insert a link to where past Council meeting materials can be accessed **OR** where the process for requesting these materials is clearly posted. ○ Materials for the past three calendar years are posted at the College's Board (Council) Meetings & Reports site. *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* — Choose an item. *Additional comments for clarification (optional)*
		b. Notice of Discipline Hearings are posted at least one month in advance and include a link to allegations posted on the public register.	The College fulfills this requirement: — Met in 2022, continues to meet in 2023 • Please insert a link to the College's Notice of Discipline Hearings. ○ Notices of Discipline Hearings are posted at least one month in advance with required information posted online via: - The College's Upcoming Discipline Hearings website. - The College's Public Register (Find a Pharmacy/Professional Tool). *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* — Choose an item. *Additional comments for clarification (optional)*

Measure: 3.3 The College has a Diversity, Equity, and Inclusion (DEI) Plan.		
Required Evidence	**College Response**	
a. The DEI plan is reflected in the Council's strategic planning activities and appropriately resourced within the organization to support relevant operational initiatives (e.g., DEI training for staff).	The College fulfills this requirement:	Yes
	• Please insert a link to the College's DEI plan: https://www.ocpinfo.com/wp-content/uploads/2023/06/june-12-2023-board-meeting-agenda-materials.pdf (Pages 73-75) • Please insert a link to the Council meeting minutes where DEI was discussed as part of strategic planning and appropriate resources were approved and indicate page number. See above	
	If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
	Additional comments for clarification (optional)	
b) The College conducts Equity Impact Assessments to ensure that decisions are fair and that a policy, or program, or process is not discriminatory. Further clarification: Colleges are best placed to determine how best to report on an Evidence. There are several Equity Impact Assessments from which a College may draw upon. The Ministry encourages Colleges to use the tool best suited to its situation based on the profession, stakeholders, and patients it serves.	The College fulfills this requirement:	Yes

	• Please insert a link to the Equity Impact Assessments conducted by the College and indicate the page number ***OR*** please briefly describe how the College conducts Equity Impact Assessments.
	  ○ The College is in the process of developing Equity Impact Assessment tools catered to specific department functions. Currently, EDI staff work across the College to provide direction on how to ensure a policy or program that is being reviewed or developed upholds the College's commitment to inclusion and fairness. For example, EDI staff have been consulted on the development of OCP's Service Charter, review of governance frameworks, as well as HR related policies and programs. In addition, relevant program and policy development topics are brought to the College's Equity, Diversity, and Inclusion Registrant Reference Group (RRG) to ensure a range of registrant experience is considered. Members of the RRG have diverse backgrounds and demonstrate expertise of EDI in the field of pharmacy.
	• If the Equity Impact Assessments are not publicly accessible, please provide examples of the circumstances (e.g., applied to a policy, program, or process) in which Equity Impact Assessments were conducted.
	  ○ Equity Impact Assessments are being used as part of the review of the College's existing policies, procedures, and processes as part of the overall EDI strategy. Preliminary work on adapting the HPRO Equity Impact Assessment Tool is underway.
	  ○ Examples include content reviews of Professional Development and Remediation learning modules, HR and corporate policies, template letters and communications tools.	

			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

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		Measure: **4.1 The College demonstrates responsible stewardship of its financial and human resources in achieving its statutory objectives and regulatory mandate.**	
DOMAIN 2: RESOURCES	**STANDARD 4**	**Required Evidence**	**College Response**
		a. The College identifies activities and/or projects that support its strategic plan, including how resources have been allocated. Further clarification: A College's strategic plan and budget should be designed to complement and support each other. To that end, budget allocation should depend on the activities or programs a College undertakes or identifies to achieve its goals. To do this, a College should have estimated the costs of each activity or program and the budget should be allocated accordingly.	The College fulfills this requirement: — Met in 2022, continues to meet in 2023 • Please insert a link to Council meeting materials that include discussions about activities or projects to support the strategic plan ***AND*** a link to the most recent approved budget and indicate the page number. ○ Every year, the College develops an annual budget based on the resources required to implement initiatives to achieve the College's strategic goals set out in the Strategic Plan established by the Board and support the College's ongoing regulatory and operational functions. - December 11, 2023, Board Meeting (2024 budget approval) (Pages 94-108). • Please briefly describe how resources were allocated to activities/projects in support of the strategic plan. ○ Project proposals and program improvements in support of the College's strategic goals and ongoing regulator and operational functions go through a series of rigorous resource planning and prioritization exercises before being added to the operating plan and annual budget. The final budget proposal is presented to the Finance and Audit Committee (FAC) for consideration and recommendation to the Board for review and final approval at the College's year-end Board meeting. *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* — Choose an item. *Additional comments for clarification (optional)*
		b. The College: i. has a "financial reserve policy" that sets out the level of reserves the College needs to build and maintain in order to meet its legislative requirements in case there are unexpected expenses and/or a reduction in revenue	The College fulfills this requirement: — Met in 2022, continues to meet in 2023 • Please insert a link to the "financial reserve policy" ***OR*** Council meeting materials where financial reserve policy has been discussed and approved and indicate the page number. ○ The College's Financial Reserve Policy is not available on the College's website. - The College has established two Reserve Funds to cover variable and/or unforeseen costs and expenses (Investigations and Hearings Reserve Fund and a Contingency Reserve Fund). - The amount to be maintained in the Investigations and Hearings Reserve Fund is calculated each year, based on best estimates of potential expenses. - The amount to be maintained in the Contingency Reserve Fund is at a minimum four (4) months operating expenses.

		and ii. possesses the level of reserve set out in its "financial reserve policy."	• Please insert the most recent date when the "financial reserve policy" has been developed ***OR*** reviewed/updated. ○ Reviewed 2021 • Has the financial reserve policy been validated by a financial auditor? Yes	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	
		c. Council is accountable for the success and sustainability of the organization it governs. This includes: i. regularly reviewing and updating written operational policies to ensure that the organization has the staffing complement it needs to be successful now and, in the future (e.g., processes and procedures for succession planning for Senior Leadership and ensuring an organizational culture that attracts and retains key talent, through elements such as training and engagement).	The College fulfills this requirement:	No
			• *Please insert a link to the College's written operational policies which address staffing complement to address current and future needs.* • Please insert a link to Council meeting materials where the operational policy was last reviewed and indicate the page number. **Note:** Colleges are encouraged to add examples of written operational policies that they identify as enabling a sustainable human resource complement to ensure organizational success.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	No
			The College believes that its current approach meets the intent of this Measure: • In considering the College's annual budget, the Board considers the anticipated human resources required to ensure sustainability. For example: ○ The 2023 budget included a significant investment in increasing staffing to meet operational requirements (See December 12, 2022 Board materials for more detail (pages 200 and 211)) ○ The 2024 budget includes significant investments in staff training (See December 11, 2023, Board materials for more detail on rational (pages 94, 98, and 108)). • Staff engagement surveys are conducted annually by a third party and reported to the Board. The Registrar/CEO has a performance goal related to retaining or surpassing current engagement scores. High scores help retain and attract the best employees to meet current and future staffing needs. For example: ○ The Board reviewed and discussed the 2023 OCP Employee Engagement Survey results at the September 17th Board meeting (See Board minutes for more detail, including survey result). ○ The Registrar's Report provides the Board with an update on people/culture activities and monthly staff survey results. (See Registrar's Report, page 21)	

		Benchmarked Evidence	• Every 3-5 years, the College conducts a job and salary evaluation that will further inform whether the College has the right staffing composition and skills and salaries are competitive to keep and attract talent. Very	
		ii. regularly reviewing and updating the College's data and technology plan to reflect how it adapts its use of technology to improve College processes in order to meet its mandate (e.g., digitization of processes such as registration, updated cyber security technology, searchable databases).	The College fulfills this requirement	Met in 2022, continues to meet in 2023
			• Please insert a link to the College's data and technology plan which speaks to improving College processes ***OR*** please briefly describe the plan. ○ In 2021, the College outlined a plan to modernize its technology infrastructure over a three-year period. The plan (know as the Technology Roadmap) includes implementation of cloud-based applications to improve collaboration, productivity, availability, and security while at the same time reducing cost and downtime. Updates on the progress of the Roadmap are regularly reviewed.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	No
			Additional comments for clarification (optional)	

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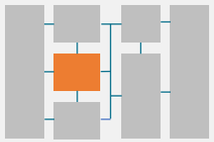
DOMAIN 3: SYSTEM PARTNER

STANDARD 5 and STANDARD 6



Measure / Required evidence: N/A	College response
	Colleges are requested to provide a narrative that highlights their organization's best practices for the following two standards. An exhaustive list of interactions with every system partner that the College engaged with is not required. ***Colleges may wish to provide information that includes their key activities and outcomes for each best practice discussed with the ministry, or examples of system partnership that, while not specifically discussed, a College may wish to highlight as a result of dialogue.***
The two standards under this domain are not assessed based on measures and evidence like other domains, as there is no 'best practice' regarding the execution of these two standards. Instead, Colleges will report on key activities, outcomes, and next steps that have emerged through a dialogue with the Ministry. Beyond discussing what Colleges have done, the dialogue might also identify other potential areas for alignment with other Colleges and system partners. -	Regulatory Principle in 2024 Strategic Plan: "We engage and collaborate with Ontario patients and other health system partners to protect the public" 2023 engagements with other colleges and system partners included (but was not limited to): • HPRO (Registrar on Management Committee and staff are on a variety of communities of interest) • SOAR • CLEAR and CNAR attendance and presentations • NAPRA • Ontario Health (regarding clinical viewers) • Universities (in research partnerships) and both Universities and Colleges in outreach activities) • Pharmacy associations • Special interest working groups (e.g. a group dealing with alternatives to reliance on lists as a basis for prescribing) • Ontario Chiefs of Police (regarding Time Delayed Safes safety initiative) • Ongoing relationships and information-sharing with colleagues across colleges on an *ad hoc* basis about matters from governance best practices to best leadership training for staff The examples are too numerous to provide details about how each has shaped College outcomes. Often this will be reflected in the environmental scanning section of briefing materials provided to the Board, or in revisions to operational documents, based on best practices identified through our community.

	Standard 6: The College maintains cooperative and collaborative relationships and responds in a timely and effective manner to changing public/societal expectations The intent of Standard 6 is to demonstrate that a College has formed the necessary relationships with system partners to ensure that it receives and contributes information about relevant changes to public expectations. This could include both relationships where the College is asked to provide information by system partners, or where the College proactively seeks information in a timely manner. • *Please provide examples of key successes and achievements from the reporting year where the College engaged with partners, including patients/public to ensure it can respond to changing public/societal expectations (e.g., COVID-19 Pandemic, mental health, labor mobility etc.). Please also describe the matters that were discussed with each of these partners and how the information that the College obtained/provided was used to ensure the College could respond to a public/societal expectation.* • *In addition to the partners it regularly interacts with, the College is asked to include information about how it identifies relevant system partners, maintains relationships so that the College is able access relevant information from partners in a timely manner, and leverages the information obtained to respond (specific examples of when and how a College responded is requested in Standard 7).* **Expanded Scope of Practice** • In work related to adding minor ailments to pharmacy scope, the College established a Scope of Practice Advisory Group comprising representatives from pharmacy, medicine, academia, public health and other health experts. • Following the advice from the advisory group, the College's Board recommended to the Minister of Health that prescribing for 17 minor ailments should be added to the pharmacist's scope of practice, on the understanding that some of these may be subject to conditions or restrictions to be determined. More information can be found here. **EDI Reference Group** • A group comprised of six pharmacists and three pharmacy technicians with diverse professional and personal experience. • Provides arm's length advice to the College about matters related to our EDI strategy.

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	Measure: **7.1 The College demonstrates how it protects against and addresses unauthorized disclosure of information.**		
DOMAIN 4: INFORMATION MANAGEMENT	**STANDARD 7**	**Required Evidence**	**College Response**
		a. The College demonstrates how it: i. uses policies and processes to govern the disclosure of, and requests for information;	The College fulfills this requirement: — Yes
			• Please insert a link to policies and processes ***OR*** please briefly describe the respective policies and processes that address disclosure and requests for information. ○ A Privacy Code outlining the kind of personal information the College collects, the rationale for collecting it, and how the College will use, disclose, and retain the information. The Code adopted the 10 principles of the Canadian Standard Association's Model Code for Protection of Personal Information. The Privacy Code can be found on the College's website. ○ Privacy and Information Access Policy & Manual that provides operational guidance to help OCP staff: - Understand privacy legislation and regulations and how it may or may not apply to the OCP. - Understand the general framework of the OCP's Privacy Management principles and practices. - Meet OCP and external administrative and operational requirements as it relates to information access and disclosure; and, - Understand and apply OCP's privacy and information access management protocols to their work at the OCP. ○ An Assessing External Requests for Data and Information process document that describes: the kinds of requests for information that the College receives, the differing ways that the College can fulfill those requests, the criteria used by the College to assess whether it is able to disclose the requested information, best practices for sending requested data depending on the sensitivity of the data, and "Terms of Use" that outline what the recipient shall and shall not do with the data they receive. ○ All College staff are required to complete training to refresh awareness on information/data responsibilities.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? — Choose an item.
			Additional comments for clarification (optional) The College is reviewing its current data sharing practices.

		ii. uses cybersecurity measures to protect against unauthorized disclosure of information; and iii. uses policies, practices and processes to address accidental or unauthorized disclosure of information. *Benchmarked Evidence*	The College fulfills this requirement:	Partially
			• Please insert a link to policies and processes ***OR*** please briefly describe the respective policies and processes to address cybersecurity and accidental or unauthorized disclosure of information. ○ Cybersecurity: The College is in the process of developing its cybersecurity policy. However, it has processes in place to routinely assess its IT/IM infrastructure and those of its vendors to ensure optimal protection. Upon identification of a potential cybersecurity threat, a thorough vulnerability assessment is conducted, and countermeasures are formulated and rapidly deployed. Events are logged, monitored, and reported to the leadership team in a structured approach in accordance with the incident management protocol. ○ Process for Addressing Accidental or Unauthorized Disclosure of Information: The College's Privacy Breach and Incident Protocol outlines the process for managing accidental or unauthorized disclosures of information which includes the Breach and Incident Protocols. At a high-level, the process steps are: 1. Any potential accidental or unauthorized disclosure of information is reported to the Privacy Officer. 2. College staff investigate the root cause of the breach, collaborate with IT Department to develop a remediation plan, and document the findings. 3. Affected parties from the incident are notified, if necessary, and follow-up is managed. 4. Cause and contributing factors relate to each privacy breach are reviewed by the Privacy Officer and the College's Risk Management lead to include in the College's Risk Register and develop mitigation strategies where deemed needed. College staff are trained on the Privacy and Information Access Policy & Manual, and a Privacy Breach Summary Report template to support staff exists.	
			If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation. • The College is developing a cybersecurity policy and a cybersecurity incidence response plan to be completed by mid-2024. The policy and response plan will be based on identified best practices among other Colleges and industries.	

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	Measure: **8.1 All policies, standards of practice, and practice guidelines are up to date and relevant to the current practice environment (e.g., where appropriate, reflective of changing population health needs, public/societal expectations, models of care, clinical evidence, advances in technology).**		
DOMAIN 5: REGULATORY POLICIES	**STANDARD 8**	**Required Evidence**	**College Response**
		a. The College regularly evaluates its policies, standards of practice, and practice guidelines to determine whether they are appropriate, or require revisions, or if new direction or guidance is required based on the current practice environment. *Benchmarked Evidence*	The College fulfills this requirement: **Met in 2022, continues to meet in 2023** • Please insert a link to document(s) that outline how the College evaluates its policies, standards of practice, and practice guidelines to ensure they are up to date and relevant to the current practice environment and indicate the page number(s) ***OR*** please briefly describe the College's evaluation process (e.g., what triggers an evaluation, how often are evaluations conducted, what steps are being taken, which stakeholders are being engaged in the evaluation and how are they involved). ○ The process outlining how the College evaluates its policies, standards of practice, and practice guidelines can be found here. ○ College staff proactively monitor the practice environment through several different mechanisms, including our practice and operational assessment process, complaints and intake trends, practice queries from professionals and the public (as received by our practice consultants), and collaborate with external stakeholders to identify the need to develop or review a policy, standards, and practice guidelines. *If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation*.

		b. Provide information on how the College takes into account the following components when developing or amending policies, standards and practice guidelines: i. evidence and data; ii. the risk posed to patients / the public; iii. the current practice environment; iv. alignment with other health regulatory Colleges (where appropriate, for example where practice matters overlap); v. expectations of the public; and vi. stakeholder views and feedback. *Benchmarked Evidence*	The College fulfills this requirement: • *Please insert a link to document(s) that outline how the College develops or amends its policies, standards of practice, and practice guidelines to ensure they address the listed components and indicate the page number(s)* ***OR*** *please briefly describe the College's development and amendment process.* o The process outlining how the College evaluates its policies, standards of practice, and practice guidelines can be found here. *If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation.*	Met in 2022, continues to meet in 2023

		c) The College's policies, guidelines, standards, and Code of Ethics should promote Diversity, Equity, and Inclusion (DEI) so that these principles and values are reflected in the care provided by the registrants of the College.	The College fulfills this requirement:	Yes
			• Please briefly describe how the College reviews its policies, guidelines, standards, and Code of Ethics to ensure that they promote Diversity, Equity and Inclusion. ○ 2024 Strategic Plan, Goal 4: "The College uses its regulatory influence to ensure that all patients are treated with respect and without discrimination via positive changes in pharmacy practice." ○ The Colleges prioritizes the review of existing standards, policies, and guidelines related to the practice of pharmacy and the operation of pharmacies to assess the existence of bias and resulting effect on patients and registrants of different races, gender identities, sexual orientation, ages, disability status, parental status, and other characteristics. ○ The College will be expanding its registrant demographics data collection to include relevant protected characteristics (as defined by the Ontario Human Rights Code) for 2025 renewal. • Please highlight some examples of policies, guidelines, standards, or the Code of Ethics where Diversity, Equity and Inclusion are reflected. ○ The Ontario College of Pharmacists' Service Charter.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

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	Measure: **9.1 Applicants meet all College requirements before they are able to practice.**	
DOMAIN 6: SUITABILITY TO PRACTICE **STANDARD 9**	**Required Evidence**	**College Response**
	a. Processes are in place to ensure that those who meet the registration requirements receive a certificate to practice (e.g., how it operationalizes the registration of members, including the review and validation of submitted documentation to detect fraudulent documents, confirmation of information from supervisors, etc.)[1]	The College fulfills this requirement: **Met in 2022, continues to meet in 2023** Please insert a link that outlines the policies or processes in place to ensure the documentation provided by candidates meets registration requirements and indicate page number ***OR*** please briefly describe in a few words the processes and checks that are carried out. Please insert a link and indicate the page number ***OR*** please briefly describe an overview of the process undertaken to review how a college operationalizes its registration processes to ensure documentation provided by candidates meets registration requirements (e.g., communication with other regulators in other jurisdictions to secure records of good conduct, confirmation of information from supervisors, educators, etc.). • To register as a pharmacist or pharmacy technician, an applicant must meet the registration requirements that are specified in the General Regulation under the Pharmacy Act, 1991. Some of these requirements are specific to the certificate of registration for which the applicant is applying (i.e., pharmacist vs. pharmacy technician). • Applicants are required to satisfy a total of eight requirements in order to be registered to practice pharmacy in Ontario: **1. Education:** ○ Canadian Council for Accreditation of Pharmacy Programs (CCAPP): The College receives graduation lists directly from the CCAPP accredited programs for pharmacists and pharmacy technicians in Ontario. For graduates of a CCAPP-accredited program outside of Ontario, the College requires an official letter directly from the education institution confirming the applicant's graduation. ○ International pharmacy graduates: i. *Through the National Association of Pharmacy Regulatory Authorities* (NAPRA), the College has agreed on national standards for registration including documentation and the authentication process. ii. *The Pharmacy Examining Board of Canada* (PEBC) is responsible for assessing the qualifications and competence of pharmacy professionals. The College accepts the documentation process that PEBC follows to verify the identification and education credential requirements and any determination that PEBC has made using an alternative verification approach. Furthermore, documents submitted to the PEBC are also reviewed by College staff upon application.

[1] This measure is intended to demonstrate how a College ensures an applicant meets every registration requirement set out in its registration regulation prior to engaging in the full scope of practice allowed under any certificate of registration, including whether an applicant is eligible to be granted an exemption from a particular requirement.

2. Jurisprudence Examination:

- The College manages applications for this computer-based exam to assess a candidate's knowledge of federal and provincial legislation affecting pharmacy practice in Ontario and informs candidates of their results. Candidates must submit proof of identification when they apply to register with the College and must present proof of their identification at the testing centre or to the remote proctor on the day of the exam.

3. Practice-based Assessment:

- The College manages applications to undergo practice-based assessments and informs candidates of their outcome. Candidates must provide valid, government-issued photo identification to their assessor.

4. Pharmacy Examining Board of Canada (PEBC) Qualifying Examination:

- A pass result list with successful candidates on each exam is electronically transmitted directly to the College from the PEBC.
- PEBC Identification Authentication: Candidates must submit proof of identification with their application for each part of the relevant Qualifying Exam and must present proof of their identification at the testing centres (or to the remote proctor) on the day(s) of the exams.

5. Language Proficiency:

- International applicants must meet the minimum acceptable test scores for one of the objectives, high stakes tests as set by NAPRA for pharmacists or pharmacy technicians, provide acceptable non-objective evidence of language proficiency, or request that a panel of the College's Registration Committee consider other evidence of the applicant's language proficiency.
- Language proficiency test score reports must be provided directly to the College (or the Pharmacists' Gateway, if applicable) from the testing institution, or are confirmed online with the testing institution by College staff. The language testing centres evaluate proof of identification for all test takers. Letters or transcripts submitted as non-objective evidence must be sent directly to the College from the applicant's pharmacy school, employer, secondary school or school board, and/or undergraduate university.

6. Good Character:

- The police background check must be provided through an OCP-contracted background and identity services provider (accessed directly by staff) or obtained at the applicant's local police station and submitted as a notarized copy or original of the documentation. The declaration of good character is completed within the College's online application.

7. Canadian Citizenship Or Legal Status In Canada:

- The applicant must provide a notarized copy or original documentation of their identity and citizenship or status in Canada. Documentation is reviewed by College staff for authenticity, and retained in the applicant's file.

8. Personal Professional Liability Insurance:

- The applicant must complete a declaration confirming that they have obtained and will maintain personal professional liability insurance as specified in the College's By-Laws while registered with the College. College staff may review evidence of personal professional liability insurance as needed.

- Mobility within Canada:

			○ Applicants who are currently licensed as a pharmacist or pharmacy technician in another Canadian province are considered to have met, and do not need to provide documentation of the education, practice-based assessment and PEBC Qualifying Exam requirements in accordance with the labour mobility provisions of the Agreement on Internal Trade (AIT). However, these applicants must provide evidence of meeting the other registration requirements as described above. ○ A current letter of standing as validation of current licensure must be provided directly to the College from the pharmacy regulator of any Canadian province or territory where the applicant holds an active license. College staff may verify the applicant's registration information using the public register of the other province(s). The College's expectations for document authentication are provided for candidates on the College's Supporting Documentation for Registration page.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	
		b. The College periodically reviews its criteria and processes for determining whether an applicant meets its registration requirements, against best practices (e.g., how a College determines language proficiency, how Colleges detect fraudulent applications or documents including applicant use of third parties, how Colleges confirm registration status in other jurisdictions or professions where relevant etc.).	The College fulfills this requirement:	Partially
			• Please insert a link that outlines the policies or processes in place for identifying best practices to assess whether an applicant meets registration requirements (e.g., how to assess English proficiency, suitability to practice etc.), a link to Council meeting materials where these have been discussed and decided upon and indicate page numbers ***OR*** please briefly describe the process and checks that are carried out. ○ The College is involved with a number of professional regulatory organizations including the Canadian Network of Agencies for Regulation (CNAR), the Council on Licensure, Enforcement & Regulation (CLEAR), and Ontario Regulators for Access Consortium (ORAC). By attending and presenting at conferences organized by these organizations, College staff keep abreast of best practices and developments in registration and assessment for entry to practice. ○ Staff in the College's Registrant Competence department also attend educational events hosted by organizations such as Touchstone Institute and Steinecke Maciura LeBlanc to learn about best practices in assessment and registration. ○ Changes in best practices in registration requirements or processes are monitored by College staff and may trigger an evaluation. ○ In general, the steps outlined below are followed: - Conduct preliminary background research and an environmental scan. - Contract with an external consultant to gather data and/or provide expert knowledge. - Review research findings and expert recommendations to determine the changes required. - If further development is required, pilot-test the proposed changes. - Launch the changes. - Evaluate the impact of the changes. ○ The Registration Committee and/or Board are informed and approve decisions as necessary.	

- Please provide the date when the criteria to assess registration requirements was last reviewed and updated.
  - The College has no specific criteria to assess registration requirements. Registration requirements are being updated based on insights gathered through the process outlined above and Ontario government direction. The most recent changes in registration requirements or processes include:
    - 2022: The College Board reaffirmed the new competency-based Jurisprudence, Ethics and Professionalism (JEP) Exam Blueprint
    - 2022: The Registration Committee approved the competency framework and bridging program for internationally educated pharmacy technician applicants
    - 2022: Ontario government legislated new registration requirements, which came into effect August 31, 2023 through corresponding regulation amendments:
      - Colleges must provide applicants with confirmation of receipt of their application materials and details about any missing information.
      - Timelines: Application decisions, or a referral to the Registration Committee, must be made within 30 days of receipt of the complete application.
      - Language Proficiency: Language proficiency testing requirements have now been codified. The requirement is that the College accept a test approved under the Immigration and Refugee Protection Act (Canada).
      - Canadian Experience: Canadian experience may not be required as a condition of registration. Section 4(3) of the regulation stipulates that this requirement does not apply to the structured practical training program for pharmacy technicians until December 31, 2024, by which time OCP will have implemented PACE for pharmacy technicians.
      - Colleges are required to establish an emergency class of registration, which the College had implemented in regulation in March 2021.

If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Yes

Additional comments for clarification (optional)

The College plans to codify the criteria for determining whether an applicant meets its registration requirements in 2024.

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		Measure: **9.2 Registrants continuously demonstrate they are competent and practice safely and ethically.**		
		A risk-based approach is used to ensure that currency[2] and other competency requirements are monitored and regularly validated (e.g., procedures are in place to verify good character, continuing education, practice hours requirements etc.).	The College fulfills this requirement:	Yes
			• Please briefly describe the currency and competency requirements registrants are required to meet. ○ Currency and Competency Requirements for Part A pharmacists (those who provide patient care): - 600 hours of patient care over the preceding three (3) years. - Successful completion of the self-assessment, practice assessment or knowledge assessment when selected. - Ongoing continuing professional development and documentation in a learning portfolio. ○ For Part B pharmacists (those who do not provide direct patient care) are required to maintain a learning portfolio, but there are no practice hour requirements or other quality assurance requirements. ○ Pharmacy Technicians are not yet included in the Quality Assurance Regulations (awaiting provincial government approval). As a result, there are no currency or quality assurance requirements for pharmacy technicians. They are participating on a voluntary basis. • Please briefly describe how the College identified currency and competency requirements. ○ Conducted a jurisdictional scan regarding the requirements of other regulators, and review of literature to determine if there is any related evidence of best practice. Competencies are set using a modified delphi process with representative members of the profession to create draft competencies, validated by representative members of the profession. • Please provide the date when currency and competency requirements were last reviewed and updated. ○ Currency requirements were last reviewed in 2016. The College proposed Registration/QA regulations in September 2016 and finalized regulation amendments in December 2017 after public consultation. Proposed amendments were submitted to the government in 2018. Additional public consultation took place over a 30-day period beginning December 13, 2023, in anticipation of regulation amendments in 2024. • Please briefly describe how the College monitors that registrants meet currency and competency requirements (e.g., self-declaration, audits, random audit etc.) and how frequently this is done. ○ Currency requirements: - Part A Pharmacists must complete a declaration that they have met the requirements at annual registration renewal (if they are unable to make this declaration, they are unable to proceed with registration renewal). As part of the declaration, they must also provide a Designated Practice	

[2] A 'currency requirement' is a requirement for recent experience that demonstrates that a member's skills or related work experience is up to date. In the context of this measure, only those currency requirements assessed as part of registration processes are included (e.g., during renewal of a certificate of registration, or at any other time).

			Assessment Site indicating the place where they provide patient care and where a QA practice assessment will take place (see for more information the College's website). - Pharmacy technicians are not required to declare currency as this portion of the regulations has yet to be approved by the Ontario government. o Competency requirements: - All Part A pharmacists are required to complete quality assurance assessment activities when randomly selected. Pharmacy technicians are not required to participate in a practice assessment as the quality assurance regulations for pharmacy technicians have yet to be approved by the Ontario government.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

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		Measure: **9.3 Registration practices are transparent, objective, impartial, and fair.**		
		a. The College addressed all recommendations, actions for improvement and next steps from its most recent Audit by the Office of the Fairness Commissioner (OFC).	The College fulfills this requirement:	Met in 2022, continues to meet in 2023
			• Please insert a link to the most recent assessment report by the OFC ***OR*** please provide a summary of outcome assessment report. ○ Based on OFC's assessment, (1) OCP was in full compliance with respect to historical factors, (2) no risk was noted in a review of forward-looking risk factors and (3) a cumulative risk rating of low risk for 2022-2023 was awarded. • Where an action plan was issued, is it: Choose an item.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

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DOMAIN 6: SUITABILITY TO PRACTICE

STANDARD 10

Measure:
10.1 The College supports registrants in applying the (new/revised) standards of practice and practice guidelines applicable to their practice.

Required Evidence	College Response	
a. Provide examples of how the College assists registrants in implementing required changes to standards of practice or practice guidelines (beyond communicating the existence of new standard, FAQs, or supporting documents). Further clarification: Colleges are encouraged to support registrants when implementing changes to standards of practice or guidelines. Such activities could include carrying out a follow-up survey on how registrants are adopting updated standards of practice and addressing identifiable gaps.	The College fulfills this requirement:	Met in 2022, continues to meet in 2023
	• Please briefly describe a recent example of how the College has assisted its registrants in the uptake of a new or amended standard: ○ Name of Standard: Pharmacy Safety Self-Assessment (PSSA), a component of the Assurance and Improvement in Medication Safety (AIMS) Program (Completion of the PSSA is a requirement under the Supplemental Standard of Practice). ○ Duration of period that support was provided: 12 months. ○ Activities undertaken to support registrants: Data showed that the completion rate of the PSSA was low. The College conducted outreach calls to identify barriers to completion. The results enabled the College to: - Make immediate improvements to the PSSA. - Develop resources to better support registrants in meeting this requirement. - Update communication to address issues identified. ○ % of registrants reached by the outreach activities: 100% of Designated Managers (DMs) that had not completed the PSSA for their pharmacy ○ Evaluation conducted on effectiveness of support provided: Feedback received from DMs that the outreach calls and new resource were very helpful. The effort contributed to significantly improved completion of the assessment. • Does the College always provide this level of support: Not always, although direct outreach to registrants to understand issues and promote compliance with standards has become more usual due to its success. *If not, please provide a brief explanation:* Each uptake of a new or amended standard requires a unique approach informed by the needs of the registrants.	
	If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
	Additional comments for clarification (optional)	

Measure: **10.2 The College effectively administers the assessment component(s) of its QA Program in a manner that is aligned with right touch regulation[3]**		
a. The College has processes and policies in place outlining: i how areas of practice that are evaluated in QA assessments are identified in order to ensure the most impact on the quality of a registrant's practice	The College fulfills this requirement:	Met in 2022, continues to meet in 2023
	• Please list the College's priority areas of focus for QA assessment and briefly describe how they have been identified ***OR*** please insert a link to the website where this information can be found and indicate the page number. ○ The College's Quality Assurance Program consists of four major components (see here for more details): 1. Pharmacist/Pharmacy Technicians self-assessment (to identify learning needs) – No priority areas. 2. Pharmacist knowledge-assessment (to evaluate current core knowledge) – Patient care, jurisprudence, ethics, and professionalism (see here for more detail) 3. Pharmacist (Part A)/Pharmacy Technicians practice-assessment (to evaluate performance) – Focuses on the processes used to deliver patient care in a registrant's place of practice through feedback and discussion with a College practice advisor. ▪ Community Pharmacist Practice Assessment Criteria can be found here. ▪ Hospital and other Healthcare Facility Pharmacist Practice Assessment Criteria can be found here. ▪ Pharmacy Technician Practice Assessment Criteria can be found here. 4. Learning portfolio (to support ongoing development and reflect learnings from the other quality assurance activities) – No priority areas. • Is the process taken above for identifying priority areas codified in a policy: Yes *If yes, please insert a link to the policy*. Practice Assessment Review and Update Policy. The policy requires a five-year review schedule for all assessment tools. The review assesses both the assessment tools and the assessment process and includes the following steps: (1) Research, (2) Analysis and Drafting, (3) Consultation, (4) Review of Feedback and Re-drafting, (5) Final Policy and Implementation, (6) Measuring Outcomes.	
	If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
	Additional comments for clarification (optional)	

[3] "Right touch" regulation is an approach to regulatory oversight that applies the minimal amount of regulatory force required to achieve a desired outcome. (Professional Standards Authority Right Touch Regulation. https://www.professionalstandards.org.uk/publications/right-touch-regulation).

	ii. details of how the College uses a right touch, evidence informed approach to determine which registrants will undergo an assessment activity (and which type of multiple assessment activities); and	The College fulfills this requirement:	Met in 2022, continues to meet in 2023
		• Please insert a link to document(s) outlining details of the right touch approach and evidence used (e.g., data, literature, expert panel) to inform assessment approach and indicate page number(s). ***OR*** please briefly describe the right touch approach and evidence used. ○ All Part A pharmacists are required to complete quality assurance assessment activities related to competency when selected. A risk-based approach is applied after the initial assessment - only those pharmacists that are unsuccessful move on to remediation (coaching) and reassessment (for both the Practice Assessment and Knowledge Assessment). Pharmacy Technicians are not yet included in the Quality Assurance Regulations (awaiting government approval). Pharmacists who do not provide patient care remain in Part B of the register and are not required to participate in assessments of clinical competency. • Please provide the year the right touch approach was implemented ***OR*** when it was evaluated/updated (if applicable). The current QA approach was reviewed and updated in 2016. *If evaluated/updated, did the college engage the following stakeholders in the evaluation:* – *Public* Yes – *Employers* Yes – *Registrants* Yes – *Other stakeholders* Yes	
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
		Additional comments for clarification (optional)	

	iii. criteria that will inform the remediation activities a registrant must undergo based on the QA assessment, where necessary.	The College fulfills this requirement:	Met in 2022, continues to meet in 2023
		• Please insert a link to the document that outlines criteria to inform remediation activities and indicate page number ***OR*** list criteria. ○ The following Practice Assessment criteria serve as a self-evaluation for pharmacists and pharmacy technicians. In addition, the results of a Practice Assessment using these criteria form the basis for remediation activities. - Practice Assessment Criteria – Community Pharmacists - Practice Assessment Criteria – Hospital and other Healthcare Facility Pharmacists - Practice Assessment Criteria – Community and Hospital Pharmacy Technicians	
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
		Additional comments for clarification (optional)	

		Measure: **10.3 The College effectively remediates and monitors registrants who demonstrate unsatisfactory knowledge, skills, and judgement.**	
		a. The College tracks the results of remediation activities a registrant is directed to undertake as part of any College committee and assesses whether the registrant subsequently demonstrates the required knowledge, skill and judgement while practicing	The College fulfills this requirement:
			Yes
			• Please insert a link to the College's process for monitoring whether registrant's complete remediation activities ***OR*** please briefly describe the process. o For Quality Assurance (QA) Committee-required remediation and for Inquiries, Complaints, and Reports Committee (ICRC)-required remediation, the College has implemented a post-remedial assessment process. • Registrants who are required by the QA Committee to complete specified remediation undergo a post-remedial assessment approximately one year later. • Registrants who are required by the ICRC to complete a SCERP are tracked for completion and undergo a post-remedial assessment once their remediation is complete. o The College tracks remediation activities ordered by the Discipline Committee to assess whether the registrant subsequently demonstrates satisfactory knowledge, skills, and judgment. In some cases, the Discipline Committee will include a Compliance Audit/Review (CAR) as part of its order. • Please insert a link to the College's process for determining whether a registrant has demonstrated the knowledge, skills and judgement following remediation ***OR*** please briefly describe the process. o A post-remediation practice assessment will be scheduled approximately one year after the completion of directed remediation at the practitioner's place of practice. The post remediation practice assessment will be conducted using the assessment tool for member practice assessments. A different practice advisor will conduct the post-remediation assessment.
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? | Choose an item.
			Additional comments for clarification (optional)

-

DOMAIN 6: SUITABILITY TO PRACTICE	STANDARD 11	**Measure 11.1** **The College enables and supports anyone who raises a concern about a registrant.**	
		Required Evidence	**College Response**
		a. The different stages of the complaints process and all relevant supports available to complainants are: i. supported by formal policies and procedures to ensure all relevant information is received during intake at each stage, including next steps for follow up; ii. clearly communicated directly to complainants who are engaged in the complaints process, including what a complainant can expect at each stage and the supports available to them (e.g., funding for sexual abuse therapy); and;	The College fulfills this requirement: — Yes • Please insert a link to the College's website that clearly describes the College's complaints process including options to resolve a complaint, the potential outcomes associated with the respective options and supports available to the complainant. - Click here for description complaints process, and click here for infographic. - Click here for information on ways to inform the College about a concern. - Click here for information on how a complainant can file a complaint, and click here for a video. - Click here for FAQ. - Click here for Information on the College providing funding for Sexual Abuse Therapy - Click here for a sheet for sexual abuse complainants/witnesses • Please insert a link to the polices/procedures for ensuring all relevant information is received during intake ***OR*** please briefly describe the policies and procedures if the documents are not publicly accessible. ○ A standard operating procedure (not publicly accessible) has been created for ensuring all relevant information is obtained during intake. The key steps are as follows: - determine what information (if any) is required to satisfy the complaint criteria. - If required, gather information from the pharmacy and/or complainant and acknowledge the intake. - Information to be gathered can include: ▪ Clarification of intent from complainant ▪ Specific details of incident(s) being complained about (e.g., patient information, medication information, etc.) ▪ Pharmacy records indicating relevant to incident(s) *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?* — Choose an item. *Additional comments for clarification (optional)*

		iii. evaluated by the College to ensure the information provided to complainants is clear and useful *Benchmarked Evidence*	The College fulfills this requirement:	Yes

			• Please provide details of how the College evaluates whether the information provided to complainants is clear and useful.
			  ○ A review of website content and other communication (e.g., templates) is conducted regularly and feedback received from members of the public and complainants is considered when making any revisions. Another such review is to be undertaken in 2023.
			  ○ Feedback is also received as part of a report provided annually by an independent third-party consultant as it relates to the experience of complainants who have made allegations of sexual abuse.	

			If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation.	
		b. The College responds to 90% of inquiries from the public within 5 business days, with follow-up timelines as necessary.	The College fulfills this requirement:	No
			• Please insert rate (see Companion Document: Technical Specifications for Quantitative CPMF Measures). ○ The College's rate for responding to public inquiries within five (5) business days was 86% in 2023.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional) The College is undertaking a process review in 2024, with the goal of streamlining processes and decreasing timelines for response to inquiries.	

		c. Demonstrate how the College supports the public during the complaints process to ensure that the process is inclusive and transparent (e.g., translation services are available, use of technology, access outside regular business hours, transparency in decision-making to make sure the public understand how the College makes decisions that affect them etc.).	The College fulfills this requirement:	Met in 2022, continues to meet in 2023
			• Please list support available for the public during the complaints process. - Accommodating accessing and participating in complaints process (e.g., if someone is unable to write or type, staff will assist a complainant in recording their concerns by alternative means; and use large font correspondence and any other accommodations required for the complainant to meaningfully participate in the process). - Providing additional information and support for those reporting sexual abuse (e.g., access to external consultant for information about investigations and discipline processes). - Providing translation services as required/requested. - Proving paper copies of the College's complaint form mailed directly to potential complainants who do not have access to email/the College's website. - For every complaint filed, staff assigned to the complaint conduct an introductory call with the complainant within five days of receipt of the complaint for the purposes of: ▪ Introducing themselves. ▪ Explaining the steps in the complaints process and their associated timelines. ▪ Clarifying the complainant's concerns and confirming the scope of the complaint. ▪ Explaining the reasons why certain registrants have been named in the complaint. ▪ For suitable cases, explore with the complainant if they are open to a resolution other than the formal complaints process. ▪ Provision of documentation for complainants that outlines possible outcomes that can be adopted by the ICRC to dispose of a complaint. Documentation to explain the next steps of the complaints process is also included with each complaint investigation as standard procedure. ○ Detailed information pertaining to the complaint process is made available on the College website. • Please briefly describe at what points during the complaints process that complainants are made aware of supports available. ○ Intake staff are trained to ask complainants during the initial point of contact about any support a complainant may require in filing a complaint. Once a complaint has been filed, complaints are assigned to a Complaints and Resolutions Officer (CRO). Complainants can contact the CRO with any questions or support they may need throughout the process. College staff also provide additional, non-legal and confidential support to sexual abuse complainants and witnesses is available from a third-party consultant retained by the College. Information about the College's commitment to accessibility is available on the College's website.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

		Measure: **11.2 All parties to a complaint and discipline process are kept up to date on the progress of their case, and complainants are supported to participate effectively in the process.**		
		a. Provide details about how the College ensures that all parties are regularly updated on the progress of their complaint or discipline case, including how complainants can contact the College for information (e.g., availability and accessibility to relevant information, translation services etc.).	The College fulfills this requirement:	Yes

			• Please insert a link to document(s) outlining how complainants can contact the College during the complaints process and indicate the page number(s) ***OR*** please provide a brief description.
			  ○ Initially through the College's general 'Contact' site (under the heading 'Concerns').
			  ○ During the complaint process:
			  - The complainant is provided with the email address and phone number for the Complaints and Resolutions Officer assigned to their file.
			  - If a complaint is referred to the Discipline Committee, the complainant is provided with contact information for the external consultant who can provide information support during the discipline process. Legal staff and prosecutors act as a point of contact for witnesses during the discipline process.
			• Please insert a link to document(s) outlining how complainants are supported to participate in the complaints process and indicate the page number(s) ***OR*** please provide a brief description.
			  ○ The College provides regular correspondence to the complainant throughout the various stages of the investigation including acknowledgement of complaints, notification that the investigation is complete and the approximate number of weeks until the matter will be reviewed by ICRC. If the complaint process exceeds the statutory timeline, in accordance with s. 28 of the Code, correspondence is sent to update the complainant at regular intervals.
			  ○ Complainants receive written decisions and reasons following discipline hearings.	

			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

		Measure: **12.1 The College addresses complaints in a right touch manner.**		
		a. The College has accessible, up-to-date, documented guidance setting out the framework for assessing risk and acting on complaints, including the prioritization of investigations, complaints, and reports (e.g., risk matrix, decision matrix/tree, triage protocol).	The College fulfills this requirement:	Met in 2022, continues to meet in 2023
			• Please insert a link to guidance document and indicate the page number ***OR*** please briefly describe the framework and how it is being applied. ○ Risk is initially assessed based on the likelihood of patient and public harm including consideration of the need for an Interim Order under the Code. As additional information is obtained during an investigation, the risk level is adjusted accordingly, and prioritization may change in accordance with the most recent risk assessment. Risk is assessed as high, medium, or low depending on the category(ies) of concern(s), the seriousness of the concerns, and whether there is a prior history of similar or other concerning conduct on the part of the registrant. • Please provide the year when it was implemented ***OR*** evaluated/updated (if applicable). ○ In 2017, the Conduct Division adopted a qualitative risk framework for conducting a risk assessment of new Complaints and Reports, and tracking began. This risk assessment carries into the investigation stage. ○ In 2020, the process was updated to document any changes to the risk assignment of the complaint or report as more information becomes available. ○ A new tool was developed to incorporate all components of the risk assessment framework for Complaints and Reports and promote consistent application among all those who use it. The tool is in use by staff as of 2023.	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (optional)	

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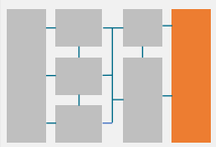
DOMAIN 6: SUITABILITY TO PRACTICE	STANDARD 13	**Measure:** **13.1 The College demonstrates that it shares concerns about a registrant with other relevant regulators and external system partners (e.g. law enforcement, government, etc.).**		
		a. The College's policy outlining consistent criteria for disclosure and examples of the general circumstances and type of information that has been shared between the College and other relevant system partners, within the legal framework, about concerns with individuals and any results.	The College fulfills this requirement:	Partially

			• Please insert a link to the policy and indicate page number ***OR*** please briefly describe the policy.
			  ○ The College has a policy regarding responding to information requests from police that can be found on the College's website.
			  ○ When new information is received about a registrant's conduct or practice, College staff review the information to determine if there is evidence of concerning conduct on the part of another regulated health professional which should be reported to the health professional's regulator or elsewhere to protect the public interest. This review continues through any subsequent investigation. If concerning conduct is identified and the pharmacy professional is also licensed with another regulator, the College discloses that information to the health professional's other regulator in accordance with that specific exception under Section 36 (1) of the Regulated Health Professions Act, 1991 (RHPA).
			  ○ The College readily shares information requested by other regulators, on request, under the relatively broad exemption granted under s. 36(1)(c) of the RHPA.
			  ○ The College has conducted joint investigations in collaboration with other health regulatory colleges when the alleged misconduct under investigation overlaps with the conduct of another regulated health professional, there is a shared practice site and/or it is a multidisciplinary setting where there may be a financial connection. The College may confirm that an investigation is taking place, if there is a compelling public interest in such disclosure, under s. 36(1)(g) of the RHPA.
			• Please provide an overview of whom the College has shared information with over the past year and the purpose of sharing that information (i.e., general sectors of system partner, such as 'hospital', or 'long-term care home').
			  ○ The College engages with a number of system partners when sharing relevant information in the course of its regulatory responsibilities:
			  - Other pharmacy regulators:
			  ▪ College of Pharmacists of British Columbia (CPBC): Provided information about an applicant also registered with OCP. Information was also provided in relation to a complaint investigation.
			  ▪ College of Pharmacists of Saskatchewan (CPS): Provided information about an applicant also registered with OCP.
			  - Other RHPA regulators:
			  ▪ College of Physicians and Surgeons of Ontario (CPSO): Information was requested by CPSO about an investigation.
			  - Government agencies:
			  ▪ Ministry of Health (Ontario) (MOH): Information was requested by the MOH about investigations.
			  ▪ Health Canada (HC): Information shared with HC regarding a joint investigation.	

			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (if needed) The College continues to work with a number of other RHPA regulators to develop a common Information Sharing Policy, intended to promote transparent and proactive information-sharing between RHPA regulators and other regulators, police, employers and other third parties. It is anticipated this work will continue through 2024.	



Measure:
14.1 Council uses Key Performance Indicators (KPIs) in tracking and reviewing the College's performance and regularly reviews internal and external risks that could impact the College's performance.

DOMAIN 7: MEASUREMENT, REPORTING & IMPROVEMENT

STANDARD 14

Required Evidence	College Response	
a. Outline the College's KPIs, including a clear rationale for why each is important.	The College fulfills this requirement:	Met in 2022, continues to meet in 2023
	• Please insert a link to a document that list College's KPIs with an explanation for why these KPIs have been selected (including what the results the respective KPIs tells, and how it relates to the College meeting its strategic objectives and is therefore relevant to track), a link to Council meeting materials where this information is included and indicate page number ***OR*** list KPIs and rationale for selection. - College staff recommendations (including rationale) 2023 (Page 119) and 2024 (Page 110) annual College Performance Scorecard to the Board. - College staff recommendations for 2023 targets and KPI definitions (Page 32).	
	If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
	Additional comments for clarification (if needed)	

		b. The College regularly reports to Council on its performance and risk review against: i. stated strategic objectives (i.e., the objectives set out in a College's strategic plan); ii. regulatory outcomes (i.e., operational indicators/ targets with reference to the goals we are expected to achieve under the RHPA); and its risk management approach.	The College fulfills this requirement:	Met in 2022, continues to meet in 2023
			• Please insert a link to Council meeting materials where the College reported to Council on its progress against stated strategic objectives, regulatory outcomes and risks that may impact the College's ability to meet its objectives and the corresponding meeting minutes and indicate the page number. ○ Through the College Performance Scorecard, the Board receives quarterly updates on progress towards strategic objectives and regulatory outcomes. See for example the December 2023 Board meeting materials (Page 64) and minutes. ○ The Board receives a semi-annual report on key risks and mitigation activities. See for example the December 2023 Board meeting materials (Page 74).	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (if needed)	

		Measure: **14.2 Council directs action in response to College performance on its KPIs and risk reviews.**		
		a. Council uses performance and risk review findings to identify where improvement activities are needed. *Benchmarked Evidence*	The College fulfills this requirement:	Yes
			• Please insert a link to Council meeting materials where the Council used performance and risk review findings to identify where the College needs to implement improvement activities and indicate the page number: ○ March 2023 Board meeting (performance): Board meeting materials (Page 24) and minutes (Page 4). ○ June 2023 Board meeting: • Performance: Board meeting materials (Page 54) and minutes (Page 3). • Risk: Board meeting materials (Page 64) and minutes (Page 4).	
			If the response is "partially" or "no", describe the College's plan to fully implement this measure. Outline the steps (i.e., drafting policies, consulting stakeholders, or reviewing/revising existing policies or procedures, etc.) the College will be taking, expected timelines and any barriers to implementation.	

		Measure: **14.3 The College regularly reports publicly on its performance.**		
		a. Performance results related to a College's strategic objectives and regulatory outcomes are made public on the College's website.	The College fulfills this requirement:	Met in 2022, continues to meet in 2023
			• Please insert a link to the College's dashboard or relevant section of the College's website: https://www.ocpinfo.com/about/performance-accountability/college-performance-scorecard/	
			If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period?	Choose an item.
			Additional comments for clarification (if needed)	

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Part 2: Context Measures

The following tables require Colleges to provide **statistical data** that will provide helpful context about a College's performance related to the standards. The context measures are non-directional, which means no conclusions can be drawn from the results in terms of whether they are 'good' or 'bad' without having a more in-depth understanding of what specifically drives those results.

In order to facilitate consistency in reporting, a recommended method to calculate the information is provided in the companion document "Technical Specifications for Quantitative College Performance Measurement Framework Measures." However, recognizing that at this point in time, the data may not be readily available for each College to calculate the context measure in the recommended manner (e.g., due to differences in definitions), a College can report the information in a manner that is conducive to its data infrastructure and availability.

In those instances where a College does not have the data or the ability to calculate the context measure at this point in time it should state: 'Nil' and indicate any plans to collect the data in the future.

Where deemed appropriate, Colleges are encouraged to provide additional information to ensure the context measure is properly contextualized to its unique situation. Finally, where a College chooses to report a context measure using a method other than the recommended method outlined in the following Technical Document, the College is asked to provide the method in order to understand how the information provided was calculated.

The Ministry has also included hyperlinks of the definitions to a glossary of terms for easier navigation.

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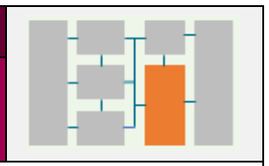
Table 1 – Context Measure 1

DOMAIN 6: SUITABILITY TO PRACTICE

STANDARD 10



Statistical data collected in accordance with the recommended method or the College's own method: Recommended

If a College method is used, please specify the rationale for its use:

Context Measure (CM)

CM 1. Type and distribution of QA/QI activities and assessments used in CY 2023*

Type of QA/QI activity or assessment:	#
i. QI - Self-Assessments	943
ii. QA - Knowledge Assessment	3685
ii. QA - Routine Practice Assessments	1,528
iii. QI - Coaching	108
iv. QA - Practice Reassessment	101
v. QA - QA Assessments	11

What does this information tell us? Quality assurance (QA) and Quality Improvement (QI) are critical components in ensuring that professionals provide care that is safe, effective, patient-centred and ethical. In addition, health care professionals face a number of ongoing changes that might impact how they practice (e.g., changing roles and responsibilities, changing public expectations, legislative changes).

The information provided here illustrates the diversity of College QA activities.

The diversity of QA/QI activities and assessments is reflective of a risk-based approach. Details of how the College determined the appropriateness of its assessment component of its QA program are described or referenced by the College in Measure 10.2(a) of Standard 10.

* *Registrants may be undergoing multiple QA activities over the course of the reporting period. While future iterations of the CPMF may evolve to capture the different permutations of pathways registrants may undergo as part of a College's QA Program, the requested statistical information recognizes the current limitations in data availability today and is therefore limited to type and distribution of QA/QI activities or assessments used in the reporting period.,*

NRN

Additional comments for clarification (optional)

1. The Pharmacy Act regulations do not yet incorporate pharmacy technicians. The regulation has been submitted to the government and is awaiting approval. Those pharmacy technicians who have engaged in QA activities have done so voluntarily.
2. OCP's Practice Assessment model involves three steps prior to referral to the QA Committee: (1) routine practice assessment; (2) coaching and re-assessment and (3) QA assessment. Note that remediation in the form of coaching is provided up-front prior to the practice reassessment. If the registrant is successful upon re-assessment, referral to the QA Committee does not occur.

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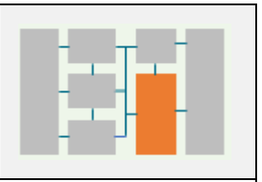
Table 2 – Context Measures 2 and 3

DOMAIN 6: SUITABILITY TO PRACTICE	
STANDARD 10	

Statistical data collected in accordance with the recommended method or the College own method: Recommended

If a College method is used, please specify the rationale for its use:

Context Measure (CM)			
	#	%	What does this information tell us? If a registrant's knowledge, skills, and judgement to practice safely, effectively, and ethically have been assessed or reassessed and found to be unsatisfactory or a registrant is non-compliant with a College's QA Program, the College may refer them to the College's QA Committee.
CM 2: Total number of registrants who participated in the QA Program CY 2023	6,041		
CM 3: Rate of registrants who were referred to the QA Committee as part of the QA Program where the QA Committee directed the registrant to undertake remediation in CY 2023	13/6,041	0.2%	
NR			

Additional comments for clarification (if needed)

1. The Pharmacy Act regulations do not yet incorporate pharmacy technicians. The regulation has been submitted to the government and is awaiting approval.
2. CM3: 10 registrants have been referred to QAC and had remediation directed and 3 registrants were directed with SDL.

Table 3 – Context Measure 4

DOMAIN 6: SUITABILITY TO PRACTICE			
STANDARD 10			
Statistical data collected in accordance with the recommended method or the College's own method: Recommended *If a College method is used, please specify the rationale for its use:*			
Context Measure (CM)			
CM 4. Outcome of remedial activities as at the end of CY 2023**	#	%	What does this information tell us? This information provides insight into the outcome of the College's remedial activities directed by the QA Committee and may help a College evaluate the effectiveness of its "QA remediation activities". Without additional context no conclusions can be drawn on how successful the QA remediation activities are, as many factors may influence the practice and behaviour registrants (continue to) display.
I. Registrants who demonstrated required knowledge, skills, and judgement following remediation*	6/10	60%	
II. Registrants still undertaking remediation (i.e., remediation in progress)	7/10	70%	
NR ** This number may include registrants who were directed to undertake remediation in the previous year and completed reassessment in CY 2023.* ***This measure may include any outcomes from the previous year that were carried over into CY 2023.*			
Additional comments for clarification (optional) CM 4 (I): Total number of registrants that were referred to the QA Committee as part of the QA Program in CY 2023 that passed the post-remedial assessment = 6 CMI 4 (II): - Total number of registrants who were required by the QA Committee to undergo a remediation activity as part of the QA Program that have not completed the remediation within the reporting period = 7; - Total number of registrants who were referred to the QA Committee as part of the QA Program in CY 2023 where the QA Committee directed the registrant to undergo a remediation activity as part of the QA Program = 10			

Table 4 – Context Measure 5

DOMAIN 6: SUITABILITY TO PRACTICE	
STANDARD 12	

Statistical data is collected in accordance with the recommended method or the College's own method: Recommended

If a College method is used, please specify the rationale for its use:

Context Measure (CM)					
CM 5. Distribution of formal complaints and Registrar's Investigations by theme in CY 2023	Formal Complaints received		Registrar Investigations initiated		
Themes:	#	%	#	%	
I. Advertising	NR	NR	NR	NR	
II. Billing and Fees	26	3.0%	7	6.0%	
III. Communication	373	43.4%	8	6.9%	
IV. Competence / Patient Care	351	40.9%	32	27.6%	
V. Intent to Mislead including Fraud	0	0%	0	0%	
VI. Professional Conduct & Behavior	37	4.3%	16	13.8%	
VII. Record keeping	NR	NR	7	14.7%	
VIII. Sexual Abuse	NR	NR	NR	NR	
IX. Harassment / Boundary Violations	NR	NR	NR	NR	
X. Unauthorized Practice	NR	NR	NR	NR	
XI. Other <non-practice related, business practices, other behavior>	64	7.5%	27	23.3%	
Total number of formal complaints and Registrar's Investigations**	526	**100%**	71	**100%**	

What does this information tell us? This information facilitates transparency to the public, registrants and the Ministry regarding the most prevalent themes identified in formal complaints received and Registrar's Investigations undertaken by a College.

Formal Complaints *NR* Registrar's Investigation ***The requested statistical information (number and distribution by theme) recognizes that formal complaints and Registrar's Investigations may include allegations that fall under multiple themes identified above, therefore when added together the numbers set out per theme may not equal the total number of formal complaints or Registrar's Investigations.*	
Additional comments for clarification (if needed) NR Formal Complaints accounted for 0.9%, NR Registrar Investigations accounted for 7.8%	

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Table 5 – Context Measures 6, 7, 8 and 9

DOMAIN 6: SUITABILITY TO PRACTICE				
STANDARD 12				
Statistical data collected in accordance with the recommended method or the College's own method: Recommended *If a College method is used, please specify the rationale for its use:*				
Context Measure (CM)				
CM 6.	Total number of formal complaints that were brought forward to the ICRC in CY 2023	476		What does this information tell us? The information helps the public better understand how formal complaints filed with the College and Registrar's Investigations are disposed of or resolved. Furthermore, it provides transparency on key sources of concern that are being brought forward to the College's Inquiries, Complaints and Reports Committee.
CM 7.	Total number of ICRC matters brought forward as a result of a Registrar's Investigation in CY 2023	84		
CM 8.	Total number of requests or notifications for appointment of an investigator through a Registrar's Investigation brought forward to the ICRC that were approved in CY 2023	71		
CM 9.	Of the formal complaints and Registrar's Investigations received in CY 2023**:	#	%	
I.	Formal complaints that proceeded to Alternative Dispute Resolution (ADR)	0	0	
II.	Formal complaints that were resolved through ADR	0	0	
III.	Formal complaints that were disposed of by ICRC	516	n/a	
IV.	Formal complaints that proceeded to ICRC and are still pending	33	7%	
V.	Formal complaints withdrawn by Registrar at the request of a complainant	89	17%	
VI.	Formal complaints that are disposed of by the ICRC as frivolous and vexatious	0	0%	

VII.	Formal complaints and Registrar's Investigations that are disposed of by the ICRC as a referral to the Discipline Committee	24	4.1%	

ADR

Disposal

Formal Complaints

Formal Complaints withdrawn by Registrar at the request of a complainant

NR

Registrar's Investigation

 # May relate to Registrar's Investigations that were brought to the ICRC in the previous year.

*** The total number of formal complaints received may not equal the numbers from 9(i) to (vi) as complaints that proceed to ADR and are not resolved will be reviewed at the ICRC, and complaints that the ICRC disposes of as frivolous and vexatious and a referral to the Discipline Committee will also be counted in total number of complaints disposed of by the ICRC.*

Additional comments for clarification (if needed)

- For CM 6 and CM 7, as in previous years, the College considered "brought forward" to be files where the ICRC reviewed the file and rendered an outcome (though the files may not be finally disposed with a decision issued yet).
- For CM 9, it indicates "formal complaints and Registrar's Investigations received in CY 2023", though we have noted that some of the subsequent values in CM 9 relate to files received before 2023.
- For CM 9 III, as indicated in the Technical Specifications, this value is all complaint files where a decision was issued in 2023 (though the file may have been opened prior to 2023).
- For CM 9 IV, denominator is 476 (the same as CM 6) and also includes files that may have been opened prior to 2023 (but proceeded to ICRC in 2023).
- For CM 9 VII, denominator is 589, which represents all ICRC decisions issued in 2023 (complaints & RIs - health inquiries excluded as per Technical Specifications).

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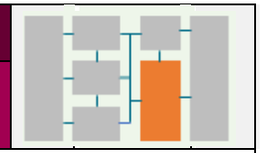
Table 6 – Context Measure 10

DOMAIN 6: SUITABILITY TO PRACTICE

STANDARD 12



Statistical data collected in accordance with the recommended method or the College's own method: Recommended

If a College method is used, please specify the rationale for its use:

Context Measure (CM)							
CM 10. Total number of ICRC decisions in 2023	589						
Distribution of ICRC decisions by theme in 2023*	# of ICRC Decisions++						
Nature of Decision	Take no action	Proves advice or recommendations	Issues a caution (oral or written)	Orders a specified continuing education or remediation program	Agrees to undertaking	Refers specified allegations to the Discipline Committee	Takes any other action it considers appropriate that is not inconsistent with its governing legislation, regulations, or By-Laws.
I. Advertising	0	0	0	0	0	0	0
II. Billing and Fees	13	7	0	NR	0	0	NR
III. Communication	208	87	NR	23	0	0	10
IV. Competence / Patient Care	118	112	6	51	0	NR	38
V. Intent to Mislead Including Fraud	0	0	0	NR	0	NR	NR
VI. Professional Conduct & Behaviour	18	13	NR	8	0	6	7
VII. Record Keeping	7	6	0	NR	0	0	NR
VIII. Sexual Abuse	0	0	0	0	0	NR	NR
IX. Harassment / Boundary Violations	0	NR	0	0	0	6	NR

X.	Unauthorized Practice	0	0	0	NR	0	NR	NR
XI.	Other *<specified by the College>* • Non-practice related - Includes employment, compensation and civil proceedings. • Business Practices - Includes restriction of choice, refusal to transfer, offering an inducement, return to stock of previously dispensed product, conflict of interest; drug distribution • Other Conduct/Behavior not included in any other OCP Theme	16	10	0	NR	0	6	8

- *Number of decisions are corrected for formal complaints ICRC deemed frivolous and vexatious AND decisions can be regarding formal complaints and registrar's investigations brought forward prior to 2023.*

++ *The requested statistical information (number and distribution by theme) recognizes that formal complaints and Registrar's Investigations may include allegations that fall under multiple themes identified above, therefore when added together the numbers set out per theme may not equal the total number of formal complaints or registrar's investigations, or decisions.*

NR

What does this information tell us? This information will help increase transparency on the type of decisions rendered by ICRC for different themes of formal complaints and Registrar's Investigation and the actions taken to protect the public. In addition, the information may assist in further informing the public regarding what the consequences for a registrant can be associated with a particular theme of complaint or Registrar investigation and could facilitate a dialogue with the public about the appropriateness of an outcome related to a particular formal complaint.

Additional comments for clarification (if needed)

- The ICRC does not issue decisions solely a specified continuing education or remediation program (SCERP). SCERP decisions are always accompanied with Advice/Recommendation or an Oral Caution. In the chart above, to avoid duplication of decisions, we entered Advice/Recommendation + SCERP decisions in the SCERP column and entered Oral Caution + SCERP decisions in the "Takes any other action it considers appropriate that is not inconsistent with its governing legislation, regulations or By-Laws" column.
- Under XI. Other we have included 1 OCP-specific theme: Business Practices - Includes restriction of choice, refusal to transfer, offering an inducement, return to stock of previously dispensed product, conflict of interest; drug distribution unapproved / counterfeit products.

Table 7 – Context Measure 11

DOMAIN 6: SUITABILITY TO PRACTICE		
STANDARD 12		
Statistical data collected in accordance with the recommended method or the College own method: Recommended *If College method is used, please specify the rationale for its use:*		
Context Measure (CM)		
CM 11. 90th Percentile disposal of:	Days	**What does this information tell us?** This information illustrates the maximum length of time in which 9 out of 10 formal complaints or Registrar's investigations are being disposed by the College. The information enhances transparency about the timeliness with which a College disposes of formal complaints or Registrar's investigations. As such, the information provides the public, Ministry, and other stakeholders with information regarding the approximate timelines they can expect for the disposal of a formal complaint filed with, or Registrar's investigation undertaken by, the College.
I. A formal complaint in working days in CY 2023	331	
II. A Registrar's investigation in working days in CY 2023	430	
Disposal		
Additional comments for clarification (if needed)		

-

Table 8 – Context Measure 12

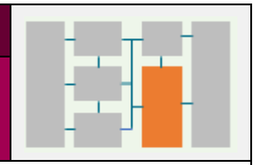
DOMAIN 6: SUITABILITY TO PRACTICE		
STANDARD 12		
Statistical data collected in accordance with the recommended method or the College's own method: Recommended *If a College method is used, please specify the rationale for its use:*		
Context Measure (CM)		
CM 12. 90th Percentile disposal of:	Days	**What does this information tell us?** This information illustrates the maximum length of time in which 9 out of 10 uncontested discipline hearings and 9 out of 10 contested discipline hearings are being disposed. The information enhances transparency about the timeliness with which a discipline hearing undertaken by a College is concluded. As such, the information provides the public, Ministry, and other stakeholders with information regarding the approximate timelines they can expect for the resolution of a discipline proceeding undertaken by the College.
I. An uncontested discipline hearing in working days in CY 2023	560	
II. A contested discipline hearing in working days in CY 2023	1205	
Disposal Uncontested Discipline Hearing Contested Discipline Hearing		
Additional comments for clarification (if needed)		

-

Table 9 – Context Measure 13

DOMAIN 6: SUITABILITY TO PRACTICE

STANDARD 12



Statistical data collected in accordance with the recommended method or the College's own method: Recommended

If College method is used, please specify the rationale for its use:

Context Measure (CM)

CM 13. Distribution of Discipline finding by type*

Type		#
I.	Sexual abuse	0
II.	Incompetence	0
III.	Fail to maintain Standard	21
IV.	Improper use of a controlled act	0
V.	Conduct unbecoming	NR
VI.	Dishonourable, disgraceful, unprofessional	22
VII.	Offence conviction	0
VIII.	Contravene certificate restrictions	NR
IX.	Findings in another jurisdiction	0
X.	Breach of orders and/or undertaking	NR
XI.	Falsifying records	6
XII.	False or misleading document	21
XIII.	Contravene relevant Acts	14

What does this information tell us? This information facilitates transparency to the public, registrants and the Ministry regarding the most prevalent discipline findings where a formal complaint or Registrar's Investigation is referred to the Discipline Committee by the ICRC.

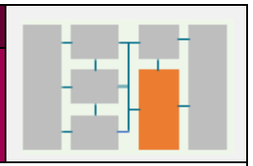
** The requested statistical information recognizes that an individual discipline case may include multiple findings identified above, therefore when added together the number of findings may not equal the total number of discipline cases.* *NR*
Additional comments for clarification (if needed)

-

Table 10 – Context Measure 14

DOMAIN 6: SUITABILITY TO PRACTICE

STANDARD 12



Statistical data collected in accordance with the recommended method or the College own method: Recommended

If a College method is used, please specify the rationale for its use:

Context Measure (CM)

CM 14. Distribution of Discipline orders by type*

Type		#
I.	Revocation	0
II.	Suspension	23
III.	Terms, Conditions and Limitations on a Certificate of Registration	23
IV.	Reprimand	NR
V.	Undertaking	23

What does this information tell us? This information will help strengthen transparency on the type of actions taken to protect the public through decisions rendered by the Discipline Committee. It is important to note that no conclusions can be drawn on the appropriateness of the discipline decisions without knowing intimate details of each case including the rationale behind the decision.

** The requested statistical information recognizes that an individual discipline case may include multiple findings identified above, therefore when added together the numbers set out for findings and orders may not equal the total number of discipline cases.*

Revocation
Suspension
Terms, Conditions and Limitations
Reprimand
Undertaking
NR

Additional comments for clarification (if needed)

Glossary

Alternative Dispute Resolution (ADR): Means mediation, conciliation, negotiation, or any other means of facilitating the resolution of issues in dispute.

Return to:-Table 5

Contested Discipline Hearing: In a contested hearing, the College and registrant disagree on some or all of the allegations, penalty and/or costs.

Return to: Table 8

Disposal: The day upon which all relevant decisions were provided to the registrant by the College (i.e., the date the reasons are released and sent to the registrant and complainant, including both liability and penalty decisions, where relevant).

Return to: Table 5, Table 7, Table 8

Formal Complaint: A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint.

Return to: Table 4, Table 5

Formal Complaints withdrawn by Registrar at the request of a complainant: Any formal complaint withdrawn by the Registrar prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest.

Return to: Table 5

NR: Non-reportable: Results are not shown due to < 5 cases (for both # and %). This may include 0 reported cases.

Return to: Table 1, Table 2, Table 3, Table 4, Table 5, Table 6, Table 9, Table 10

Registrar's Investigation: Under s.75(1)(a) of the *Regulated Health Professions Act, 1991,* (RHPA) where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent, they can appoint an investigator which must be approved by the Inquiries, Complaints and Reports Committee (ICRC). Section 75(1)(b) of the RHPA, where the ICRC receives information about a member from the Quality Assurance Committee, it may request the Registrar to conduct an investigation. In situations where the Registrar determines that the registrant exposes, or is likely to expose, their patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days.

Return to: Table 4, Table 5

Revocation: Of a member or registrant's Certificate of Registration occurs where the discipline or fitness to practice committee of a health regulatory College makes an order to "revoke" the certificate which terminates the registrant's registration with the College and therefore their ability to practice the profession.

Return to: Table 10

Suspension: A suspension of a registrant's Certificate of Registration occurs for a set period of time during which the registrant is not permitted to:

- Hold themselves out as a person qualified to practice the profession in Ontario, including using restricted titles (e.g., doctor, nurse),
- Practice the profession in Ontario, or
- Perform controlled acts restricted to the profession under the Regulated Health Professions Act, 1991.

Return to: Table 10

Reprimand: A reprimand is where a registrant is required to attend publicly before a discipline panel of the College to hear the concerns that the panel has with their practice.

Return to: Table 10

Terms, Conditions and Limitations: On a Certificate of Registration are restrictions placed on a registrant's practice and are part of the Public Register posted on a health regulatory College's website.

Return to: Table 10

Uncontested Discipline Hearing: In an uncontested hearing, the College reads a statement of facts into the record which is either agreed to or uncontested by the Respondent. Subsequently, the College and the respondent may make a joint submission on penalty and costs or the College may make submissions which are uncontested by the Respondent.

Return to: Table 8

Undertaking: Is a written promise from a registrant that they will carry out certain activities or meet specified conditions requested by the College committee.

Return to: Table 10

Ontario College of Pharmacists
Putting patients first since 1871

BOARD BRIEFING NOTE

MEETING DATE: March 25, 2024

FOR INFORMATION

From: Thomas Custers, Director, Corporate Services

Topic: 2023 College Performance Scorecard, Fourth Quarter (Q4) Reporting

Issue/Description: Q4 performance update on the College's 2023 key indicators and milestones

Public interest rationale: To support the Board in providing oversight and being accountable to the Board and the public on the College's performance on its 2023 goals.

Strategic alignment, regulatory processes, and actions: Maintaining and reporting on regulatory performance supports the Board in its oversight role, strengthens trust and confidence in the College's capacity to address emerging issues and to strive for regulatory excellence.

Background:

- Each year the College Performance Scorecard is developed and approved by the Board to enable the Board (and the public) to evaluate how well the College is performing in achieving its goals and executing its strategic initiatives.
- The College provides the Board with quarterly updates on its performance on the indicators and milestones ("scorecard measures") included in the College Performance Scorecard.
- The College's performance is highlighted using colour coding based on the traffic light system (green, yellow, and red). The colour coding corresponds to a predefined performance range for each target that has been set for an indicator or achieving a milestone.
- Descriptions of the indicators, and project milestones are available in the 2023 Scorecard Measure Definitions document, which accompanies the scorecard. This document explains the rationale behind each indicator and milestone, along with the assumptions and targets set for the year.
- The Q4 2023 Performance Summary/Improvement Strategies report highlights the College's accomplishments towards targets and milestones and sets out strategies underway to address obstacles that may impede achieving the stated objective.

Analysis:

- The 2023 College Performance Scorecard has 18 scorecard measures (14 indicators and 4 milestones) crossing seven domains of the Ministry of Health's College Performance Measurement Framework (CPMF).
- Overall, the College achieved or exceeded its 2023 performance on 12 of the 18 scorecard measures in Q4, while five measures have not met the 2023 target. However, the College came close to meeting the 2023 target on three of those five measures. One measure did not have a target.

2023 performance overview (by the end of Q4)				
Measures	**Meets or exceeds target (or completed)**	**Approaching target < 25% or at potential risk**	**Beyond target > 25% or at risk/roadblock**	**Collecting Baseline**
14 Indicators	9	2	2	1
4 Milestones	3	1	0	-

- The three measures the College came close to meeting the 2023 targets in Q4 are:

Measure	Target	Performance
Percentage of Board Directors completing evaluation surveys	100%	98%
Cycle time in average days from previous assessment to most recent assessment for community pharmacies in highest risk category	441	≤365 days
Acquisition and initial implementation of the new Registrant Record Information system	12/31/23	See Summary

- The College will continue to improve its performance on the measures for which it has not met its targets yet to meet them in 2024.
- The attached Performance Summary/Improvement Strategies report provides further details on each indicator and milestone.

Attachments:

- 5.3a - Q4 2023 College Performance Scorecard
- 5.3b - Q4 2023 Performance Summary/Improvement Strategies
- 5.3c - 2023 Scorecard Measures Definitions

2023 College Performance Scorecard

No.	Strategic Alignment SP1	SP2	SP3	2022 Actual	BOARD MONITORED Key Performance Indicators and Milestones (M)	2023 YTD (year-to-date) YTD Q1	YTD Q2	YTD Q3	YTD Q4	2023 Target
					Domain 1: Governance					
1			✓	95%	**Percentage of Board Directors voluntarily contributing at each Board meeting**	94%	94%	96%	97%	≥95%
2			✓	87%	**Percentage of Board Directors completing evaluation surveys**	95%	97%	98%	98%	100%
					Domain 2: Resources					
3			✓	-6.0%	**Variance of year-end actuals to annual operating budget**	Annual Report January 2024			-2%	+/- 5%
4			✓	78%	**Percentage of employee engagement (Inclusion survey subset)**	Scheduled for June 2023	88%			≥78%
5			✓	62%	**Percentage of employee engagement (Culture survey subset)**	Scheduled for June 2023	78%			≥70.5%
6			✓	n/a	***Acquisition and initial implementation of the new Pharmacy, Registrant & Information Management Environment system (PRIME) on time in keeping with benchmarks(M)***					12/31/23
					Domain 3: System Partner					
7	✓	✓		n/a	***Develop and implement a stakeholder engagement strategy on the expansion of scope of practice (M)***			Aug-23		12/31/23
					Domain 4: Information Management					
8			✓	n/a	***SharePoint Online implementation for Corporate Service & Quality Division on time in keeping with benchmarks (M)***					12/31/23
					Domain 5: Regulatory Policies					
9	✓		✓	82%	**Percentage of community pharmacists passing quality assurance (QA) re-assessment**	100% (18/18)	94% (29/31)	85% (46/54)	86% (59/69)	≥82%
10	✓		✓	25%	**Prioritized practice documents (policies/guidelines/guidance) updated within target timeline**	0% (0/6)	0% (0/6)	0% (0/6)	0% (0/6)	≥50%
11	✓	✓	✓	n/a	***Introduction of Equity, Diversity & Inclusion strategy (EDI) and initial implementation of action plan in keeping with benchmarks (M)***					12/31/23
					Domain 6: Suitability To Practice					
12		✓	✓	27%	**Percentage of high and moderate risk complaints disposed of within 150 days**	9% (4/44)	22% (17/77)	38% (43/114)	38% (55/143)	≥30%
13		✓	✓	58%	**Percentage of high and moderate risk Registrar's inquiries disposed of within 365 days**	68% (13/19)	64% (20/31)	61% (24/39)	60% (39/65)	≥50%
14		✓		96%	**Percentage of HPARB complaint decisions confirmed**	100% (4/4)	100% (6/6)	91% (10/11)	88% (15/17)	≥88%
15	✓			582	**Cycle time in average days from previous assessment to most recent assessment for community pharmacies in highest risk category**	496	501	488	441	≤365 days
16	✓	✓	✓	43%	**Percentage of community pharmacies entering events on AIMS platform**	23%	33%	39%	43%	≥80%
					Domain 7: Measurement, Reporting & Improvement					
17			✓	98%	**Percentage of Board Directors report receiving appropriate info. to exercise oversight role**	100%	100%	100%	99%	≥95%
18			✓	n/a	**Percentage of Board Directors indicating availability to sit on a Discipline Committee (DC) contested or uncontested hearing panel**	40%	41%	43%	45%	Collecting Baseline

LEGEND			
Strategic Alignment	**Indicator Range**	**Milestone Range**	**Symbols**
SP1: Enhance system and patient outcomes through collaboration & optimization of current scope of practice	Meets or Exceeds target	On Track (proceeding per plan)	n/a Not Avail.
SP2: Strengthen trust and confidence in the College's role as a patients-first regulator	Approaching Target ≤ 25%	Potential Risk	*(M) Milestone*
SP3: Enhance capacity to address emerging opportunities & advance quality & safe pharmacy practice & regulatory excellence	Beyond Target > 25%	Risk/Roadblock	Completed

Approve by: Board of Directors

Approve on: Mar 21, 2023

Last updated: 26/02/2024

Scorecard Measure	Q4 2023 Performance Summary / Improvement Strategies
#1 Percentage of Board Directors voluntarily contributing at each Board meeting	The College ended the year with a 100% contribution in Q4 and a year-to-date contribution of 97%. The trend throughout the year showed an improved score over the 4 quarters. This metric will continue to be monitored in 2024.
#2 Percentage of Board Directors completing evaluation surveys	The College ended the year with a 98% completion, slightly below the College's target. Two out of four quarters during the year we achieved 100%, two did not. Our goal into 2024 will be to achieve 100% in all four quarters.
#3 Variance of year-end actuals to annual operating budget	Total actual operating expenses in 2023 are 98% (variance -2%) of budget.
#4 Percentage of Employee engagement (*Inclusion survey subset*)	This survey was completed in Q2, and results were presented at the September Board meeting. Result (88%) exceeded industry benchmark (78%).
#5 Percentage of Employee engagement (*Culture survey subset*)	This survey was completed in Q2, and results were presented at the September Board meeting. Result (78%) exceeded industry benchmark (70.5%).
#6 *Acquisition and initial implementation of new Pharmacy Registrant information Management Environment (PRIME)[1] on time in keeping with benchmarks(M)*	The validation phase is currently tracking behind schedule. All requirement gathering sessions are completed, and the team is working together to complete final reviews and edits. All requirements will be approved by February 23rd. OCP and KPMG will then determine which requirements must be included in phase 1 and which requirements can be deferred to a future release.
#7 *Develop and implement a stakeholder engagement strategy on the expansion of scope of practice (M)*	This project was completed in August 2023.
#8 *SharePoint Online implementation for Corporate Service & Quality Division on time in keeping with benchmarks (M)*	The College successfully transitioned to SharePoint. Ongoing staff support will be provided in 2024 to ensure staff has the knowledge and comfort to use SharePoint to its fullest, and work will be undertaken to effectively reorganize SharePoint files post-transition.
#9 Percentage of community pharmacists passing quality assurance (QA) re-assessment	Achieved 86% YTD in Q4, exceeding 2023 target of 82%.
#10 Prioritized practice documents (policies/guidelines/guidance) updated within target timeline	This year there was ongoing work on two policies. By the end of the year, one policy went through the public consultation process, and was in the final stages of approval, and the other policy was due for public consultation review. Due to change in leadership, team restructuring, and a different approach to policy development and review, both policies were paused.

[1] Formerly referred to as RSS.

Scorecard Measure	Q4 2023 Performance Summary / Improvement Strategies
#11 *Introduction of Equity, Diversity & Inclusion strategy (EDI) and initial implementation of action plan in keeping with benchmarks (M)*	Achieved. EDI Strategy activities in Q4 saw the completion of the following: • Two meetings of the Registrant Reference Group. Members provided staff with considerations and guidance for exploring diversification of the Board, expanding demographic data collection from registrants, and progressing on a path towards reconciliation while making progress on strategic goal #4. • Board, Registration Committee and Discipline Committee training sessions held on understanding the terms in the Ontario Human Rights Code and using inclusive language. • Board direction that the EDI Strategy have a focus on Indigenous Cultural Humility while making progress on identified priorities in 2024 that will have high impact on respectful and non-discriminatory patient care.
#12 Percentage of high and moderate risk complaints disposed of within 150 days	Achieved 38% YTD in Q4, exceeding 2023 target of 30%.
#13 Percentage high and moderate risk Registrar's inquiries disposed of within 365 days	Achieved 60% YTD in Q4, exceeding 2023 target of 50%.
#14 Percentage of HPARB complaint decisions confirmed	Achieved 88% YTD in Q4, equaling 2023 target of 88%.
#15 Cycle time in average days from previous assessment to most recent assessment for community pharmacies in highest risk category	Achieved cycle time of 414 days in Q4 and YTD cycle time of 441 days. While not meeting the target of 365 days, the College improved both from previous quarters and cycle time for 2022 of 582 days. The objective for 2023 was to begin to see an improvement in cycle time. **Q4's performance was impacted by the following factors:** • Lingering pandemic aftermath necessitated catch-up efforts. • Unanticipated issues, including pharmacy factors and deferral requests, causing scheduling disruptions. **Improvement Strategies:** • Monitoring ongoing cycle times closely. • Refining risk priorities for strategic resource allocation. • Anticipated improvements based on 2023 groundwork, setting the stage for continued enhancement in assessment planning

Scorecard Measure	Q4 2023 Performance Summary / Improvement Strategies

#16
Percentage of community pharmacies entering events on AIMS platform
	In Q4, 43% (YTD) of community pharmacies entered events on the AIMS platform.
	Q4's performance was impacted by the following factors:
	• College receipt of an engagement report from Pharmapod was delayed until midway in Q4. The report identifies pharmacies with low engagement which helps facilitate direct outreach to improve engagement.
	Improvement Strategies:
	• An engagement strategy will be implemented in Q1 2024.
	  ○ Community operation advisors will be given access to engagement data for pharmacies that they are assessing. This will facilitate meaningful discussions to improve engagement and create action plans as necessary.
	  ○ Corporate leads will be provided with engagement data for their pharmacies.
	  ○ Outreach with targeted communication planned for the remaining unengaged pharmacies.

#17 Percentage of Board Directors receiving appropriate information to exercise oversight role	The College ended the year with a 98% score, exceeding the 2023 target of 95%.
#18 Percentage of Board Directors indicating availability to sit on a Discipline Committee (DC) contested or uncontested hearing panel	Achieved 54% in Q4 with a year-to-date total of 45%. No target has been established for this indicator yet, as this is a new indicator and the first time the College is collecting this data. The 2023 data will be used to establish a baseline and inform the target for next year. The data for calculating this indicator in Q4 includes Board Director availability for 7 hearings (1 single day uncontested hearing, 1 two-day partially contested hearing, 1 single day contested hearing, 3 multi-day contested hearings, and 1 single day contested motion). Constituting panels for these hearings was challenging when conflicts were considered in addition to availability. A hearing day was cancelled for one of the contested hearings due to inability to constitute a panel that could sit for all the hearing days scheduled. In addition, following the appointments being made a number of panel members recused themselves due to no longer being available or personal conflicts being identified, resulting in replacement panel members being required.

LEGEND	
(M) represents measurement against a milestone	
Indicator Range	**Milestone Range**
Meets or Exceeds target	On Track (proceeding per plan)
Approaching Target ≤ 25%	Potential Risk
Beyond Target > 25%	Risk/Roadblock

2023 Scorecard Measure Definitions

Scorecard Measure	Indicator or Milestone Definition	Target Justification	Performance
#1 Percentage of Board Directors voluntarily contributing at each Board meeting.	The purpose of this measure is to ensure that the OCP Board is creating an environment that encourages equal participation by all. It measures the % of Board Directors providing input without being called upon individually during Board meetings.	Maintain and demonstrate governance principles relating to preparedness, expertise, and inclusion.	% Performance is: ≥ 95.0% 71.3 – 94.9% ≤ 71.2%
#2 Percentage of Board Directors completing evaluation surveys.	The purpose of this indicator is to ensure that the OCP Board is creating an environment that encourages equal participation by all. This indicator measures the % of Board Directors that complete the evaluation following quarterly board meetings.	High performing boards are conscientious about self-assessment, which is used as a basis for continuing quality improvement.	% Performance is: 100% 75.0 – 99.9% ≤ 74.9%
#3 Variance of year-end actuals to annual operating budget.	This indicator measures the variance of actual operating expenses against the annual budget.	Accurate forecasting is essential to balancing cost containment against mandate achievement.	% Variation is: +/- 5.0% +/- 6.0 – 25.0% +/- 25.1% or more
#4 Percentage of employee engagement (Inclusion survey subset).	This indicator measures staff perception of inclusion, as measured by certain questions in the annual survey.	Achievement of the target will demonstrate the impact of our internal HR Equity, Diversity, and Inclusion initiative. The target is based on McLean's industry benchmark.	% Engagement is: ≥ 78.0% 58.5 - 77.9% ≤ 58.4%
#5 Percentage of employee engagement (Culture survey subset).	This indicator measures staff's evaluation of the college's culture.	Achievement of the target will demonstrate the impact of efforts to improve college culture. The target is based on McLean's industry benchmark.	% Engagement is: ≥ 70.5% 52.9 – 70.4% ≤ 52.8%
#6 *Acquisition and initial implementation of new Customer Relationship Management (CRM) system on time in keeping with*	This milestone-based measure tracks progress on modernization of the college's information technology infrastructure.	Milestones will be established based on a project schedule and will include completion of the signed contract,	Milestone is: On Track Potential Risk Risk/Roadblock

2023 Scorecard Measure Definitions

benchmarks (M).		project initiation and planning phases by December 2023.	
Scorecard Measure	**Indicator or Milestone Definition**	**Target Justification**	**Performance**
#7 *Develop and implement a stakeholder engagement strategy on the expansion of scope of practice (M).*	Through the development and implementation of a stakeholder engagement strategy, this milestone tracks planned stakeholder activities related to recent and potentially new expanded scope of practice with health system stakeholders that are impacted by expanded scope.	Achievement of this milestone will be based on the creation and implementation of the stakeholder engagement strategy by December 2023.	Milestone is: On track Potential Risk Risk/Roadblock
#8 *SharePoint Online implementation for Corporate Service & Quality division on time in keeping with benchmarks (M).*	This milestone measures the completion of SharePoint software in Corporate Service & Quality division, key to modernizing the college's information technology infrastructure, which includes a transition of all college documents from the current platform to the cloud-based SharePoint.	Milestones set based on approved project schedule. Milestones will include migration of documents, staff training and skill levels, and adequate staff access to create, access and update documents in accordance with privacy protocols by December 2023.	Milestone is: On track Potential Risk Risk/Roadblock
#9 Percentage of community pharmacists passing Quality Assurance (QA) re-assessment.	This indicator measures the % of community pharmacists that pass the practice re-assessment following peer coaching.	Maintain 2022 target and performance.	% Success is: ≥ 82.0% 61.5 – 81.9% ≤ 61.4%
#10 Prioritized practice documents (policies/guidelines/guidance) updated within target timeline.	This indicator measures the completion rate of the review of selected practice documents by year end.	Target based on completing 3 out of 6 practice documents in 2023. Success will depend on the current practice environment as it relates to the policy review process and supporting resources.	% Completion is: ≥ 50% 37.5% - 49.9% ≤ 37.4%
#11 *Introduction of Equity, Diversity & Inclusion strategy*	This milestone-based measure tracks progress on developing an EDI	Milestones will be based on approved	Milestone is: On Track Potential Risk

2023 Scorecard Measure Definitions

(EDI) and initial implementation of action plan in keeping benchmarks (M).	strategy that encompasses the Colleges' programs, policy and governance functions, and the implementation of the first prioritized action plan.	project schedule and will include engagement with relevant external & internal stakeholders.	Risk/Roadblock
Scorecard Measure	**Indicator or Milestone Definition**	**Target Justification**	**Performance**
#12 Percentage of high and moderate risk complaints disposed of within 150 days.	This indicator measures the % of high and moderate risk complaints meeting the statutory requirement to dispose of all complaints within 150 days from date of filing to date the ICRC decision is sent.	2022 target performance not met. Continue with same target for 2023.	% Complaints are: ≥ 30.0% 22.5 – 29.9% ≤ 22.4%
#13 Percentage of high and moderate risk Registrar's Inquiries disposed within 365 days.	This indicator measures the % of high and moderate risk Registrar's Inquiries (RI's) (s. 75(1) (a) investigations, disposed within 365 days from date of filing to date the ICRC decision is sent.	2022 performance exceeded target. Target set to maintain performance at 50%.	% Registrar's Inquiries are: ≥ 50.0% 37.5 – 49.9% ≤ 37.4%
#14 Percentage of HPARB complaint decisions confirmed.	This indicator measures the % of HPARB (Health Professions Appeal and Review Board) reviews of ICRC complaints investigations and decisions, requested by either party, that are confirmed by HPARB.	Maintain 2022 performance. Keep same target for 2023.	% Complaints are: ≥ 88.0% 66.0 – 87.9% ≤ 65.9%
#15 Cycle time in average days from previous assessment to most recent assessment for community pharmacies in highest risk category.	This indicator measures the average days between assessments (cycle time) from the previous assessment date to the most recent assessment date. The subset category is the highest-risk sites in community pharmacies.	Target based on best practice and available resources.	Average days are: ≤ 365 366 – 456 ≥ 457
#16 Percentage of community pharmacies entering events on AIMS platform.	This indicator measures the % of community pharmacies actively recording events (incidents & near misses) on the AIMS (Assurance & Improvement in Medication Safety) platform out of the total accredited pharmacies.	Target set to the terms in the contractual agreement with vendor.	% Pharmacies are: ≥ 80.0% 60.0 – 79.9% ≤ 59.9%

2023 Scorecard Measure Definitions

#17 Percentage of Board Directors report receiving appropriate info. to exercise oversight role.	Shows the % of Board Directors indicating that the meeting materials were appropriate to exercise their oversight role. Knowing this is important to ensure that OCP Board Directors receive the information they need to effectively execute their oversight role and make informed decisions in accordance with the College's Values and Regulatory Principles.	Maintain an acceptable level of performance.	% Performance is: ≥ 95.0% 71.0 – 94.9% ≤ 70.9%
Scorecard Measure	**Indicator or Milestone Definition**	**Target Justification**	**Performance**
#18 Percentage of Board Directors indicating availability to sit on a Discipline Committee (DC) contested or uncontested hearing panel.	This indicator measures the % of Board Directors indicating their availability to sit on a DC hearing panel on all dates scheduled for the hearing.	New indicator. Collecting baseline.	

LEGEND	
(M) represents measurement against a milestone	
Indicator Range	**Milestone Range**
Meets or Exceeds target	On Track (proceeding per plan)
Approaching Target ≤ 25%	Potential Risk
Beyond Target > 25%	Risk/Roadblock

BOARD BRIEFING NOTE

MEETING DATE: March 25, 2024

FOR DECISION

From:	Thomas Custers, Director, Corporate Services
Topic:	2024 College Dashboard targets and reporting progress on 2024 strategic priorities
Issue/Description:	Seek approval of proposed targets for 2024 College Dashboard and provide an initial update on the College's progress in executing its 2024-2028 strategic plan and 2024 operational goals.

Public interest rationale: To support the Board with its responsibility for providing oversight and being accountable to the public for the overall performance of the College.

Background:

- The Board approved the 2024 College Dashboard at its December 11th, 2023, meeting which will provide the Board with a clear understanding of how well the College is achieving its public interest mandate, including its progress against its 2024-2028 strategic plan, 2024 operational goals, and its organizational capacity to execute its mandate now and in the future. (See appendix 1 for the 2024 College Dashboard domains).
- The 2024 College Dashboard includes two types of measures:
    - **Performance measures:** Measures for which a target is set that the College wants to achieve related to its strategic and operational goals (strategic priorities) or organizational capacity.
    - **Monitoring measures:** Measures of College performance for which no targets have been set. Provides context and informs about the College's performance in other areas of its mandate to support future strategic or operational planning.
- The 2024 College Dashboard has 19 measures, of which 14 are performance and five are monitoring measures. Of the 14 performance measures, the first two speak to how well the College executes its 2024 strategic and operational goals.
- Targets for the performance measures are set by carefully analyzing historical data trends and looking at industry benchmarks, where possible, and activities the College plans to undertake in 2024 to improve its performance.
- Starting at the June Board meeting, staff will provide the Board with quarterly updates on its progress toward meeting the 2024 targets. While the first quarter data will be available following the end of March, updates can already be provided on how well the College is progressing on two measures related to executing the College's 2024 strategic and operational goals, recognizing that 2024 just started.

Analysis:

I. 2024 Targets:

- Staff propose maintaining the College's current performance levels on eight of the 14 performance measures. The College is already performing well in those areas. All eight measures speak to OCP's organizational capacity.
- The staff proposes to improve the College's performance on the other six measures.

II. Update on progress 2024 priorities:

For 2024, the College's operational plan identified six priorities to advance its 2024-2028 strategic plan and 12 operational priorities. (See appendix 2 for detailed overview).

Overview progress 2024 priorities (Jan-Feb)			
	On Track	At Risk	Off Track
	#	#	#
2024 strategic goals	6	0	0
Operational goals	11	1	0

- The priority at risk is the implementation of the College's new Registrant Record System (RRS) due to the longer than expected time required to capture the business requirements.

Motion: **That the Board approves the 2024 College Dashboard targets as presented**.

ATTACHMENTS:

6.1 - 2024 College Dashboard
6.2 - 2024 College Dashboard Measures Definitions
6.3 - Rational 2024 College Dashboard Targets

Appendix 1

2024 College Dashboard Domains

*To come in 2024

Appendix 2

Overview status and execution stage of each of the 2024 goals (Jan-Feb 2024)*

2024 Strategic Priorities: Strategic Goals	Status	Stage
Strategic Goal 1 (Pharmacy Setting Doesn't Create Barriers)		
1. Identify tactics that the College will deploy to advance Strategic Goal 1 starting 2025.	G	I
Strategic Goal 2 (Effective College Communications in All External Interactions)		
2. Refresh OCP website to provide useful, timely & accessible information to the public, registrars, and other partners.	G	P
3. OCP Brand refresh	G	P
4. Update all OCP communication materials to ensure the information that is shared is precise, understandable & accurate	G	I
Strategic Goal 3 (We Have the Resources)		
5. Finalize implementation new organizational structure	G	P
Strategic Goal 4 P (Patients Receive Respect/No Discrimination)		
6. Establish a prioritized list of high impact activities to be implemented starting in 2024.	G	P

2024 Strategic Priorites: Operational Goals	Status	Stage
7. Implement Registrant Record System	Y	E
8. Finalize SharePoint migration	G	E
9. Develop and implement a data governance framework.	G	I
10. Build first components of a data warehouse.	G	NS
11. Implement a more efficient registration process & enhanced approach to QA (Registration & QA Regulation Implementation) - *Pending Ministry Direction*	G	NS
12. Implement a revised program to conduct pharmacists' assessments more efficient & effective.	G	E
13. Implement policies to improve patient safety for sterile, non-sterile & hazardous compounding.	G	E
14. Transition Structured Practical Training (SPT) Program to Practice Assessment of Competence at Entry (PACE) for intern technicians.	G	E
15. Develop recommendations for future AIMS program	G	P
16. Develop recommendations to strengthen & sustain effective governance	G	I
17. Discipline Committee review – Phase II	G	E
18. Implement a practice-based risk framework to review & prioritize all College regulatory activities.	G	E

**Legend:*

Status	***Green***: On Track	***Yellow***: At Risk	***Red***: Off Track

Priority Execution Stage	Not Yet Started (NS)	Initiation (I)	Planning (P)	Execution (E)

2024 College Dashboard

I. Performance Measures

Strategic Priorities				
Strategic Goals		actual	**target**	status
1	% of 2024 strategic goals on track		**100%**	
Operations		actual	**target**	status
2	% of 2024 operational goals on track		**100%**	

Organizational Capacity				
People and Culture		actual	**target**	status
3	Average rating (1-10) of staff likely to recommend the College to a qualified friend or family member as a great place to work		**8.2**	
4	Average rating (1-7) of staff that feels OCP supports them in having the right skills to be successful in their current role		**6.5**	
5	% of staff engagement (inclusion)		**80%**	
6	% of staff engagement (culture)		**78%**	
7	Voluntary staff turnover rate		**3.8%**	
Finance		actual	**target**	status
8	% of variance of operating annual budget to year end actuals		**+/- 5%**	
Technology		actual	**target**	status
9	% of up-time of business-critical information systems		**99.9%**	
10	Click rate of phishing campaigns		**4.7%**	
Compliance		actual	**target**	status
11	% of CPMF standards fully met		**83%**	
Governance		actual	**target**	status
12	% of Board Directors voluntary contributing at each Board meeting		**100%**	
13	% of Board Directors report receiving appropriate information to exercise oversight role		**100%**	
14	% of Board Directors indicating availability to sit on a Discipline Committee contested or uncontested Hearing panel, when asked		**85%**	

II. Monitoring Measures

Regulatory Competence			
Registration		actual	trend analysis
15	% of Registrar decisions made within 30 days after receiving the complete application		
Quality Assurance		actual	trend analysis
16	Cycle time for high risk assessments		
Conduct		actual	trend analysis
17	90th percentile disposal of formal complaint		
18	90th percentile disposal of Registrar's investigation		

Organizational Capacity			
Finance		actual	trend analysis
19	% of reserve fund balance to required reserve amount per College's Reserve Policy		

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Attachment 6.2: Measurement Definitions

Dashboard Measures: Performance

Measure	Definition	Rationale and Understanding this Measure
DOMAIN: STRATEGIC PRIORITIES		
% of 2024 strategic goals on track	• The number of 2024 goals to advance the 2024-2028 strategic plan (strategic goals) that are “on track” divided by the total number of 2024 strategic goals multiplied by 100.	• Demonstrates the College's progress towards achieving the 2024 goals that will advance the College's 2024-2028 strategic plan.
% of 2024 operational goals on track	• The number of 2024 operational goals that are “on track” divided by the total number of 2024 operational goals multiplied by 100.	• Demonstrates the College’s progress toward achieving its 2024 operational priorities related to College operations (the College’s ongoing regulatory and operational functions).
DOMAIN: ORGANIZATIONAL CAPACITY (PEOPLE & CULTURE)		
Average rating of staff likely to recommend the College to a qualified friend or family member as a great place to work	• Monthly staff survey question: “how likely would you be to recommend this organization to a qualified friend or family member as a great place to work?” on scale from 1 (not likely) to 10 (very likely). • The average rating is calculated by the sum of all ratings divided by the number of staff who responded.	• Provides a quick snapshot of how staff feel about their experience working at the College and their level of engagement. This is critical as highly engaged employees are more productive and loyal, reducing the risk of voluntary turnover.

Dashboard Measures: Performance (*Cont'd*)

Measure	Definition	Rationale and Understanding this Measure
DOMAIN: ORGANIZATIONAL CAPACITY (PEOPLE & CULTURE)		
Average rating of staff that feels OCP supports them in having the right skills to be successful in their current role	• Monthly staff survey question: "OCP is supporting me in having the right skills to succeed in my current role" on a scale from 1 (strongly disagree) to 7 (strongly agree). • The average rating is calculated by the sum of all ratings divided by the number of staff who responded.	• Ensuring staff have the right skills to be successful in their current job will help them to be more effective and efficient. Furthermore, a culture that is known to promote staff learning and development helps improve employee engagement and retention. To that end, staff development continues to be a priority for 2024.
% of staff engagement (inclusion)	• Staff survey score that is based on a range of questions related to whether a staff experience discrimination, bullying or harassment and whether a staff experiences an inclusive environment and is comfortable being themselves at OCP. • The survey is conducted annually by an external organization.	• The College performed exceptionally well on this measure in 2023 (88%). As 'inclusion' is a critical organizational driver affecting a staff's overall engagement and speaks to the College's EDI commitment, the College will continue undertaking efforts in 2024 related to inclusion as needed to maintain its performance on this measure. • Reporting on this measure will demonstrate the impact of the College's internal HR Equity, Diversity, and Inclusion activities in maintaining an inclusive organization.
% of staff engagement (culture)	• Staff survey score that is based on a range of questions related to whether staff identify with OCP's values, sees a fit with OCP's culture, whether OCP has a friendly atmosphere, whether OCP's policies and processes create a positive working environment, how OCP manages performance and encourages staff to contribute as much as possible. • The survey is conducted annually by an external organization.	• Like 'inclusion,' 'culture' is critical to overall engagement. The College improved significantly its performance on this measure (78% in 2023 vs. 64% in 2022). • Recognizing its importance, the College aims to maintain last year's performance, with improvements being made on an as-needed basis identified through the engagement surveys or recommendations from the College's internal Culture Advisory group. • Reporting on this measure will demonstrate the impact of the College's activities in maintaining its performance on this measure.

Dashboard Measures: Performance (*Cont'd*)

Measure	Definition	Rationale and Understanding this Measure
DOMAIN: ORGANIZATIONAL CAPACITY (PEOPLE & CULTURE)		
% voluntary staff turnover	• The number of staff who left OCP voluntarily divided by the average number of employees for that quarter of the year multiplied by 100.	• Generally, high turnover rates signal a problem – with the organization's culture, its compensation and benefits structure, individual managers, training and career progression paths, and more. • Replacement costs for talent include recruiting, onboarding, training, loss of productivity and, if turnover is high, a decrease in overall staff morale. • Reporting on this measure will demonstrate the College's success in preventing high voluntary staff turnover. Planned activities for 2024 that may positively impact retention include an organization-wide job evaluation and salary review, the College's ongoing efforts to ensure an inclusive and healthy workplace culture and continue investing in staff training and development.
DOMAIN: ORGANIZATIONAL CAPACITY (FINANCE)		
% of variance of annual operating budget to year end actuals	• The total actual operating expenditures for the year divided by the total budgeted operating expenditures, multiplied by 100.	• Compares the College's actual performance to budget, illuminating the accuracy of budget planning to revenue and cost. • For example, if the annual spend was 95% of budget, the % of variance reported would be -5%. This would indicate the College under spent. • A significant underspend may be a signal that the College is delayed in achieving its goals or has not benefited fully from the resources available, potentially resulting in poorer outcomes. Overspending could indicate a lack of prudence in seeking out cost-effective options.

Dashboard Measures: Performance (*Cont'd*)

Measure	Definition	Rationale and Understanding this Measure
DOMAIN: ORGANIZATIONAL CAPACITY (TECHNOLOGY)		
% of up-time of business-critical information systems	• Shows the percentage of network and host server availability within AGT (agreed service time), i.e., systems have been running continuously without restarting between 7 am to 7 pm, excluding scheduled maintenance.	• Provides a snapshot of the College's performance in ensuring its IT systems perform robustly and reliably, whether it is the hardware, software, network infrastructure, human factors, compliance with Service Level Agreements.
% click rate of phishing campaigns	• Shows the percentage of staff who clicked on a simulated phishing link or attack.	• Employees can pose the biggest cyber security risk due to opening malicious emails. This measure indicates the College's level of vulnerability to phishing attempts and the effectiveness of activities surrounding awareness training and cyber security risk prevention.
DOMAIN: ORGANIZATIONAL CAPACITY (COMPLIANCE)		
% of CPMF Standards fully met	• Is calculated by number of Standards 'met' divided by the total number of Standards (for which Colleges must state whether it has either 'met,' 'partially met,' or 'not met,' the respective Standard) multiplied by 100. • A Standard is met when the College meets all the requirements associated with a Standard.	• The CPMF is a self-assessment tool required annually by the Ministry of Health. It measures college performance against a set of standards which set expectations for performance by Ontario's 26 health regulatory colleges. Meeting those standards provides the public, ministry, and other partners with the confidence that the College is well-positioned to execute its mandate effectively now and in the future.

Dashboard Measures: Performance (*Cont'd*)

Measure	Definition	Rationale and Understanding this Measure
DOMAIN: ORGANIZATIONAL CAPACITY (GOVERNANCE)		
% of Board Directors voluntarily contributing at each Board meeting	• At the meeting, staff tracks whether Board Directors actively participate in the meeting.	• The purpose of this measure is to ensure that the OCP Board is creating an environment that encourages equal participation by all. It measures the % of Board Directors providing input without being called upon individually during Board meetings.
% of Board Directors report receiving appropriate information to exercise oversight role	• The data for this measure comes from the Board Meeting Evaluation that is being conducted after each meeting. It includes the question: "Were the materials appropriate to exercise your oversight role?“	• Knowing the % of Board Directors indicating that the meeting materials are appropriate to exercise their oversight role is critical to ensure that OCP Board Directors receive the information they need to effectively execute their oversight role and make informed decisions in accordance with the College's values and regulatory principles.
% of Board Directors indicating availability to sit on a Discipline Committee (DC) contested or uncontested hearing panel, when asked	• College staff canvasses Board Director availability to sit on hearings.	• This indicator measures the % of Board Directors indicating their availability to sit on a DC hearing panel on all dates scheduled for the hearing.

Dashboard Measures: Monitoring

Measure	Definition	Rationale and Understanding this Measure
DOMAIN: REGULATORY COMPETENCE		
REGISTRATION		
% of Registrar decisions made within 30 days after receiving the completed application.	• Number of applications completed within 30 days or less out of the total applications completed.	• The College is required to make a timely decision to register an applicant or refer the application to the Registration Committee.
QUALITY		
Average cycle time between assessments for community pharmacies in highest risk category, measured in average days	• Average number of days between current calendar assessment date to the previous assessment date for sterile compounding pharmacies classified as "high risk".	• If pharmacies providing high risk services fail to meet standards, patients are exposed to a high risk of harm. Ensuring ongoing compliance with standards is core to ensuring patient safety. A measure of the time between assessments will provide information that will help us refine and test our assessment model and resourcing needs.

Dashboard Measures: Monitoring

Measure	Definition	Rationale and Understanding this Measure
DOMAIN: REGULATORY COMPETENCE		
CONDUCT		
90th percentile disposal of complaints, expressed in business days.	• In business days, the time the College takes to process 90 percent of disposed complaints. • Exclusions from this measure are all concerns that a Panel of the ICRC determines are frivolous and vexatious in nature; complaints withdrawn by the Registrar at the request of a complainant; all health-related inquiries; and all formal complaints.	• Provides information about the time it takes the College to dispose of 9 out of 10 complaints/Registrar investigations.* • The time it takes the College to dispose of a complaint/Registrar's investigation may impact public trust in the College's ability to ensure they receive safe, competent and ethical care. It may also provide the College with information about patient risk exposure, our business processes and resources.
90th percentile disposal of a Registrar's Investigation in business days.	• In business days, the time the College takes to process 90 percent of disposed Registrar's Investigations • Exclusions from this measure are appeals to the Divisional Court, and active uncontested Discipline Committee hearings in which the panel has not yet issued its written decision and reasons.	

*

Complaint: A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint.

Registrar Investigation: The Registrar can appoint an investigator if there are reasonable and probable grounds to believe that a registrant has committed an act of professional misconduct or is incompetent (upon approval from the Investigations, Complaints, and Reports Committee).

Dashboard Measures: Monitoring (*Cont'd*)

Measure	Definition	Rationale and Understanding this Measure
DOMAIN: ORGANIZATIONAL CAPACITY (FINANCE)		
% of Reserve fund balance to required reserve amount per College's Reserve Policy	• This indicator shows the % balance of funds available out of the amount of funds on hand. Policy states that the College should have four months of operating expense in reserve.	This measure will inform the Board of the degree to which the College meets the required reserve amounts (four months of operating expenses). It is one measure of financial health and stability.

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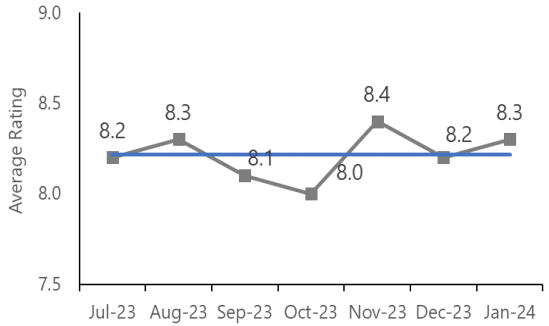
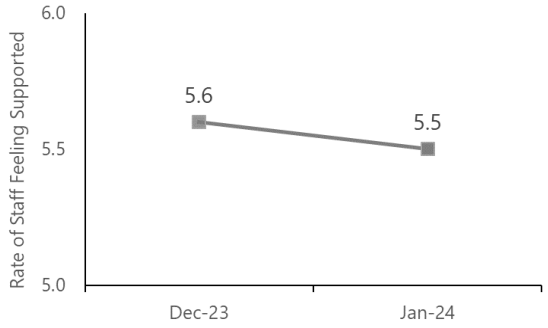
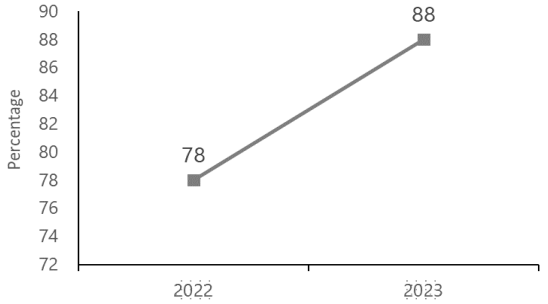
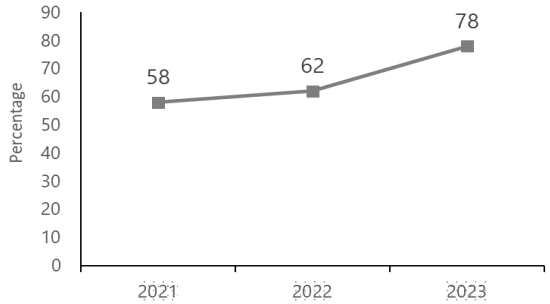
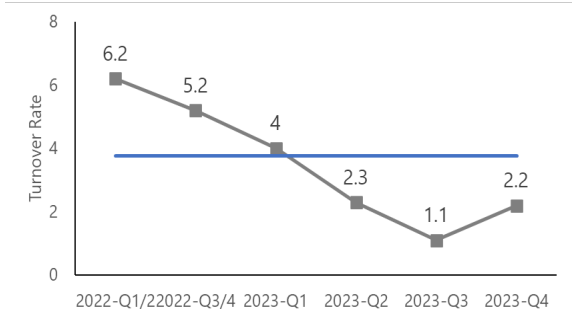
Attachment 6.3: Rationale for 2024 College Dashboard Targets

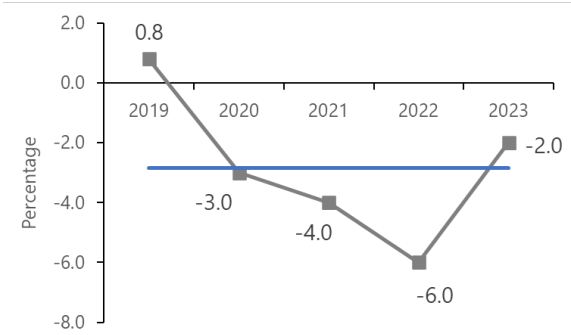
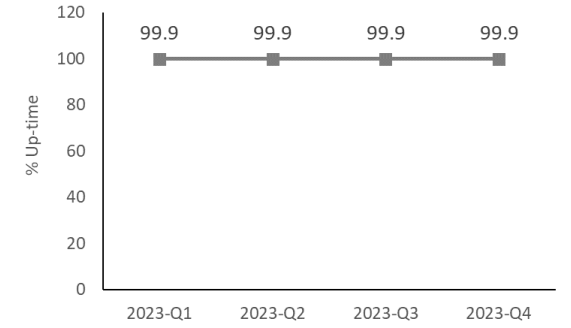
Rationale for Proposed Targets

Measure	Past Performance	Target	Target Justification
DOMAIN: STRATEGIC PRIORITIES			
% of 2024 strategic goals on track	N/A	**100%**	• Recognizing that the College operates in a dynamic environment with changing or emerging priorities, the College aims to achieve all the goals associated with the identified priorities for 2024 and as set out in the College's 2024 Operational plan.
% of 2024 operational goals on track	N/A	**100%**	
DOMAIN: ORGANIZATIONAL CAPACITY (PEOPLE & CULTURE)			
Average rating of staff likely to recommend the College to a qualified friend or family member as a great place to work		**8.2**	• No baseline information is available for this measure. However, initial data points suggest that the average rate is around 8.2 (rating goes from 1=not likely to 10=very likely). • Staff who rate 7-8 are considered neutral, suggesting they had neither positive nor negative experiences with the organization. Staff who rate 9-10 are considered promotors, suggesting they are highly engaged, satisfied employees who are very likely to recommend the organization as a place to work. • The target for 2024 is to maintain the current rate, as the data points to date suggest that the College's performance is already on the higher end.
Average rating of staff that feels OCP supports them in having the right skills to be successful in their current role		**6.5**	• No baseline information is available for this measure (rating goes from 1=strongly disagree to 7=strongly agree). • Performance should improve on this measure as the College continues to invest in staff training in 2024 (e.g., managers' training, emerging leaders' program, supporting specific and unique staff-identified professional development opportunities).

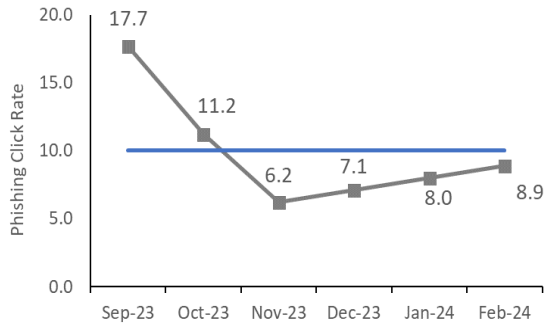
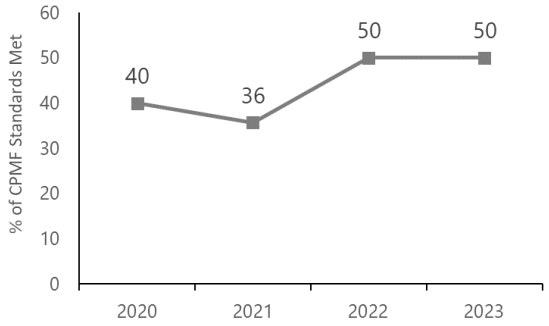
Rationale for Proposed Targets *(Cont'd)*

Measure	Past Performance	Target	Target Justification
DOMAIN: ORGANIZATIONAL CAPACITY (PEOPLE & CULTURE)			
% of staff engagement (inclusion)		**80%**	• Inclusion is one of the organizational drivers that impacts employee engagement. The College significantly improved its performance on inclusion by 13%. • The goal for 2024 is to maintain at least the industry benchmark (80%). The 2023 score was exceptionally high and not realistic to maintain despite the College's internal HR Equity, Diversity, and Inclusion initiatives that will continue in 2024.
% of staff engagement (culture)		**78%**	• College has continuously improved its performance on this measure over the last three years, achieving an improvement of 10.4%. • The goal for 2024 is to maintain the College's 2023 performance, with improvements being made on an as-needed basis identified through the engagement surveys or recommendations from the College's internal Culture Advisory group.
Voluntary staff turnover rate		**3.8%**	• The College has significantly improved the voluntary staff turnover rate since the summer of 2022 (from 6.2% to 2.2% in the last quarter of 2023) while recognizing that the number of staff has increased over that period that impacts to some degree the rates. Voluntary turnover speaks to employees leaving an organization of their own will. • The goal for 2024 is to maintain the College's baseline. It is expected that the various HR initiatives the College is planning to undertake, such as a job evaluation and salary review, and investments in staff training and development, will positively impact this measure. However, the degree of impact is unknown as the College has reached a point where it is already performing well.

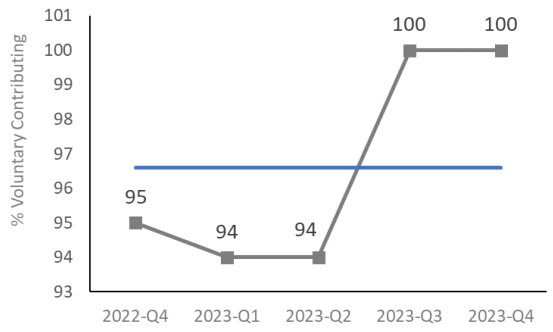
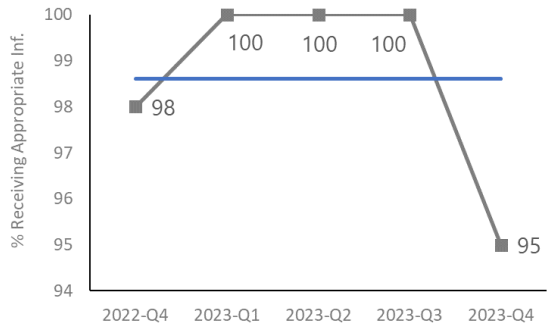
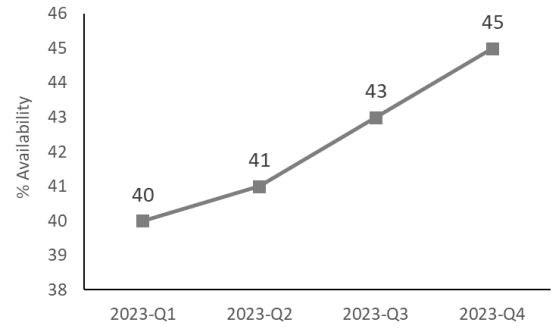
Rationale for Proposed Targets *(Cont'd)*

Measure	Past Performance	Target	Target Justification
DOMAIN: ORGANIZATIONAL CAPACITY (FINANCE)			
% of variance of annual operating budget to year end actuals		**+/-5%**	• In general, a budget variance ranging from 5%-10% is common, and therefore, the College suggests maintaining, as in previous years, the target at the industry standard.
DOMAIN: ORGANIZATIONAL CAPACITY (INFORMATION TECHNOLOGY)			
% of up-time of business-critical information systems		**99.9%**	• The College is currently performing at the Industry standard of 99.875%. The goal is to maintain the industry standard.

Rationale for Proposed Targets *(Cont'd)*

Measure	Past Performance	Target	Target Justification
DOMAIN: ORGANIZATIONAL CAPACITY (INFORMATION TECHNOLOGY)			
% Click rate of phishing campaigns		**4.7%**	• The College implemented the program that sends simulated phishing links or attacks to staff just over a year ago, and significant improvements have been made since it was implemented. • The proposed target aligns with the industry standard.
DOMAIN: ORGANIZATIONAL CAPACITY (COMPLIANCE)			
% of CPMF Standards fully met		**83%**	• The College's goal is not to achieve 100% compliance as, in several instances, the College believes its current processes and activities achieve or surpass the respective Standards mentioned in the CPMF (there are 14 Standards, on 12 of them, the College must state whether it has either 'met,' 'partially met,' or 'not met,' the respective Standard). • The College plans to improve its performance on four CPMF Standards in 2024.

Rationale for Proposed Targets *(Cont'd)*

Measure	Past Performance	Target	Target Justification
DOMAIN: ORGANIZATIONAL CAPACITY (GOVERNANCE)			
% of Board Directors voluntarily contributing at each Board meeting		**100%**	• The purpose of this measure is to ensure that the OCP Board is creating an environment that encourages equal participation by all. To that end, the goal should be that all Board Directors are well-equipped and feel comfortable contributing**.**
% of Board Directors report receiving appropriate information to exercise oversight role		**100%**	• The goal for 2024 is to ensure that all Board Directors have the appropriate information to exercise their oversight role effectively at each meeting.
% of Board Directors indicating availability to sit on a Discipline Committee contested or uncontested hearing panel when asked		**85%**	• Planning to make operational changes in 2024 to diminish demands on individual Board members' time and focus election recruitment on availability to serve.

BOARD BRIEFING NOTE

MEETING DATE: MARCH 2024

FOR DECISION

From: Finance and Audit Committee

Topic: Audited Financial Statements

Issue/Description: Approval of 2023 Audited Financial Statements

Public interest rationale: The Finance and Audit Committee engages external auditors to assess and test the College's internally produced financial statements, significant accounting policies, management judgements and estimates, and the internal control environment to obtain reasonable assurance about whether the financial statements are free from material misstatement.

Strategic alignment, regulatory processes, and actions: By completing the audit and publishing its results, the public trust in the financial health of the College can be maintained.

Background: The audit was conducted by a team of auditors from Tinkham LLP Chartered Professional Accountants. Prepared as a result of the audit, the Audited Financial Statements comprise of the College's statement of financial position as of December 31, 2023, the statement of operations, changes in net assets and cash flows for the year then ended, and notes to the financial statements including a summary of significant accounting policies.

The statements reflect the adjustments to the reserve values, with funds allocated to the investigations and hearings reserve fund based on an estimation of files for which external prosecution is expected. The surplus from 2023 will be retained in unrestricted reserves to cover a portion of the budgeted shortfall of revenue over expenditure for 2024. The remaining shortfall will be drawn from the restricted reserves.

Analysis: The Finance and Audit Committee reviewed the Auditor's Report and the internal controls and met in camera with the auditors both before and after the audit and is satisfied that the financial reporting risks outlined in the audit planning letter are being appropriately addressed.

The opinion of the auditor is that the financial statements present fairly, in all material respects, the financial position of the College as of December 31, 2023, its results of operations and its cash flows for the year then ended in accordance with Canadian Accounting Standards for not-for-profit organizations.

Motion: **That the Board of Directors approve the attached Audited Financial Statements for the operations of the Ontario College of Pharmacists for 2023 as prepared by management and audited by Tinkham LLP Chartered Professional Accountants.**

Attachments:

- 2023 Audited Financial Statements

ONTARIO COLLEGE OF PHARMACISTS

Financial Statements

December 31, 2023

TINKHAM LLP | CHARTERED PROFESSIONAL ACCOUNTANTS

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Ontario College of Pharmacists

Opinion

We have audited the financial statements of the Ontario College of Pharmacists (the "College"), which comprise the statement of financial position as at December 31, 2023, and the statements of operations, changes in net assets, and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2023, and its results of operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the College in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian accounting standards for not-for-profit organizations and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the College's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the College or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the College's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the College's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast doubt on the College's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the College to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

TORONTO, Ontario
March 25, 2024

Licensed Public Accountants

ONTARIO COLLEGE OF PHARMACISTS
Statement of Financial Position

As at December 31	2023	2022
Assets		
Current		
Cash	**$ 5,246,061**	$ 2,450,948
Investments (note 4)	**16,600,000**	12,000,000
Accounts receivable (note 3)	**366,611**	385,442
Prepaid expenses	**386,434**	387,481
	22,599,106	15,223,871
Accounts receivable (note 3)	**22,831**	42,875
Property and equipment (note 5)	**2,542,065**	4,035,461
	$ 25,164,002	$ 19,302,207
Liabilities		
Current		
Accounts payable and accrued liabilities	**$ 2,615,409**	$ 2,785,863
Deferred revenue	**6,257,693**	5,751,181
	8,873,102	8,537,044
Net assets		
Internally restricted (note 6)	**10,700,000**	9,200,000
Unrestricted	**5,590,900**	1,565,163
	16,290,900	10,765,163
	$ 25,164,002	$ 19,302,207

Commitments (note 7)

Approved on behalf of the Board of Directors

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ONTARIO COLLEGE OF PHARMACISTS
Statement of Operations

Year ended December 31	2023	2022
Revenues		
Registrant fees - Pharmacists	**$ 14,704,568**	$ 13,537,579
- Pharmacy technicians	**3,249,025**	2,927,840
Community pharmacy fees	**6,997,918**	6,503,462
Hospital pharmacy fees	**1,139,266**	1,068,079
Investment income	**978,546**	350,781
Registration fees	**902,864**	795,045
Discipline cost recoveries	**351,017**	466,100
	28,323,204	25,648,886
Expenses		
Board and committee (schedule I)	**659,662**	712,237
Personnel (schedule II)	**22,203,701**	17,879,876
Regulatory programs (schedule III)	**3,235,992**	3,459,068
Operations (schedule IV)	**2,771,873**	2,396,053
	28,871,228	24,447,234
Excess of revenues over expenses (expenses over revenues) from operations for the year before amortization and gain on disposals of property and equipment	**(548,024)**	1,201,652
Amortization	**350,474**	362,096
Gain on disposals of property and equipment (net)	**(6,424,235)**	(1,475)
Excess of revenues over expenses for the year	**$ 5,525,737**	$ 841,031

See accompanying notes to the financial statements.

ONTARIO COLLEGE OF PHARMACISTS
Statement of Changes in Net Assets

Year ended December 31

	Internally Restricted (note 6)	Unrestricted	2023 Total	2022 Total
Balance, beginning of year	**$ 9,200,000**	**$ 1,565,163**	**$ 10,765,163**	$ 9,924,132
Excess of revenues over expenses for the year	**-**	**5,525,737**	**5,525,737**	841,031
	9,200,000	**7,090,900**	**16,290,900**	10,765,163
Inter-fund transfers representing:				
Contingency reserve fund:				
Transfer from unrestricted net assets	**1,500,000**	**(1,500,000)**	**-**	-
Balance, end of year	**$ 10,700,000**	**$ 5,590,900**	**$ 16,290,900**	$ 10,765,163

See accompanying notes to the financial statements.

ONTARIO COLLEGE OF PHARMACISTS
Statement of Cash Flows

Year ended December 31	2023	2022
Cash flows provided from (used in) operating activities		
Excess of revenues over expenses for the year	**$ 5,525,737**	$ 841,031
Item not requiring a cash outlay		
Amortization	**350,474**	362,096
Gain on disposals of property and equipment (net)	**(6,424,235)**	(1,475)
	(548,024)	1,201,652
Changes in non-cash working capital balances:		
Accounts receivable	**38,875**	(151,364)
Prepaid expenses	**1,047**	(59,837)
Accounts payable and accrued liabilities	**(170,454)**	561,244
Deferred revenue	**506,512**	338,057
	(172,044)	1,889,752
Cash provided from (used in) investing activities		
Purchase of investments (net)	**(4,600,000)**	(5,000,000)
Purchase of property and equipment	**(183,065)**	(164,012)
Building renovations	**(188,330)**	-
Proceeds from disposals of property and equipment	**7,938,552**	1,475
	2,967,157	(5,162,537)
Change in cash during the year	**2,795,113**	(3,272,785)
Cash, beginning of year	**2,450,948**	5,723,733
Cash, end of year	**$ 5,246,061**	$ 2,450,948

See accompanying notes to the financial statements.

1 Organization

The Ontario College of Pharmacists (the "College") regulates pharmacy to ensure that the public receives quality services and care. The vision of the College is to lead the advancement of pharmacy to optimize health and wellness through patient centered care.

The College is the registering and regulating body for pharmacy in Ontario. All persons within Ontario who wish to dispense prescriptions and sell products defined as drugs to the public must first have met the professional qualifications set by the College, and be registered as a pharmacist or pharmacy technician. Likewise, all pharmacies must meet certain standards for operations and be accredited by the College. In addition to setting initial standards, the College ensures ongoing adherence to the professional and operational standards.

The College is a not-for-profit organization, incorporated as a non-share corporation in 1871 under the laws of Ontario and, as such, is exempt from income taxes.

2 Significant accounting policies

These financial statements have been prepared by management in accordance with Canadian accounting standards for not-for-profit organizations.

a) Financial instruments

The College initially measures its financial assets and financial liabilities at fair value. The College subsequently measures all financial assets and financial liabilities at amortized cost.

b) Property and equipment

Property and equipment are recorded at cost. Amortization is provided over the estimated useful lives of the assets at the following annual rates:

Buildings	4% declining balance
Furniture and equipment	15% declining balance
Computer equipment	straight line over 3 years
Computer software	straight line over 2 years

The above rates are reviewed annually to ensure they are appropriate. Any changes are adjusted for on a prospective basis. If there is an indication that the assets may be impaired, an impairment test is performed that compares carrying amount to net recoverable amount. There were no impairment indicators in 2023.

c) Revenue recognition

i) Fees

The College's principal source of revenue is registrant and pharmacy fees which are recognized as revenue in the period to which these fees relate. Registrant and pharmacy fees received in the current year, applicable to a subsequent year are recorded as deferred revenue on the statement of financial position and will be accounted for in income in the year to which they pertain.

ii) Investment income

Investment income consists of interest and is recognized as earned.

iii) Discipline cost recoveries

Discipline cost recoveries are recognized in the year in which the files have been settled and costs have been awarded.

iv) Other revenues

All other revenues being registration and other fees, rental income and other miscellaneous income are recognized as revenue when services are provided or as earned.

2 Significant accounting policies continued

d) Management estimates

The preparation of the College's financial statements in conformity with Canadian accounting standards for not-for-profit organizations requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the year.

Key areas where management has made difficult, complex or subjective judgments, often as a result of matters that are uncertain, include, among others, accounts receivable valuation, useful lives for amortization of property and equipment and other assets and liabilities valuation. Actual results could differ from these and other estimates, the impact of which would be recorded in future periods. Estimates and underlying assumptions are reviewed on an ongoing basis.

3 Accounts receivable

As at December 31		**2023**		2022
Accounts receivable and cost recoveries from registrants	**$**	**567,465**	$	962,299
Allowance for impaired receivables		**(398,259)**		(746,237)
Net		**169,206**		216,062
HST receivable		**149,525**		132,923
Accrued interest and other receivables		**70,711**		79,332
	$	**389,442**	$	428,317
Current portion		**366,611**		385,442
Long term portion - due 2025 to 2026 (2022 - due 2024 to 2026)		**22,831**		42,875
	$	**389,442**	$	428,317

4 Investments

As at December 31		**2023**		2022
Guaranteed investment certificates				
5.11%, maturing December 13, 2024, redeemable before maturity	**$**	**9,600,000**	$	-
5.69%, maturing December 16, 2024, not redeemable before maturity		**5,000,000**		-
4.95%, maturing September 5, 2024, redeemable before maturity		**2,000,000**		-
4.25%, maturing December 15, 2023, redeemable before maturity		**-**		7,000,000
1.50%, maturing March 20, 2023, not redeemable before maturity		**-**		5,000,000
	$	**16,600,000**	$	12,000,000

5 Property and equipment

As at December 31	2023		2022	
	Cost	**Accumulated amortization**	Cost	Accumulated amortization
Land	**$ 31,394**	**$ -**	$ 363,134	$ -
Buildings	**4,527,906**	**2,494,715**	6,738,547	3,599,554
Furniture and equipment	**702,097**	**399,448**	727,054	354,857
Computer hardware	**938,757**	**763,926**	851,844	690,707
Computer software	**399,323**	**399,323**	507,973	507,973
	$ 6,599,477	**$ 4,057,412**	$ 9,188,552	$ 5,153,091
Net book value		**$ 2,542,065**		$ 4,035,461

6 Net assets - internally restricted

The Board of Directors of the College has internally restricted net assets to be used for specific purposes. These funds are not available for unrestricted purposes without approval of the Board.

As at December 31	**2023**	2022
Investigations and hearing reserve fund	**$ 1,300,000**	$ 1,300,000
Contingency reserve fund	**9,400,000**	7,900,000
	$ 10,700,000	$ 9,200,000

a) Investigations and hearings reserve fund

The Investigations and Hearings Reserve Fund is designated to cover external legal costs for the conduct of inquiries, discipline hearings, fitness to practice hearings and appeals which exceed annual budget provisions for those activities.

b) Contingency reserve fund

The Contingency Reserve Fund is designated to provide for extraordinary expenses that exceed or fall outside of the provisions of the College's operating budget and to fund the College's obligations in extreme circumstances as determined and approved by the Board of Directors.

7 Commitments

a) The College entered an agreement with Think Research (formerly Pharmapod Canada Limited) in December 2020 for a term of five years to provide a medication incident reporting system. The annual future payments are estimated to be $1,300,000.

b) The College entered an agreement for the development and implementation of computer software. The future payments are estimated to be $1,400,000 for 2024.

7 Commitments continued

c) The College has indemnified its past, present and future directors, officers and volunteers against expenses (including legal expenses), judgments and any amount actually or reasonably incurred by them in connection with any action, suit or proceeding, subject to certain restrictions, in which they are sued as a result of their involvement with the College, if they acted honestly and in good faith with a best interest of the College. The College has purchased directors' and officers' liability insurance to mitigate the cost of any potential future suits and actions, but there is no guarantee that the coverage will be sufficient should any action arise.

In the normal course of operations, the College has entered into agreements that include indemnities in favour of third parties, either express or implied, such as in service contracts, lease agreements and purchase contracts. In these agreements, the College agrees to indemnify the counterparties in certain circumstances against losses or liabilities arising from the acts or omissions of the College. The terms of these indemnities are not explicitly defined and the maximum amount of any potential liability cannot be reasonably estimated.

8 Credit facility

The College has a credit facility available in the amount of $1,500,000 bearing interest at bank prime rate, subject to certain terms and conditions. At December 31, 2023, the facility had not been drawn upon.

9 Financial instruments

The College is exposed to various risks through its financial instruments. The following analysis provides a measure of the College's risk exposure at the statement of financial position date.

General objectives, policies and processes

The Board of Directors has overall responsibility for the determination of the College's risk management objectives and policies.

Credit risk

Credit risk is the risk that one party to a financial instrument will cause a financial loss for the other party by failing to discharge an obligation. The College is exposed to credit risk through its cash, investments, and accounts receivable and cost recoveries from registrants.

Accounts receivable from registrants are generally unsecured. This risk is mitigated by the College's requirement for registrants to pay their fees in order to renew their annual license to practice. The College also has collection policies in place.

Credit risk associated with cash and investments is minimized by ensuring that these assets are invested in financial obligations of a major Canadian financial institution. All funds are held by one major Canadian financial institution and therefore a concentration risk exists. Balances exceed the maximum insured amount.

Liquidity risk

Liquidity risk is the risk that the College will not be able to meet a demand for cash or fund its obligations as they come due. The College meets its liquidity requirements and mitigates this risk by monitoring cash activities and expected outflows and holding assets that can be readily converted into cash, so as to meet all cash outflow obligations as they fall due.

Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk is comprised of currency risk, interest rate risk and equity risk.

The College is not exposed to currency or equity risk.

9 Financial instruments continued

Market risk continued

Interest rate risk

Interest rate risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate due to changes in market interest rates. The exposure of the College to interest rate risk arises from its interest bearing investment and cash. The primary objective of the College with respect to its fixed income investments ensures the security of principal amounts invested and achieves a satisfactory investment return giving consideration to risk.

Changes in risk

There have been no significant changes in risk exposures from the prior year.

ONTARIO COLLEGE OF PHARMACISTS
Schedule I
Board and Committee

Year ended December 31	2023	2022
Board of directors	**$ 142,684**	$ 99,907
Committees		
Accreditation	**5,107**	5,133
Discipline	**320,278**	383,497
Drug preparation premises (DPP)	**2,262**	2,717
Executive	**3,202**	4,920
Finance and audit	**3,811**	26,618
Fitness to practice	**9,104**	16,994
Governance and screening committees	**11,243**	8,421
Inquiries, complaints and reports (ICRC)	**95,064**	99,607
Patient relations	**41,355**	35,480
Quality assurance	**8,457**	5,876
Registration	**17,095**	23,067
	$ 659,662	$ 712,237

Schedule II
Personnel

Year ended December 31	2023	2022
Salaries	**$ 17,320,607**	$ 14,577,725
Benefits	**3,399,317**	2,855,385
Termination costs	**878,209**	-
Personnel costs - other	**605,568**	446,766
	$ 22,203,701	$ 17,879,876

ONTARIO COLLEGE OF PHARMACISTS
Schedule III
Regulatory Programs

Year ended December 31	2023	2022
Association fees - NAPRA	**$ 139,407**	$ 132,769
Communication initiatives	**17,661**	26,676
Election expenses	**5,667**	5,650
Examinations, certificates and registrations	**271,858**	234,436
Health inquiry / investigation & intake	**27,983**	52,284
Legal - conduct external	**1,036,265**	1,192,378
Legal - regulatory	**25,595**	57,153
Medication safety programs	**1,374,002**	1,376,090
Practice assessment of competence at entry	**75,861**	79,329
Practice input initiatives	**72,525**	90,958
Professional development / remediation	**1,952**	-
Professional health program	**80,799**	77,052
Quality assurance - program administration	**106,417**	134,293
	$ 3,235,992	$ 3,459,068

Schedule IV
Operations

Year ended December 31	2023	2022
Association fees - general	**$ 12,898**	$ 14,804
Audit	**30,800**	28,800
Bank / credit card charges	**601,442**	535,731
Consulting - operations	**375,739**	367,524
Courier and delivery	**3,758**	3,860
Information system maintenance	**606,891**	619,618
Insurance - errors and omissions	**7,476**	7,176
Legal - operations	**69,794**	25,370
Niagara Apothecary:		
Expenses	**56,409**	46,584
Sales and donations	**(20,412)**	(14,877)
Office services equipment leasing and maintenance	**13,253**	12,621
Postage	**4,781**	2,166
Property:		
Expenses	**358,655**	351,695
Rental income	**(1,815)**	(108,285)
Publications - annual report and Pharmacy Connection	**10,515**	8,833
Subscriptions	**41,750**	38,466
Supplies and stationery	**37,449**	28,203
Telecommunications	**235,415**	204,872
Travel	**327,075**	222,892
	$ 2,771,873	$ 2,396,053

BOARD BRIEFING NOTE

MEETING DATE: MARCH 2024

FOR DECISION X	**INFORMATION**
From:	Finance and Audit Committee
Topic:	Changes to *Board Policy 4.12 - Investments*
Issue/Description:	Revisions to the Board Investments Policy based on recommendations from the Investment Manager

Public interest rationale: The Board Investments Policy guides the College in seeking the highest return on investment of its reserve funds and revenue collected but not yet required to fund operating expenses. Prudently investing those funds and revenue strengthens the College's overall financial health and, as such, its ability to execute its legislative mandate to protect the public now and in the future. The proposed amendments will enable investments that may achieve a potentially higher return.

Strategic alignment, regulatory processes, and actions: Enabling investments that may achieve a higher potential return was the intent of the Board Investment Policy revisions in 2022.

Background:

- In December 2022, the Board approved the revised *Board Policy 4.12 – Investments* and the supporting *Investment Policy Statement and Procedures for Reserve Funds* aimed at diversifying the financial assets within the College's Reserve Funds. The goal was to enhance the potential for increased investment income while maintaining liquidity and preservation of capital.
- To achieve the goal of increasing investment income while maintaining an acceptable level of risk, the revised Investment Policy mandates that investments:
  - must be short-term, interpreted as having a maturity term between 1 and 5 years; and
  - are only permitted within six distinct categories, with a minimum and maximum allocation for each category.
- Following the policy's approval, Frank Teti, Senior Portfolio Manager from BMO Nesbitt Burns, was selected as the Investment Manager for the Ontario College of Pharmacists.
- Upon reviewing *Board Policy 4.12 – Investments* and the supporting *Investment Policy Statement and Procedures for Reserve Funds*, Frank Teti recommended two changes to potentially achieve higher returns.

Analysis:

- After carefully reviewing the Board Investment Policy and supporting document, Frank Teti identified the following areas to achieve a potentially higher return, considering the current economic climate and investment outlook.

Area of Improvement	Concern	Improvement Suggestion[1]
1. Diversification of Fixed Income Investments	Restricting short-term fixed-income investments, currently 1 to 5 years as per the current Investment Policy, may hinder potential gains and diversification.	*Expand fixed income investment timeline options*: include mid-term (5 to 10 years) fixed-income investments in the College's portfolio, adding duration diversification, potentially leading to higher returns.
2. Streamlining Investment Categories	The six investment categories may be overly complex and restrictive.	*Consolidate investment categories*: reduce the number of investment categories from six to three, simplifying the selection process and optimizing investment choices.

- Recognizing the intention of the proposed changes to increase earnings and better protect against inflation, it is imperative to consider the Board's financial risk appetite statement in combination with the risks associated with the proposed changes. The new asset mix may be more or less optimal than the mix outlined in the existing policy. In addition, longer-term fixed-income investments are susceptible to interest rate fluctuations, potentially creating unfavourable conditions when funds are required for early redemption.
- The Finance and Audit Committee reviewed Frank Teti's suggestion on March 4, 2024, and subsequently passed a motion to approve the recommended changes for recommendation to the Board.

Recommendation:

That the Board vote on the following motion: **That the Board approve the proposed changes to *Board Policy 4.12 – Investments* and the supporting *Investment Policy Statement and Procedures for Reserve Funds*:**

- **expanding the fixed income investment timeline options; and**
- **consolidating of investment categories.**

Next Steps:

- The policy will be updated, pending the Board's approval of the recommendation. Furthermore, Frank Teti will be informed of the Board's direction.

Attachments:

1. Details of recommended changes to *Investment Policy Statement and Procedures for Reserve Funds*.
2. *Board Policy 4.12 – Investments* and the supporting *Investment Policy Statement and Procedures for Reserve Funds*.

[1] See attachment 1 for more detail.

Attachment 1

Recommended changes to the *Investment Policy Statement and Procedures for Reserve Funds* (page 5).

The Contingency Reserve Fund (Current and Proposed by Frank Teti, BMO Nesbitt Burns)

Investment Category		Benchmark		Policy Allocation		Minimum and Maximum Ranges			
						Current		Proposed	
Current	Proposed	Current	Proposed	Current	Proposed	Minimum	Maximum	Minimum	Maximum
Cash and cash equivalents	Cash and cash equivalents	FTSE Canada 91 Day T- Bill Index	FTSE Canada 91 Day T- Bill Index	10%	10%	5%	15%	5%	15%
Canadian Short-Term Fixed Income	**Fixed Income**	FTSE Canada Short Term Overall Bond Index	50% FTSE Canada Short Term Overall Bond Index **and 50% FTSE Canada Mid Term Overall Bond Index**	45%	**70%**	35%	55%	**55%**	**85%**
Canadian Short Term Corporate Bonds		FTSE Canada Short Term Corporate Bond Index		25%		20%	30%		
Canadian Equity	**Equities**	S&P/TSX Capped Composite Index	50% S&P/TSX Capped Composite Index / 45% S&P 500 Index ($Cad) / 5% MSCI EAFE Net ($Cad)	6%	**20%**	3%	9%	**11%**	**31%**
U.S. Equity		S&P 500 Index ($Cad)		10%		6%	14%		
International Equities		MSCI EAFE Net ($Cad)		4%		2%	6%		
Total				100%	100%				

Attachment 2

Policy 4.12 Investments

Purpose:

To ensure a shared understanding of the intentions and limitations respecting the investment of College funds. The goal underlying this policy is to ensure that the funds are invested in a prudent and diversified manner within the context of the *Trustee Act*.

Application:

This policy applies to:

The College Staff – who will administer the investment of College funds.

The Finance and Audit Committee – who will direct investment advisors and monitor the investments as part of their oversight responsibilities as set out in the by-laws.

The Board of Directors – who shall approve the *Investment Policy Statement and Procedure for Reserve Funds* and receive a report at the end of each fiscal year on the status of the College's investments as set out in the audited financial statements.

Policy:

In accordance with the College by-laws, surplus funds, including those allocated to a Reserve Fund, may be deposited for safekeeping and withdrawn, from time to time, with one or more chartered bank, trust company or other financial institution.

Procedure

1. The Board may establish Reserve Funds as required. At the end of each fiscal year, an allocation from any excess of revenue over expenses shall be made to maintain the Reserve Funds as established by the Board.

2. Surplus funds not allocated to Reserve Funds, and not needed to meet the College's operating expenses in the immediate future, may be invested in short-term instruments with a term of 0 days to 18 months or in a pool of such investments. The primary objectives of such investments, in order of importance, shall be maintenance of liquidity, preservation of capital and yield.

Acceptable Investments shall include:

- Debt obligations issued or guaranteed by the Government of Canada or its agencies or Crown Corporations or managed pools of such instruments. The College may invest in individual instruments or a managed portfolio of Government of Canada guaranteed securities.

- Debt obligations issued or guaranteed by Canadian, provincial or territorial governments, banks listed in Schedule I or Schedule II under the *Bank Act* (Canada), or Canadian corporations or managed pools of such instruments. The College may invest in high quality debt obligations issued or guaranteed by Canadian, provincial, or territorial governments, and banks incorporated in Canada or Canadian corporations, or in a managed fund of such securities. All investments will be with issuers who have a long-term credit rating of at least AA low (Dominion Bond Rating Service) or its equivalent or a short-term credit rating of R-1 Mid (DBRS) or its equivalent.

3. The Director of Corporate Services (DCS) is responsible for the administration of the College's surplus funds.

4. The Reserve Funds may be invested in accordance with the *Investment Policy Statement and Procedure for Reserve Funds* approved by the Board.

Approval Date: December, 2022
Last Review: October, 2022
Last Revision: 2018
Next Review Date: 2024

INVESTMENT POLICY STATEMENT AND PROCEDURE FOR RESERVE FUNDS

Ontario College of Pharmacists

Effective: December 2022

CONTENTS

1

Overview

Purpose and Scope

1.1 The Council of the Ontario College of Pharmacists (“the College”) has established reserve funds in order to cover variable and/or unforeseen costs and expenses. The purpose of this Policy is to summarize the nature of the funds and to set out the investment objectives and guidelines under which the funds are to be invested.

1.2 In developing the Policy, the College has considered the obligations and objectives of the funds as well as applicable regulatory requirements.

Nature of the Funds

1.3 The Ontario College of Pharmacists

The Ontario College of Pharmacists, incorporated in 1871, is the registering and regulating body for the profession of pharmacy in Ontario. The College’s mandate, established through legislation and expressed through associated objects, is to serve and protect the public interest and hold Ontario's registered pharmacists and pharmacy technicians accountable to the established legislation, standards of practice, Code of Ethics and policies and guidelines relevant to pharmacy practice.

The College also regulates and accredits community and hospital pharmacies, holding them accountable to operational standards and relevant policies and legislation; pharmacies must be accredited by the College in order to operate in Ontario.

In accordance with the College By-Law, surplus funds, including those allocated to a reserve fund, may be deposited for safekeeping and withdrawn, from time to time.

1.4 The Investigations and Hearings Reserve Fund

The Fund is designated to cover costs that exceed budget provisions for activities relating to external legal costs of the conduct of inquiries, investigations, discipline hearings, fitness to practice hearings, and appeals.

1.5 The Contingency Reserve Fund

The Fund is designated to provide for extraordinary expenses that exceed or fall outside of the provisions of the College’s operating budget and are not otherwise covered by the Investigations and Hearings Reserve Fund or to fund the College’s obligations in extreme circumstances as determined and approved by the Board including in the event that the College ceases to exist as a statutory corporate body.

Governance

1.6 The Board is the legal trustee and administrator of the Fund and is therefore responsible for all matters relating to the administration, interpretation and application of the Fund, including developing, monitoring and amending this Policy.

1.7 The Board has delegated certain responsibilities to The Finance and Audit Committee, including monitoring of the Fund and its investments, appointing and terminating investment managers and advisors to the Fund, reporting to the Board on the performance of the Fund and recommending changes to the Fund and this Policy. The Finance and Audit Committee is supported by The College Staff.

Beliefs

1.8 The Board has from time to time reviewed and confirmed the investment beliefs which guide it when decisions are made concerning this Policy and under the authority of this Policy. Currently, the Board of Directors believes:

- that each Fund should be invested in a matter that considers its time horizon, liquidity, risk tolerance, and operational considerations;
- that the Fund should be substantially fully invested because long-term cash holdings will reduce long-term rates of return;
- that it is prudent to diversify the Fund across multiple holdings or asset classes to minimize the risk of large losses, and without undue reliance on a single security, market and/or strategy;
- that investing in pooled investment vehicles provides a more cost-effective way to achieve diversification;
- that equity investment will generally provide greater long-term returns than fixed income investments, although with greater volatility;
- that an allocation to foreign equities increases portfolio diversification and thereby decreases the volatility of returns;
- that debt securities have a role in the Fund because they reduce the volatility of returns, provide a hedge against deflation;
- that a passive management approach shall be considered where there is a belief that indexing is an efficient and cost-effective means to gain exposure to an asset class. An active management approach may be used where a belief is held that the manager can add value above the benchmark on an after-fee basis and/or reduce the volatility of returns.

2

Investment Policies

Diversification

2.1 Asset mix diversification is the key risk management strategy and the Board shall review the asset mix policy at least every four years to ensure it aligns with the overall objectives of the Fund.

2.2 The use of broadly diversified investment funds is an additional risk management strategy used to mitigate risks associated with any one particular security, country, region, industry and currency.

2.3 When investing in guaranteed investment certificates, the use of holding multiple investments with different institutions, holding periods and interest rates help to mitigate risks associated with any one particular security.

Investment Objective

2.4 The primary investment objective of the Funds is to preserve real capital. The Board recognize that short term market volatility may cause temporary losses in the market value of the Fund.

2.5 The long-term investment objective of the Funds are to achieve a nominal annual rate of return equal to the return that could have been earned by passively investing in the Benchmark Index outlined below on a rolling 4-year basis. However, in any one year the annual rate of return may be above or below this objective.

2.6 In order to achieve the return objective of the Funds at an acceptable level of volatility, the Fund will be invested in the following asset classes, subject to the following minimum and maximum aggregate investment limits:

The Investigations and Hearings Reserve Fund

Investment Category	Benchmark	Policy Allocation	Minimum	Maximum
Cash and cash equivalents	FTSE Canada 91 Day T-Bill Index	50%	40%	60%
Canadian Short-Term Fixed Income	FTSE Canada Short Term Overall Bond Index	15%	10%	20%
Canadian Short Term Corporate Bonds	FTSE Canada Short Term Corporate Bond Index	25%	20%	30%
Canadian Equity	S&P/TSX Capped Composite Index	3%	1%	6%
U.S. Equity	S&P 500 Index ($Cad)	5%	2.5%	7.5%
International Equities	MSCI EAFE Net ($Cad)	2%	1%	4%
Total		100%		

The Contingency Reserve Fund

Investment Category	Benchmark	Policy Allocation	Minimum	Maximum
Cash and cash equivalents	FTSE Canada 91 Day T-Bill Index	10%	5%	15%
Canadian Short-Term Fixed Income	FTSE Canada Short Term Overall Bond Index	45%	35%	55%
Canadian Short Term Corporate Bonds	FTSE Canada Short Term Corporate Bond Index	25%	20%	30%
Canadian Equity	S&P/TSX Capped Composite Index	6%	3%	9%
U.S. Equity	S&P 500 Index ($Cad)	10%	6%	14%
International Equities	MSCI EAFE Net ($Cad)	4%	2%	6%
Total		100%		

2.7 The College shall monitor the asset mix relative to the target asset mix at least quarterly. Rebalancing shall occur if any of the constraints set out in the above table are not met.

Rebalancing will be performed by the Investment Advisor at the direction of the Director of Corporate Services within two quarters of an imbalance being identified, using either or both of (1) redirecting net cash flows to and from the Fund; and, (2) transfers of cash between portfolios.

Should a transfer of cash between portfolios be required (because cash flows alone cannot rebalance allocations within two quarters), the Director of Corporate Services will arrange for

the Investment Advisor to place trades to effect such transfers between funds so as to bring the allocation to within the permitted ranges.

2.8 Notwithstanding the investment limits stated in this Section, the Finance and Audit Committee may authorize temporary asset mix positions outside those ranges.

Derivatives, Options, and Futures

2.9 Derivatives such as options, futures, swaps, forward contracts on any securities including indices are permitted investments. Derivatives may be used to:

- hedge fully or partially any investment risk, including market, interest rate, credit, and liquidity risk; or
- replicate direct investments in the underlying assets or group of assets so as to achieve some advantage of lower cost, transactional ease or market exposure.

Derivative investment is permitted only through the investment of an Investment Fund. Derivatives shall not be used to create leverage or for speculative purposes.

Permitted Investments and Investment Guidelines

2.10 The following broad categories of investments are permitted for the Fund:

- Equities;
- Fixed Income;
- Cash, demand deposits, guaranteed investment certificates (GICs) and money market securities.

Investment Funds

2.11 Where investments are made through pooled funds and exchange traded funds, those investments are to be governed in accordance with the investment policy of the pooled fund. The College shall satisfy itself that the pooled fund investment policy is generally consistent with the objectives and risk tolerances expressed in this Policy.

Performance Measurement Monitoring

2.12 Investment performance will be reviewed on a quarterly basis by the Finance and Audit Committee and reported to the Board at least annually.

2.13 Performance of an investment manager will be evaluated with respect to an appropriate market index.

2.14 For the purpose of measuring rates of return, all returns shall be measured before investment management fees, but after transaction costs, and over rolling four-year periods. All index returns shall be total returns. All foreign index returns shall be Canadian dollar returns.

Selection, Monitoring and Termination of Investment Managers

2.15 The selection and monitoring of investment managers by the Finance and Audit Committee

involves consideration of both qualitative and quantitative factors, which may include:

- Investment performance relative to benchmark and/or peers;
- Overall adherence to this Policy;
- Characteristics of the firm and organization and evaluation of any changes to the firm or key personnel; and
- Competitiveness of fees and expenses.

2.16 If an investment manager fails to meet the criteria used for selection and monitoring, the Finance and Audit Committee shall consider whether further action should be taken, as appropriate.

3

General Policies

Conflicts of Interest

3.1 "Affected Persons" means Board, Finance and Audit Committee, and College staff.

3.2 A conflict of interest is defined as any direct, indirect, actual or perceived material pecuniary interest of an Affected Person in, or any other direct or indirect personal benefit, actual or perceived, to be derived by an Affected Person from any arrangement, contract, investment, transaction or other matter related to the Affected Person's duties or powers with respect to the Funds.

3.3 Each Affected Person shall adhere to Board Policy 3.9 Conflicts of Interest.

Lending of Securities

3.4 Other than through making investments as allowed by this Policy, assets of the Funds shall not be loaned to any party. Pooled Funds may lend securities if permitted under their investment policies.

Voting Rights

3.5 With respect to the portion of the Fund invested in pooled funds, the authority for exercising all voting rights is delegated to the investment manager of the pooled fund, to be exercised in accordance with the pooled fund's policies.

3.6 With respect to the portion of the Fund invested in segregated mandates where individual securities are beneficially owned by the Fund, the authority for exercising all voting rights is delegated to the investment manager of the segregated mandate, provided that the Finance and Audit Committee reserves the right to direct or override the voting decisions of the investment manager if, in its view, such action is in the best interests of the Fund and its beneficiaries.

3.7 Any rights acquired to exercise the votes of pooled fund units and interests in partnerships or limited partnership within the Fund shall be the responsibility of the Finance and Audit Committee, which shall vote in the best interests of the Fund's beneficiaries.

Custody

3.8 To maintain a proper segregation of duties and adequate controls, all securities held must remain with third-party custodians.

Valuation of Investments

3.9 Investments in pooled funds shall be valued according to the unit values published by the investment manager.

3.10 If any of the Fund assets are invested in assets or securities that are not regularly traded at a marketplace, then such securities will be valued at least once annually by the custodian and its agents. Where deemed by the Finance and Audit Committee to be prudent and cost effective, external independent valuations will be obtained. In the absence of any other valuation by the Trustee or independent appraiser, such assets or securities will be held at their book value.

3.11 With respect to the portion of the Fund invested in segregated mandates where individual securities are beneficially owned by the Fund:

- Investment in publicly traded securities shall be valued at their fair market value no less frequently than monthly.
- If a market valuation of an investment is not readily available, then, where expertise exists, the security will be valued at least monthly by the Investment Manager using best judgment in consultation with market makers. Securities that fall outside this area of expertise will be valued by external, independent, qualified specialists that will be retained at a minimum of once per calendar year.
- Derivatives not traded over public exchanges will be valued by an entity independent of the counterparty to the derivative transaction.

Liquidity of Investments

3.12 Investment of the assets will be undertaken with a view to providing for sufficient liquidity to enable the Fund to meet its obligations as they become due.

Compliance Reporting by the Investment Manager(s)

3.13 The investment managers are responsible for completing a compliance report each quarter. The compliance report should indicate whether or not the manager was in compliance with the established investment guidelines throughout the quarter. Where the Fund is invested in a manager's pooled fund, the manager will report on compliance with the pooled fund policy.

3.14 In the event that a manager is not in compliance with the guidelines, the manager is required to detail the nature of the non-compliance and recommend an appropriate course of action to remedy the situation.

Standard of Professional Conduct

3.15 The investment managers are expected to comply, at all times and in all respects, with the Code of Ethics and Standards of Professional Conduct as promulgated by the CFA Institute.

3.16 The investment managers will manage the Fund with the care, diligence and skill that an investment manager of ordinary prudence would use in dealing with assets of another

person. The investment manager will also use all relevant knowledge and skill that it possesses or ought to possess as a prudent investment manager.

Review and Approval of Policy

3.17 The Finance and Audit Committee shall review the Policy periodically, but in any event no less than annually. Amendments to the Policy require approval by the Board.

BOARD BRIEFING NOTE

MEETING DATE: March 25, 2024

FOR DECISION

From: Katya Masnyk, Director, Policy, Engagement and Strategy Implementation

Topic: Time-Delayed Safes - Revised Policy

Issue/Description: The previously approved Time-Delayed Safes policies have been updated to address recent issues that came to light during implementation. The Board is being asked to review the updated policy and approve it.

Public interest rationale: Armed robberies involve the threat and/or use of violence. The universal installation of time-delayed safes and accompanying signage has been shown in other jurisdictions to deter robberies, thereby protecting patients and pharmacy personnel in community pharmacies.

Strategic alignment, regulatory processes, and actions: A single updated time-delayed safes policy aligns with the College's guiding principles of risk-based and right-touch regulation by acting to reduce or prevent harm in a very high-risk situation. The creation of a single policy also aligns with Strategic Goal #2 – focusing on clear, up-to-date, and relevant information for registrants and members of the public.

Background: In March of last year, the Ontario College of Pharmacists (OCP) approved the mandatory use of time-delayed safes and College-approved public signage in all community pharmacies to deter armed robberies. These requirements were established by amending two existing policies, Medication Procurement and Inventory Management and Required Signage in a Community Pharmacy.

To support the province-wide approach recommended by the Ontario Association of the Chiefs of Police (OACP) (December 2022 meeting materials, page 153), signage was made available in October 2023 once over 80% of pharmacies had declared their time-delayed safe installed. Printing and posting instructions for signage were emailed directly to Designated Managers and published on the OCP website's Pharmacy Safety Initiative page.

For reference:

- September 2022 Board Meeting Materials: Pharmacy Safety Initiative Briefing Note p. 118
- December 2022 Board Meeting Materials: Pharmacy Safety Initiative Briefing Note p. 143
- March 2023 Board Meeting Materials: Pharmacy Safety Initiative Briefing Note p. 41

Analysis: In January 2024, data from 104 community operational assessments completed in November and December 2023 indicated only 59% of pharmacies were fully compliant with the signage requirements, despite over 90% of pharmacies declaring they had a time-delayed safe installed. The operational assessments also revealed that in some instances, safes were not being used properly, for example, operations advisors observed safes left open or unlocked for extended periods, and/or personnel were using override codes or keys to bypass the time-delay.

In addition, the College continues to receive inquiries about our requirements: 60% of inquiries about time-delayed safes since October 2023 were related to signage. Responses to these inquiries often involve referring the Designated Manager to multiple information sources:

- Two separate policies
- Pharmacy Safety Initiative webpage
- Printing and posting guidelines

- e-Connects
- Direct emails to Designated Managers

The College also received inquiries about implementation of time-delayed safes and signage in exceptional situations. For examples, 1) certain pharmacies such as pharmacies providing central fill services must meet stringent security requirements if they hold a Health Canada dealer's license; and 2) pharmacies with sophisticated security systems that are exclusively service providers for licensed long-term care homes. The new policy acknowledges that there may be alternative storage methods that meet or exceed the time-delayed safe specifications as described in the original policies.

A single, standalone Time-Delayed Safes policy has been developed to efficiently and proactively address the issues highlighted above. The updated policy:

- Addresses questions around implementation by clarifying policy scope and definitions;
- Consolidates information for registrants into a single source;
- Addresses a few key operational gaps (e.g., the use of override codes, the acceptability of stronger safes);
- Strengthens wording related to the College's expectations around the proper use and specifications of signage.

Substantively, the updated policy is identical to previous Board direction, pulling relevant information from the two existing policies.

Motion: That the Board approve the updated Time-Delayed Safes Policy.

Operational considerations: To support implementation, College staff will launch a communications plan to inform Designated Managers of the updated policy, highlighting policy clarifications, the importance of using the safe properly and posting the required signage correctly.
The College will continue to monitor compliance with the Time-Delayed Safes Policy through operational assessments.

Attachments:

- 9.1 - Draft Time-Delayed Safes Policy
- 9.2 - Jurisdictional Scan of Provinces with a Time-Delayed Safes Policy/Standard

Time-Delayed Safes Policy

Scope Statement

This policy applies to all accredited community pharmacies and remote dispensing locations with a dispensary. It does not apply to accredited hospital pharmacies or remote dispensing locations with an automated pharmacy system.

Purpose

This policy articulates the College's expectations of the Designated Manager (DM) with respect to meeting the Standards of Accreditation and Standards of Operation for the storage of narcotics. It should be read and applied in conjunction with the above standards and the Designated Manager policies.

The Standards of Accreditation require every pharmacy to have the necessary equipment to ensure the safe and appropriate storage of drugs. The Standards of Operation dictate that controlled substances must be stored and managed according to national guidelines and provincial requirements.

Definitions

Designated Manager (DM): The Part A pharmacist designated by the owner(s) and reported to the College as responsible for managing the pharmacy. The DM carries the same liability for the operation of the pharmacy as the owner(s). (DPRA, Standard of Operation)

Narcotic: Any product or preparation which contains a drug named in the Schedule to the federal *Narcotic Control Regulations*. (NCR)

Remote Dispensing Location: A place where drugs are dispensed or sold by retail to the public under the supervision of a pharmacist who is not physically present. (O. Reg. 264/16)

Time-delayed safe: A safe that is constructed of solid metal and contains an integrated electronic locking mechanism with a time-delayed release.

Policy

Storage of Narcotics

All narcotics must be kept in a time-delayed safe located inside the dispensary. This includes unusable inventory awaiting local destruction or return to a licensed dealer.

- The safe must be secured in place, preferably to the floor, or of a size and weight that it cannot easily be removed.
- Exclusions:
    - Exempted ("Low-Dose") Codeine Preparations that may be sold without a prescription.
    - Prepared prescriptions awaiting pick up.
    - Post-consumer waste in the Ontario Medication Return Program.

The **time-delayed release must be set to a minimum of five minutes**.

- Longer times may be warranted depending on the location of the pharmacy and law enforcement response times.

The use of override codes, keys, or other methods to bypass the time-delay are **strictly prohibited**.

- Access to safe codes should be restricted to as few employees as possible.

The door of the time-delayed safe must **always remain closed and locked**, opened only to:

- Retrieve stock to fill a prescription or perform a physical count.
- Return stock after filling a prescription or performing a physical count.
- Put away stock immediately upon receipt of an order from a wholesaler.

Temperature-sensitive narcotics must be stored in a locked refrigerator or in a refrigerator inside a locked room.

Signage

Prominent signage provides a consistent, province-wide deterrent message that the additional security measure of a time-delayed safe is in place. The following are required to be clearly displayed where they are readily visible to the public:

Community Pharmacy:

- At each public entrance, an 11” x 17” ‘Narcotics Secured in a Time-Delayed Safe’ sign.
- At the area(s) where a patient should approach the dispensary, an 8.5” x 11” *or* 11” x 17” ‘Narcotics Secured in a Time-Delayed Safe’ sign.

Remote Dispensing Location with a dispensary:

- At each public entrance, an 11” x 17” ‘No Narcotics on Site’ sign.
- At the area(s) where a patient should approach the dispensary, an 8.5” x 11” *or* 11” x 17” ‘No Narcotics on Site’ sign.

Sign must be colour printed and securely fastened in place. Damaged, faded, worn or illegible signs must be replaced promptly.

Printing and posting guidelines

- 11”x17” (English | French)
- 8.5”x11” (English | French)

Exceptional situations

Community pharmacies that do not have a safe which conforms to the specifications above must have a secure room or vault with walls and a door meeting Health Canada Directive on Physical Security Requirements *security level - 3* or higher. Entrance doors to the pharmacy must remain locked at all times. There must be at least one door with a time-delayed lock, or at least two secured doors in sequence which take at least 5 minutes to bypass, between the exterior entrance(s) to the building and the narcotic storage area.

Community pharmacies with a Dealer's License issued by Health Canada[1] must have a vault meeting Health Canada Directive on Physical Security Requirements *security level - 3* or higher. These pharmacies may post the 11" x17" signage so it is visible immediately after entering the accredited area.

There are no exceptions for community pharmacies based on their business model or location (e.g., not open to the public, situated in non-residential areas, not on the ground floor of a building, "mail-order" or delivery only, do not have or intend to have narcotics inventory).

Personnel Training

The DM is responsible for establishing written standard operating procedures and for the training and supervision of pharmacy personnel involved in handling narcotics.

Pharmacy personnel, and staff who work in a clinic or other business with a pharmacy on the premises, should receive training on the standards operating procedures, covering topics such as:

- Operation of the time-delayed safe
- Expectations for proper use and signage outlined in this policy
- What to do in the event of an armed robbery
- Reporting of suspicious activity
- Keeping sensitive information about the pharmacy confidential

Legislative References

- *Drug and Pharmacies Regulation Act*, 1990
  - O. Reg. 264/16
- *Controlled Drugs and Substances Act*, 1996
  - *Narcotic Control Regulations*

Additional References

- Designated Manager – Medication Procurement and Inventory Management
- Designated Manager – Professional Supervision of Pharmacy Personnel
- Designated Manager – Required Signage in a Community Pharmacy Policy
- Health Canada – Controlled Substances Guidance for Community Pharmacists: Security, Inventory Reconciliation and Record-Keeping (Jan 2023)

Implementation

Published: March ## 2024
Version #: 1.00
College Contact: Pharmacy Practice

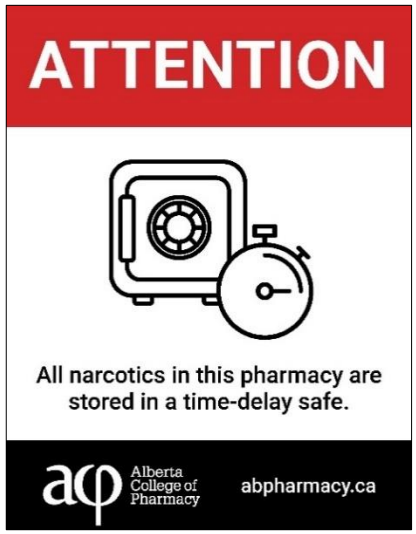
[1] Health Canada's Office of Controlled Substances establishes national guidelines and oversees compliance and enforcement activities related to narcotics under federal legislation.

Revision History

VERSION #	DATE	ACTION
1.00	March ## 2024	New policy created

POLICY ELEMENT	BRITISH COLUMBIA	ALBERTA	SASKATCHEWAN
Timelines	Policy approved: February 20, 2015 Implementation: **September 15, 2015**	Standard approved: September 16, 2021 Implementation: • New pharmacies: **January 1, 2022** • Existing pharmacies: **July 1, 2022**	Policy approved: August 2022 Implementation: • New pharmacies: **November 30, 2022** • Existing pharmacies: **November 30, 2023**
Scope	Community pharmacies and Telepharmacies	Licensed Pharmacies	All pharmacies
Exclusions	Pharmacies that: • Do not stock Schedule 1A drugs *[see "what has to go in the safe" below]* A pharmacy that is never open to the public and has no external signage identifying it as a pharmacy is exempt from the signage requirements.	Pharmacies that: • Do not stock inventory of the drugs described in Standard 5.14 *[see "what has to go in the safe" below]*, • Are institution pharmacies, or • Are compounding and repackaging pharmacies that are not accessible to the public and have alternative security measures in place	None. *[SCPP had considered exempting pharmacies with a dealer's license and met Health Canada's security requirements however they did not have a pharmacy that this would've applied to.]*
Safe require-ments	Metal safe, securely anchored in place, preferably to the floor, equipped with a time delay lock.	Metal safe that is secured in place and equipped with a time delay lock. *Additional guidance provided in article "What qualifies as a "safe"?* The safe must: • Be strong, fireproof, constructed of solid metal • Contain an internal complex locking mechanism, equipped with a certified digital lock operated in conjunction with a time-delay release • Be of a nature that it cannot be easily removed from the facility, either having the ability to be bolted to the ground or having a size and weight that cannot be readily moved • Be large enough to store all drugs	The safe must: • Be strong and constructed of solid steel on all six (6) sides • Have a safe body of at least quarter-inch thick steel (total) and the door must be at least half-inch thick • Contain an internal locking mechanism, equipped with a certified (e.g. Underwriters Laboratories of Canada Inc. (ULC), VdS Schadenverhütung), digital time-delayed lock (i.e. integrated into the safe door) • Be of a nature that it cannot be easily removed from the pharmacy, either by having the ability to be securely anchored in place (preferably to the floor) or by being of a size and weight that it cannot be readily moved
What must go in the safe	• **All Schedule 1A drugs** (Triplicate/Duplicate Prescription Program drugs) [22 narcotics] • Expired narcotics • Raw narcotic materials for compounding	• **All Schedule 1** [prescription] **narcotics** • All drugs designated as type 1 Tracked Prescription Program (TPP) [19 narcotics] • Any drugs required by council	• **All narcotics** • Unusable or expired narcotics

What does *not* have to go in the safe		• Controlled drugs • Schedule 2 narcotics (such as acetaminophen with 8mg codeine) Targeted drugs including benzodiazepines	• Low-dose codeine products; • Temperature-sensitive drugs, which must be stored in a locked refrigerator (e.g. prepared doses of methadone) as per SCPP's Opioid Agonist Therapy (OAT) Standards); and • Drugs returned to the pharmacy (i.e., post-consumer returns)
Time-delay	Minimum of **five** minutes	Minimum of **five** minutes *ACP encourages each pharmacy team to evaluate their pharmacy's specific situation … In some instances, it may be more appropriate to have the time delay set at more than five minutes.*	Minimum of **five** minutes *SCPP encourages the pharmacy manager or proprietor to evaluate their pharmacy's specific situation and set the time-delay at the time that is most appropriate for their location.*
Use of override codes	The use of override codes has been documented on occasion and pharmacies are expected to remove these codes as they defeat the purpose of the safe.	Updated draft standards to state there can be no override code as it defeats purpose of the safe.	Not addressed.
Other direction re: safe use	• The safe should only be open when items are being placed into or removed from the safe. • It is never appropriate for the safe to be left open; this would defeat the purpose of the time-delay lock security measure.	• The door of the safe must remain closed and locked except for times when pharmacy team members need to open the safe as part of the process to fill a prescription or to re-stock the safe. • Once the drugs are accessed to fill the prescription or added to the safe, the safe door must be closed and locked again. • Restrict access, keys, or lock combinations to as few employees as possible	• The door of the safe must remain closed and locked except for times when pharmacy team members need to open the safe as part of the process to fill a prescription or to re-stock the safe. • Once the drugs are accessed to fill the prescription or added to the safe, the safe door must be closed and locked again. • Access to keys or lock combinations must be restricted to pharmacists only. • Dispensing automation may be loaded with a narcotic when it is utilized consistently during a period of time (e.g., completing orders for a nursing home) ○ After orders have been completed, the cell must immediately be removed from the device and stored in the safe

Signage	• Displayed at the dispensary counter and all external entrances. • Sent to all new pharmacies at the time of licensure approval. • Can also be ordered via the e-Services portal. • Can also be downloaded and printed in colour and trimmed to the appropriate size [8.5”x 11” and 5”x 5”]. 	• Displayed in the dispensary and at all external entrances to the pharmacy. • Each pharmacy received two 8.5”×11” posters and two 5”×5” double-sided vinyl decals. • Poster also available for download on the robberies and burglaries page. 	• Displayed on the external entrance doors and at the pharmacy counters. • External entrance door signage must be the SCPP-provided signage in colour. • Pharmacy counter signage may use alternate wording but must look professional. 
Other Policies and Procedures Regarding Pharmacy Security	Policies and procedures should contain information on the following: • Training • Pharmacy security equipment • Emergency Response Kit • Incident review, and • Pharmacy security evaluation Other requirements: • Critical stress debriefing and stress counseling is offered as soon as possible following an incident. • Privacy Breach Response Plan • Annual Incident Review and security evaluation	*[not in Standards; guidance only]* • Administrative/loss prevention policies and procedures • Robbery procedures (what to do during and after)	Not addressed.

Staff Training	Pharmacy managers should ensure that staff members are trained (includes initial training and periodic review/refresher of skills) and retrained at least annually to maintain knowledge of pharmacy security policies and procedures. Training should include instruction on: • Operation of security-related equipment, such as security camera, alarms, safes, etc., • What to do in the event of a pharmacy security breach, and • How to handle potential precursors to robbery (e.g., the presence of suspicious customers and phishing style phone calls)	Train staff members to • Be alert and observant...regularly offer assistance to clients. • Be aware of suspicious behaviour from customers, such as the following: ・Is the visitor looking around or up as if to see if they are being watched or observed? ・Is the customer spending an excessive amount of time looking at the same high-priced merchandise, or loitering outside, by the cashier stations, or near the dispensary? ・Does the customer seem secretive or uneasy when an employee asks if they need assistance? • Make mental or written notes, including descriptions of any of the above … report to pharmacy management.	Not addressed.
Notification to College	• Pharmacy managers notify the Registrar of any incident of loss of narcotic and controlled drug substances through the College's Robbery Prevention Portal within 24 hours. • Pharmacy managers should provide the Registrar with a copy of the mandatory Health Canada report within 10 days of an occurrence.	• Licensees may voluntarily report the details of a robbery and burglary to ACP by completing a report "to help the college look at the issue systemically and make policy decisions that will help pharmacy teams prevent or minimize the possibility of a robbery or burglary." • Report details (including redactions if necessary) will be made available… sharing of information may help other pharmacies take effective preventative measures.	Not addressed.
Other Security Equipment	• Security Camera System • Motion Sensors • Monitored Alarms Systems (optional if a full pharmacist is present at all times and the premise is accessible by non-registrants) • Physical barriers (standard for licensure unless a pharmacist is present at all times)	*[not in Standards; guidance only]* • Display [other] deterrent signage • Physical security measures (barriers, remote locking doors, security lights) • Video surveillance systems • Trackers on drug products • Alarms	Not addressed.

Panic alarms	*From the 2010 Guidelines for Addressing Pharmacy Robbery in B.C.; not by-law or policy:* "Explore the possibility of installing a *silent* panic alarm. Audible alarms are not favoured for robbery offences, as they can induce panic which leads to increased risk from the situation. Local visits to victimized pharmacies would suggest that the presence of these alarms should not give a false sense of security, as the speed of the incident and inability to activate them may prevent them from assisting in the event of a robbery."	*From the document on Robberies and Burglaries, not a Standard of Operation:* "A dedicated robbery alarm under the pharmacy counter and perhaps in an office at the back is ideal. If you have the resources, source out a silent panic alarm system that is connected to your local 911 dispatch."	Not addressed.

References	• PROFESSIONAL PRACTICE POLICY- 74: Community Pharmacy and Telepharmacy Security
	• *Pharmacy Operations and Drug Scheduling Act (PODSA) bylaws* s26(3)
	• DrugSafeBC | College of Pharmacists of British Columbia
		• Standards for the Operation of Licensed Pharmacies (SOLP)
		• Pharmacy robberies and burglaries
		• Several articles such as:
		  ○ Jan 12, 2022
		  ○ July 13, 2022
		  ○ January 11, 2023
			• SCPP Reference Manual: Time Delayed Safes
			• SCOPe articles:
			  ○ October 2023 pg 14
			  ○ December 2023 pg 18

Ontario College of Pharmacists
Putting patients first since 1871

BOARD BRIEFING NOTE
MEETING DATE: March 25, 2024

FOR DECISION

INITIATED BY: Sandra Winkelbauer, Special Projects Manager
Melanie Zabawa, Senior Community Practice Policy Advisor

TOPIC: OCP approved training for compounding supervisors

ISSUE: Pharmacy operational assessments indicate that compounding standards are not being fully met, in part due to insufficient training of compounding supervisors.

PUBLIC INTEREST RATIONALE:
The compounding of non-sterile and sterile preparations (including hazardous) (Appendix 1) in Ontario pharmacies poses potential risk of harm to patients if not done properly and in accordance with minimum safety and quality requirements. To minimize risk of harm, the College adopted National Association of Pharmacy Regulatory Authorities (NAPRA) compounding standards of practice (2016, 2017). Community and hospital pharmacies engaged in compounding are assessed against the standards once every 1-7 years.[1] OCP operational assessment data reveals that there remains a significant compliance gap with the standards.

STRATEGIC ALIGNMENT, REGULATORY PROCESSES AND ACTIONS:
Ensuring compliance with compounding standards aligns with the College's core public protection mandate and our regulatory principle associated with risk. Specifically, "to act to reduce or prevent harm, we use our data to anticipate or measure risk and measure the outcome of our actions to adapt our regulatory response to ensure the most beneficial impact." Compounding has a potential risk of significant harm to patients and therefore meets the threshold for priority regulatory response.[2]

WHAT IS THE PROBLEM?
- Based on previous adverse events, the Theissen Report[3] and other academic research have identified non-sterile and sterile compounding as a risk for patient safety.
- To address concerns for patient safety and recommendations from the Thiessen report, standards of practice and competencies were created (by NAPRA) for sterile and non-sterile compounding. The College adopted standards for sterile compounding in September 2016 and non-sterile compounding in December 2017. Our initial regulatory response for sterile compounding emphasized the critical elements of "people and processes" that are key to minimizing risk to patients.
- Aggregate data from operational assessments in community and hospital pharmacies indicate that compounding standards are not being fully met. (Attachment 10.1)
- Based on expert opinion from OCP operations advisors conducting pharmacy operational assessments, compliance issues are related to: (1) insufficient training; (2) challenges with the risk assessment and (3) the gap between the expectations set out in the standards and the realities encountered in practice.

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[1] Depends on the type of compounding – every 1-2 years for sterile compounding and every 2-7 years for non-sterile compounding.
[2] In keeping with the principles of right touch regulation and OCP's value of discernment.
[3] Thiessen, JJ. A Review of the Oncology Under-Dosing Incident. A Report to the Ontario Minister of Health and Long-Term Care July 12, 2013. 08-09-13-Canada.pdf (SECURED) (fdanews.com)

- According to the registrant survey conducted in February 2024, lack of facilities, staffing and time were the most significant barriers to engaging in compounding and to meeting standards for compounding.
- OCP is addressing patient risk related to compounding for all the factors identified through a multi-pronged approach (including as part of OCP strategic goal 1). This briefing note focuses on the next most common barrier, insufficient training.
- Current compounding standards include an expectation for training, however the expectations, especially for non-sterile compounding, are not specific enough and do not require training mapped to competencies.[4]
- Based on expert opinion from OCP operations advisors, lack of competency-based training, especially for compounding supervisors, affects pharmacies' performance on standards involving policies and procedures, implementing quality assurance programs, and supervising other members of the compounding team.

Problem statement: There are a number of compounding standards that 20 % or more of assessed pharmacies are not meeting, in part due to insufficient training, especially for compounding supervisors.[5,6]

DOES THIS ISSUE WARRANT A REGULATORY RESPONSE?

- Using the principles of right-touch regulation, a regulatory response is warranted if the risk of harm to patients is high.
- OCP's Practice-based Risk Framework (draft) (Attachment 10.2) has identified compounding as a very high risk to patient safety, therefore supporting a strong regulatory response.

Evidence Regarding Risk of Harm

- Compounding errors can have significant impact on patients as demonstrated by the oncology underdosing incident (Thiessen Report[3]) and the Andrew Sheldrick case[7], a child who died due to a compounding error.
- Compounding related medication incidents and patient harm continue to occur, as shown by national level data and OCP's conduct data (see below). More fulsome Ontario level aggregate data regarding incidents and near misses (good catches) involving compounding are not yet available but are expected in the near future.[8]

  At the national level:

  - October 2023 Institute for Safe Medication Practices (ISMP) Canada Safey Bulletin alerts regarding 2 cases where Clonidine Compounding Errors Continue to Harm Children due to 10- to 1000-fold errors in intended doses
    - Several of the ISMP recommendations for Pharmacy Managers are embedded in the NAPRA Standards and fall under the responsibility of compounding supervisors.

  Specifically in Ontario, concerns brought to the attention of the College include:

  - December 2019: Two pharmacy technicians received an oral caution and remedial training from the Inquiries, Complaints and Reports Committee (ICRC) for a compounding error that resulted in 22 patients receiving a suboptimal dose of epidural during labor and delivery.

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[4] There is currently one Canadian Council on Continuing Education in Pharmacy (CCCEP) accredited competency-mapped program available for sterile compounding, but the content addressing competencies for compounding supervisors is not available separately.

[5] Insufficient training refers to either incomplete training prior to starting as a compounding supervisor or completion of training that is not robust or not mapped to competencies.

[6] NAPRA compounding standards of practice state that a compounding supervisor is required for both sterile and non-sterile compounding. If a compounding supervisor has not been identified, the designated manager / pharmacy manager is responsible for the compounding supervisor responsibilities and requirements.

[7] Andrew Sheldrick Compounding Error: Our Story | Melissa Sheldrick

[8] Enhancements to reporting capabilities for OCP's medication safety program (Assurance and Improvement in Medication Safety, AIMS) will enable collection of aggregate data for compounding incidents and near misses.

- November 2020: Pharmacist found guilty of professional misconduct by the Discipline Committee for failing to meet sterile compounding standards for atropine eye drops.
- January 2024: Investigation ongoing into March 2023 complaint about a dispensing error involving compounded preparation for tube feeding.

IS MANDATORY TRAINING AN APPROPRIATE REGULATORY RESPONSE?

- for required training for compounding have been identified in previous reports:
  - The Thiessen report recommended that OCP "specify credentials beyond education and licensing for personnel engaged in non-sterile and sterile product preparation practices within a licensed pharmacy".
  - The NAPRA report[9], *Report on competence in compounding at entry to practice*, recommends that provincial regulatory authorities develop options for ensuring competence in this specialty area post-licensure (e.g., micro-credentialing, education/training requirements, etc.)

Evidence Regarding Mandatory Training in Compounding

- In the *Pharmaceutical Compounding: a History, Regulatory Overview, and Systematic Review of Compounding Errors* (2021)[10] article of regulatory responses to compounding errors, the authors conclude that standardized training, and perhaps mandatory credentialling, should be considered:
  - "Many concentration errors are of orders of magnitude, suggesting that simple mathematical and measurement mistakes are to blame…we call on the pharmacy industry to emphasize and standardize compounding training amongst its students and even consider a mandatory credential before allowing a pharmacist or pharmacy technician to compound a medication [26, 97–99]."
- In a scan of international jurisdictions (USA, Australia, United Kingdom, Ireland) only the United Kingdom has a specific requirement for personnel training:
  - Product Approval (Release) in Aseptic Services must be carried out under the supervision of a pharmacist by an Accredited Produce Approver: An authorized pharmacist or pharmacy technician who has been through a nationally recognized accreditation program.
  - "It was recognized that developing a specific training package to address these issues was necessary, to at least maintain, and potentially improve, current levels of patient safety."
- Compounding subject matter experts, both internal and external (through the OCP Compounding Advisory Groups), have indicated that consistent training for compounding supervisors might be helpful in meeting a number of compounding standards, specifically those focusing on ensuring required expertise (e.g., training programs), competency/skill assessments, quality assurance programs, and cleaning, disinfecting or deactivating procedures. OCP Compounding Advisory Groups supported modules for OCP approved training mapped to NAPRA competencies for compounding professionals (Attachment 10.3).

Registrant Consultation

- In early February 2024, the OCP conducted a survey of pharmacy professionals regarding OCP approved training for compounding. Based on registrant feedback (583 responses), 67 % fully agreed or are neutral regarding OCP required mandatory training for compounding supervisors (full survey results available on request).

WHAT ARE THE OPTIONS TO ADDRESS THIS PROBLEM?

1. OCP approved training is mandatory for all compounding supervisors.

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[9] National Association of Pharmacy Regulatory Authorities. Report on competence in compounding at entry to practice. June 2023

[10] Watson CJ, Whitledge JD, Siani AM, Burns MM. Pharmaceutical Compounding: a History, Regulatory Overview, and Systematic Review of Compounding Errors. J Med Toxicol. 2021 Apr;17(2):197-217. doi: 10.1007/s13181-020-00814-3. Epub 2020 Nov 2. PMID: 33140232; PMCID: PMC7605468.

2. OCP approved training is mandatory for new compounding supervisors and compounding supervisors in pharmacies where standards are not met.
3. OCP approved training for compounding supervisors is recommended, but not mandatory.

Implementation Considerations

- A number of registrants indicated that successful implementation of mandatory training was contingent on the following factors:
    - Ease of access (preferably on-line)
    - Training includes clear, concise expectations and tools
    - Minimal or no cost burden for registrants or pharmacies
- Implementation could include one of the following:
    - Continuing professional development (CPD) providers create and deliver programs (based on OCP identified competencies for compounding supervisor modules) – cost to registrants or pharmacies
    - OCP creates and delivers programs – no additional funds need to be allocated
    - OCP hires an external consultant to create and deliver programs – additional funds need to be allocated
- Implementation decisions made by OCP staff will be based on Board direction regarding OCP approved training and OCP capacity / resources.

WHAT IS THE BEST OPTION TO ADDRESS THIS PROBLEM?

Analysis of Options

1. OCP Approved Training is mandatory for all compounding supervisors.

    Pros:
    - Risk – most comprehensive response to address risk – confident that all compounding supervisors will have required and consistent training
    - Supported by literature and compounding subject matter experts
    - 67 % of registrants supported this option or were neutral
    - Identifies competency-mapped training modules for compounding personnel and compounding supervisors

    Cons:
    - Is this right-touch? Some compounding supervisors might already have required knowledge and skills
    - 33 % of registrants do not believe mandatory training would be helpful for them

2. OCP Approved Training is mandatory for new compounding supervisors and compounding supervisors in pharmacies where standards are not met.

    Pros:
    - Right-touch - training is targeted to those who are identified with highest risk
    - Identifies competency-mapped training modules for compounding personnel and compounding supervisors

    Cons:
    - Risk – not as comprehensive, some compounding supervisors that require training may not be identified
    - Timeliness – although operational assessments for sterile compounding pharmacies occur every 1-2 years, operational assessments for pharmacies providing non-sterile compounding can range from every 2-7 years
    - Fairness – valid, evidence-based criteria would need to be developed to determine who should be selected for mandatory training if compounding standards are not met

3. OCP Approved Training for compounding supervisors is recommended, but not mandatory.

    Pros:

    - Commitment of time (outside of clinical responsibilities) is only required for those choosing to engage in learning
    - Identifies competency-mapped training modules for compounding personnel and compounding supervisors

    Cons:

    - Risk may not be adequately addressed

SUMMARY

What is the problem? There are a number of compounding standards of practice where 20 % or more of assessed pharmacies are not meeting the standards, in part due to insufficient training, especially for compounding supervisors.[5,6]

Does this issue warrant a regulatory response? Yes, using the principles of right-touch regulation, a regulatory response is warranted if the risk of harm to patients is high. Evidence shows that compounding can pose a high risk to patient safety.

Is mandatory training an appropriate regulatory response? Yes, the literature, external reports (Theissen and NAPRA), internal and external subject matter experts, and pharmacy professionals (through a registrant survey) indicate that mandatory training is an appropriate regulatory response.

What are the options to address this problem?

- OCP Approved Training is mandatory for all compounding supervisors.
- OCP Approved Training is mandatory for new compounding supervisors and compounding supervisors in pharmacies where standards are not met.
- OCP Approved Training for compounding supervisors is recommended, but not mandatory.

What is the best option to address this problem? Option 2 (Mandatory OCP-Approved Training for new compounding supervisors and compounding supervisors in pharmacies where standards are not met) best balances addressing risk of harm to patients and right-touch regulation. This option is best supported by the available evidence from literature, external reviews, compounding subject matter experts and registrants.

RECOMMENDATION:

That the board approve the following:

OCP Approved Training is mandatory for new compounding supervisors and compounding supervisors in pharmacies where standards are not met.

Appendix 1

Glossary

Competencies: Significant job-related knowledge, skills, abilities, attitudes, and judgments required for competent performance of duties by members of a profession. (NAPRA)

Compounding: The combining or mixing together of two or more ingredients (of which at least one is a drug or pharmacologically active component) to create a final product in an appropriate form for dosing. It can involve raw materials or the alteration of the form and strength of commercially available products. It can include reformulation to allow for a novel drug delivery. Compounding does not include mixing, reconstituting, or any other manipulation that is performed in accordance with the directions for use on an approved drug's labelling material. (Health Canada)
There are three types of compounding generally encountered in pharmacy practice:

> **Non-sterile compounding**: combining, admixing, diluting, pooling, reconstituting other than as provided in the manufacturer's labeling, or otherwise altering a drug product **or bulk** drug substance to create a nonsterile preparation. (USP 795)
>
> **Sterile compounding**: combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug or bulk drug substance to create a sterile medication. Sterility means the absence of viable organisms. (USP 797)
>
> **Hazardous compounding: compounding** that involves a hazardous product.
>
> > **Hazardous product**: A substance that entails risks for personnel because of their effects. For the purposes of these Model Standards, the term "hazardous product" refers to both hazardous drugs and hazardous materials, depending on the situation.

Compounding supervisor: A pharmacist or pharmacy technician who develops, organizes, and oversees all activities related to compounding of preparations in the pharmacy.

Quality assurance program (for compounding): a program established by a compounding supervisor to ensure the clear definition, application and verification of all activities that will affect the quality of compounded preparations and the protection of personnel.

Attachment 10.1

List of Standards where less than 80 % of Pharmacies Assessed Met the Standard

Based on 2023 Community and Hospital Compounding Assessments Data

Community Compounding Assessment Data	
Inspection Module	**Hazardous Sterile Preparations**
Standard #	Standard Statement
Inspection Section	***Core Requirements - Personnel***
51	The hazardous sterile compounding supervisor develops, organizes and oversees all activities related to the compounding of hazardous sterile preparations.
53	All hazardous compounding personnel have received specific training and completed a competency assessment program in the workplace.
54	All cleaning and disinfecting personnel for hazardous sterile compounding have received initial training and completed a competency assessment program in the workplace.
Inspection Section	***Personnel involved in Aseptic Compounding***
55	There is a quality assurance program in place that addresses the personnel involved in hazardous aseptic compounding.
56	There is a quality assurance program in place for hazardous sterile compounding that addresses the content of the program itself, the results & actions taken, the product preparation process and documentation.
Inspection Section	***Compounded Sterile Preparation Protocols, Compounded Sterile Log Preparation & Patient File***
58	Effective documentation and record keeping processes are in place according to standards of practice and NAPRA Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations.
Inspection Section	***Core Requirements – Facilities and equipment***
62	The storage of hazardous drugs is in compliance with NAPRA Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations.
64	Personal Protective Equipment (PPE) for the compounding of hazardous sterile preparations must meet the NAPRA Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations.
65	Equipment for the compounding of hazardous sterile preparations is designed, built, and maintained in accordance with NAPRA Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations.
66	There is a cleaning, disinfecting, deactivating and surface decontaminating procedure in place that addresses all hazardous compounding areas
Inspection Section	***Verification of equipment and facilities***
67	There is an environmental verification program in place that meets the NAPRA Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations.
68	There is a quality assurance program in place that addresses the verification of equipment and facilities for hazardous sterile compounding.
Inspection Section	***Beyond Use date (BUD) and dating methods***
69	The Pharmacy's operating procedures describe the risk assessment process used to establish the BUD and the storage conditions according to NAPRA Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations.
Inspection Section	***Receipt, Transport and Delivery of hazardous products***
72	The Pharmacy has policies and procedures in place to ensure safe receipt, transport and delivery of compounded hazardous sterile preparations.

Community Compounding Assessment Data

Inspection Module	**Non-hazardous Sterile Preparations**
Standard #	Standard Statement
Inspection Section	***Core Requirements - Personnel***
76	The sterile compounding supervisor develops, organizes and oversees all activities related to the compounding of non-hazardous sterile preparations.
78	All compounding personnel have received specific training and completed a competency assessment program in the workplace.
79	All cleaning and disinfecting personnel have received initial training and completed a competency assessment program in the workplace.
Inspection Section	***Personnel involved in Aseptic Compounding***
80	There is a quality assurance program in place that addresses the personnel involved in aseptic compounding.
81	There is a quality assurance program in place that addresses the content of the program itself, the results & actions taken, the product preparation process and documentation.
Inspection Section	***Compounded Sterile Preparation Protocols, Compounded Sterile Log Preparation & Patient File***
83	Effective documentation and record keeping processes are in place according to standards of practice and NAPRA Model Standards for Pharmacy Compounding of Non-Hazardous Sterile Preparations.
Inspection Section	***Core Requirements – Facilities and equipment***
89	Personal Protective Equipment (PPE) for the compounding of non-hazardous sterile preparations must meet the NAPRA Model Standards for Pharmacy Compounding of Non-Hazardous Sterile Preparations.
90	Equipment for the compounding of non-hazardous sterile preparations is designed, built, and maintained in accordance with the NAPRA Model Standards for Pharmacy Compounding of Non-Hazardous Sterile Preparations.
91	There is a cleaning and disinfecting procedure in place that addresses all sterile compounding areas.
Inspection Section	***Verification of equipment and facilities***
92	There is an environmental verification program in place that meets the NAPRA Model Standards for Pharmacy Compounding of Non-Hazardous Sterile Preparations.
93	There is a quality assurance program in place that addresses the verification of equipment and facilities.
Inspection Section	***Beyond Use date (BUD) and dating methods***
94	The Pharmacy's operating procedures describe the risk assessment process used to establish the Beyond Use Date (BUD) and the storage conditions according to the NAPRA Model Standards for Pharmacy Compounding of Non-Hazardous Sterile Preparations.
Inspection Section	**Receipt, Transport and delivery**
97	The Pharmacy has policies and procedures in place to ensure safe receipt, transport and delivery of compounded non-hazardous sterile preparations.

Community Compounding Assessment Data	
Inspection Module	**Non-Sterile Preparations**
Standard #	Standard statement
Inspection Section	**Section 2: Objectives and Section 3: Regulatory Framework**
100	The pharmacist or pharmacy technician uses professional judgment to determine if non-sterile compounding is appropriate.
Inspection Section	**Section 4: Assessing Risk for Compounding Non-Sterile Products**
101	A risk assessment has been performed to identify the appropriate level of requirements to minimize contamination of each non-sterile compounded product and to provide adequate protection for personnel.
Inspection Section	**Section 5: Requirements for All Levels of Non-Sterile Compounding Activities**
103	Policies and procedures are in place for all activities related to non-sterile compounding.
104	All personnel involved in non-sterile compounding have the required expertise.
107	Equipment, instruments and accessories are appropriate for the type of preparations to be compounded, and are maintained and cleaned
Inspection Section	**Section 6: Product and Preparation Requirements**
109	Master formulation records are established for each non-sterile compound and are readily retrievable.
111	The pharmacy keeps a complete compounding record for each individual prescription as well as for non-sterile preparations made in batches.
113	Steps are taken to verify each stage of the process, as well as the final compounded non-sterile preparation.
114	The pharmacy has processes in place to ensure compounded products are labelled and packaged appropriately.
Inspection Section	**Section 7: Quality Assurance**
116	A quality assurance program is in place to verify that all non-sterile compounding activities are being carried out according to the standards.
Inspection Section	**Section 9: Requirements for Hazardous Preparations**
120	The pharmacy has procedures in place to ensure that the areas used for compounding of hazardous non-sterile preparations are kept clean.
121	The pharmacy has procedures in place for deactivating, decontaminating and cleaning in areas reserved for the compounding of hazardous non-sterile preparations.
122	The pharmacy has policies and equipment are in place to handle incidents and spills involving hazardous products.
123	Procedures for the destruction and/or disposal of pharmaceutical waste are implemented.
124	Controlled areas and C-PEC are certified and verified according to standards.

Hospital Compounding Assessment Data	
Inspection Module	**Hazardous Sterile Preparations**
Standard #	Standard Statement
Inspection Section	***Personnel involved in Aseptic Compounding***
56	The sterile compounding supervisor must establish a quality assurance program to ensure the clear definition, application and verification of all activities that will affect the quality of compounded sterile preparations and the protection of personnel. In addition, must also ensure that sterile preparations are compounded in compliance with established procedures.
Inspection Section	***Core Requirements – Facilities and equipment***
66	Personnel must comply with the requirements for cleaning and disinfecting as outlined in NAPRA.

Inspection Module	**Non-hazardous Sterile Preparations**
Inspection Section	***Personnel involved in Aseptic Compounding***
81	There is a quality assurance program in place that addresses the content of the program itself, the results & actions taken, the product preparation process and documentation.
Inspection Section	***Core Requirements – Facilities and equipment***
Standard # 91	There is a cleaning and disinfecting procedure in place that addresses all sterile compounding areas.

Inspection Module	**Non-Sterile Preparations**
Inspection Section	***Section 5: Requirements for All Levels of Non-Sterile Compounding Activities***
104	All personnel involved in non-sterile compounding have the required expertise.
Inspection Section	***Section 7: Quality Assurance***
116	A quality assurance program is in place to verify that all non-sterile compounding activities are being carried out according to the standards.

The Risk Framework (draft)

Potential Harm

(to patients and/or the public)

DRAFT OCP Approved Training Modules for Compounding

Adapted from NAPRA-Compounding-Competencies-July-2022-EN-Final.pdf
For additional details and footnotes, refer to original.

Module 1 - Non-sterile compounding for pharmacists and pharmacy technicians	
1. Compounding: Pharmacy professionals safely compound quality preparations by adhering to legislation, standards, policies, and procedures. Compounding pharmacy professionals are able to:	
1.1 perform the required preparatory steps prior to compounding preparations	1.1.1 determine whether pharmacy compounding should occur or whether the activity would be considered a form of manufacturing according to the federal legislative framework 1.1.2 for non-sterile compounding complete a formal assessment of risk to the preparation and risk to persons using decision algorithms and evidence based references 1.1.3 determine whether any required components are hazardous products 1.1.4 confirm that the pharmacy has the required environment, facilities, and equipment for compounding and storing a preparation 1.1.5 facilitate patient access to preparations that cannot be compounded at their pharmacy by outsourcing compounding or referring patients to another compounding pharmacy 1.1.6 adhere to a current, previously verified MFR/ CStPP 1.1.7 modify existing or develop new MFR/CStPP using an evidence-based approach *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 1.1.8 for non-sterile compounding: establish BUD by assessing the components and applying evidence-based compounding references on stability and compatibility *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 1.1.9 perform calculations to determine the quantities of components needed 1.1.10 confirm that the components are of required quality, appropriately sourced and stored, and available in the required amounts 1.1.11 follow requirements for personnel conduct, hygiene, and hand-washing and garbing procedures, including use of PPE, and identify when health or other conditions prohibit compounding 1.1.12 prepare the compounding components, equipment, and area, including cleaning and calibration 1.1.13 ask for additional information or guidance to address any issue of concern, uncertainty, or competence before proceeding to compound the preparation
1.2 compound preparations according to the MFR/ CStPP and the prescription	1.2.1 measure required components using the appropriate equipment 1.2.2 ensure verification of calculations, component identity, and measurements prior to compounding 1.2.2a for non-sterile compounding: only when independent verification is not possible, complete a verification of their own calculations, component identity, and measurements

	In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist. 1.2.3 combine components using evidence-based, systematic techniques that are consistent with the MFR/CStPP and prescription 1.2.3c for hazardous compounding: follow safe handling and containment strategies required for hazardous components throughout the compounding process 1.2.4 use compounding equipment in accordance with manufacturer specifications and standards 1.2.5 for hazardous compounding: follow emergency measures for managing accidental exposures and spills
1.3 finish preparations according to the MFR/ CStPP and the prescription	1.3.1 package preparations in containers that maintain preparation quality 1.3.2 label preparation containers in a manner that ensures correct storage and use, including supplementary and auxiliary labels 1.3.3 store the preparation as required to ensure quality 1.3.3a for hazardous compounding: package, label, and store hazardous preparations in the manner required to minimize safety risks
1.4 assure the quality of the preparations they have compounded	1.4.1 complete a visual inspection of the physical appearance of compounded preparations and containers, and ensure accuracy of labelling 1.4.2 ensure verification of the quality and accuracy of final compounded preparations, and packaging, labelling, and documentation 1.4.2a for non-sterile compounding: only when an independent verification is not possible, complete a verification of the quality and accuracy of final preparations they compounded, and their packaging, labelling, and documentation *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.*
1.5 clean and organize after compounding	1.5.1 clean the equipment and compounding area, using designated equipment and processes 1.5.1a for hazardous compounding: deactivate, decontaminate, clean, and disinfect premises and equipment 1.5.2 for hazardous compounding: destroy and/or dispose of hazardous waste in a manner that minimizes risks 1.5.3 store compounding equipment and components safely and following manufacturer's instructions, to ensure quality and to minimize risk of contamination
1.6 complete documentation for compounding of each preparation	1.6.1 for non-sterile compounding: document risk assessment rationale, references, and mitigation requirements on the MFR 1.6.2 document development of and modifications to MFR/ CStPP

	In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist. 1.6.3 complete compounding records or CSP logs for both individual and batch compounding including any deviations from the MFR/ CStPP
2. Quality control of compounded preparations: Pharmacy professionals ensure the quality and safety of compounded preparations prior to dispensing or release. Compounding pharmacy professionals are able to:	
2.1 perform independent verification of the quality of preparations compounded by other pharmacy professionals or non-regulated pharmacy personnel	2.1.1 for non-sterile compounding: provide independent verification of new MFR and modifications to existing MFR *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 2.1.2 prior to compounding by other pharmacy professionals or nonregulated pharmacy personnel, verify calculations, component identity, and measurements 2.1.3 verify the quality of final compounded preparations, including components, adherence to MFR/ CStPP, appearance, and accuracy and completeness of labelling and documentation of preparations compounded by other pharmacy professionals or nonregulated pharmacy personnel *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.*
2.2 maintain the quality and safety of compounded preparations prior to dispensing or release	2.2.1 ensure transportation and delivery of preparations as required to ensure their quality and safety 2.2.1a for hazardous compounding: ensure transportation and delivery of hazardous preparations as required to minimize risks 2.2.2 for preparations compounded on behalf of other pharmacies, package and transport preparations appropriately, and communicate required information to the pharmacy where the preparations will be dispensed 2.2.3 for preparations compounded by other pharmacies, receive, verify, store, and label preparations appropriately
3. Compounding pharmacy management: Pharmacy professionals participate in the management of the pharmacy to ensure the quality and safety of compounding. Compounding pharmacy professionals are able to:	
3.2 implement QA programs that ensure compliance with a pharmacy's compounding P&P	3.2.4 complete required QA verifications and determine the level of compliance to the pharmacy's compounding P&P as specified in the pharmacy's QA program *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 3.2.4b for hazardous compounding: perform required facility/ environmental QA testing for chemical contamination

	In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist. 3.2.5 take immediate action to minimize risks when potential non-compliance with the QA program is detected, including notifying the compounding supervisor
3.3 supervise other members of the compounding team	3.3.1 provide and document results of training and skills assessments to pharmacy personnel for compounding of preparations *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 3.3.1a for hazardous compounding: provide and document results of training to compounding and cleaning personnel regarding containment strategies for hazardous products, including prevention and management of spills and accidental exposure, and waste management *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 3.3.2 supervise non-regulated pharmacy personnel when they are performing assigned compounding tasks
3.4 contribute to pharmacy compounding operations	3.4.1 complete required cleaning and maintenance of equipment and facilities, and document in general maintenance logs 3.4.2 document results of quality assurance verifications, including logs, reports, and follow-up
3.5 contribute to pharmacy inventory management	3.5.1 source required compounding components, materials, equipment, and supplies 3.5.2 for hazardous compounding: follow procedures and PPEuse required for receipt, unpacking, and storing of hazardous products 3.5.3 manage recalled, returned, and expired components and compounded preparations

Module 2 - Non-sterile compounding for compounding supervisors and pharmacy managers (module 1 is a pre-requisite)	
3. Compounding pharmacy management: Pharmacy professionals participate in the management of the pharmacy to ensure the quality and safety of compounding. Compounding supervisors and pharmacy managers are able to:	
3.1 develop, review, and update compounding P&P that operationalize the compounding standards of practice	3.1.1 develop and maintain P&P specifying the obligations and required conduct of compounding and cleaning personnel 3.1.2 develop and maintain P&P specifying the training and skills assessment programs required for compounding and cleaning personnel, including required documentation 3.1.3 develop and maintain P&P assigning the performance of compounding activities to other pharmacy professionals or nonregulated pharmacy personnel 3.1.4 develop and maintain P&P for assigning the performance of compounding management to another pharmacy professional and designating them as the compounding supervisor 3.1.5 for non-sterile compounding: develop and maintain P&P for determining the cumulative risk of compounding and incorporating into risk assessments 3.1.6 develop and maintain P&P specifying required compounding facilities, equipment, references, scheduled cleaning, maintenance, certification, and documentation 3.1.6a for hazardous compounding: develop and maintain P&P specifying deactivation and decontamination requirements 3.1.7 develop and maintain P&P requiring evidence-based development and review of MFR/CStPP, including for determining and extending BUD *(pharmacist only)* 3.1.8 develop and maintain P&P specifying sourcing, supply, storage, traceability, disposal, safety data information, and documentation requirements of components 3.1.8a for hazardous compounding: develop and maintain P&P specifying receipt / unpacking, and hazardous waste management requirements 3.1.9 develop and maintain P&P specifying compounding procedure requirements, including required processes, techniques, use of PPE, verifications, and compounding records 3.1.9a for hazardous compounding: develop and maintain P&P specifying prevention, management, equipment, documentation, and reporting requirements for spills and accidental exposure to hazardous products 3.1.10 develop and maintain P&P specifying the labelling, packaging, storage, and transportation requirements for compounded preparations 3.1.10a for hazardous compounding: develop and maintain P&P specifying requirements for transport and management of spills and accidental exposure to hazardous preparations during transportation 3.1.11 develop and maintain P&P managing returned and/or expired components and preparations 3.1.12 develop and maintain P&P ensuring traceability, managing recalled compounded components and preparations, and for post-recall analysis 3.1.13 develop and maintain P&P for acquisition of prescribed preparations for patients from other compounding pharmacies

	3.1.14 develop and maintain P&P for compounding of prescribed preparations on behalf of other pharmacies
3.2 implement QA programs that ensure compliance with a pharmacy's compounding P&P	3.2.1 develop, review, update, and document a QA program, specifying the verifications of the facilities, equipment, personnel conduct/ skills, and compounding procedures to be completed to evaluate compliance with compounding P&P, the frequency of these verifications, corrective actions to be taken, and required documentation 3.2.2 ensure the compounding supervisor develops, maintains, documents, and makes available the required compounding P&P 3.2.3 ensure the compounding supervisor develops, implements, and evaluates compliance with the required QA program, including investigating and acting upon deviations, and documenting results 3.2.6 analyze the results of the QA program verifications, take required corrective/ preventive actions and complete/retain documentation to ensure adherence to compounding P&P 3.2.6c for hazardous compounding: analyze environment testing for chemical contamination, responding as required to minimize or mitigate safety risks and completing required documentation 3.2.7 for non-sterile compounding: determine the cumulative risk of compounding for incorporation into risk assessments for non-sterile compounding

Module 1 – Sterile (Non-hazardous) compounding for pharmacists and pharmacy technicians	
1. Compounding: Pharmacy professionals safely compound quality preparations by adhering to legislation, standards, policies, and procedures. Compounding pharmacy professionals are able to:	
1.1 perform the required preparatory steps prior to compounding preparations	1.1.1 determine whether pharmacy compounding should occur or whether the activity would be considered a form of manufacturing according to the federal legislative framework 1.1.3 determine whether any required components are hazardous products 1.1.4 confirm that the pharmacy has the required environment, facilities, and equipment for compounding and storing a preparation 1.1.5 facilitate patient access to preparations that cannot be compounded at their pharmacy by outsourcing compounding or referring patients to another compounding pharmacy 1.1.6 adhere to a current, previously verified MFR/ CStPP 1.1.7 modify existing or develop new MFR/CStPP using an evidence-based approach *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 1.1.7a for sterile compounding: ensure approval of modified or newly developed CStPP by the sterile compounding supervisor or delegate 1.1.8a for sterile compounding: establish BUD by applying evidence-based compounding references, assessing risk level for contamination and/or completing sterility testing *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 1.1.8b for sterile compounding: adhere to BUD requirements for single-dose, open ampoules and multi-dose component containers 1.1.9 perform calculations to determine the quantities of components needed 1.1.10 confirm that the components are of required quality, appropriately sourced and stored, and available in the required amounts 1.1.11 follow requirements for personnel conduct, hygiene, and hand-washing and garbing procedures, including use of PPE, and identify when health or other conditions prohibit compounding 1.1.12 prepare the compounding components, equipment, and area, including cleaning and calibration 1.1.13 ask for additional information or guidance to address any issue of concern, uncertainty, or competence before proceeding to compound the preparation
1.2 compound preparations according to the MFR/ CStPP and the prescription	1.2.1 measure required components using the appropriate equipment 1.2.2 ensure verification of calculations, component identity, and measurements prior to compounding 1.2.2b for sterile compounding: ensure independent verification of calculations, component identity, and measurements prior to compounding

	1.2.3 combine components using evidence-based, systematic techniques that are consistent with the MFR/CStPP and prescription 1.2.3a for sterile compounding: follow aseptic techniques throughout the compounding process 1.2.3b for sterile compounding: perform required sterilization and sterility testing of high-risk compounded preparations 1.2.4 use compounding equipment in accordance with manufacturer specifications and standards
1.3 finish preparations according to the MFR/ CStPP and the prescription	1.3.1 package preparations in containers that maintain preparation quality 1.3.2 label preparation containers in a manner that ensures correct storage and use, including supplementary and auxiliary labels 1.3.3 store the preparation as required to ensure quality
1.4 assure the quality of the preparations they have compounded	1.4.1 complete a visual inspection of the physical appearance of compounded preparations and containers, and ensure accuracy of labelling 1.4.1a for sterile compounding: verify the sterility of high-risk preparations by conducting sterility and bacterial endotoxin tests *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 1.4.2 ensure verification of the quality and accuracy of final compounded preparations, and packaging, labelling, and documentation 1.4.2b for sterile compounding: ensure independent verification of the quality and accuracy of final CSP and packaging, labelling, and documentation.
1.5 clean and organize after compounding	1.5.1 clean the equipment and compounding area, using designated equipment and processes 1.5.3 store compounding equipment and components safely and following manufacturer's instructions, to ensure quality and to minimize risk of contamination
1.6 complete documentation for compounding of each preparation	1.6.2 document development of and modifications to MFR/ CStPP *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 1.6.3 complete compounding records or CSP logs for both individual and batch compounding including any deviations from the MFR/ CStPP
2. Quality control of compounded preparations: Pharmacy professionals ensure the quality and safety of compounded preparations prior to dispensing or release. Compounding pharmacy professionals are able to:	
2.1 perform independent verification of the quality of preparations compounded by other pharmacy professionals or non-	2.1.1a for sterile compounding: provide independent verification of new CStPP and modifications to existing CStPP

regulated pharmacy personnel	*In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 2.1.2 prior to compounding by other pharmacy professionals or nonregulated pharmacy personnel, verify calculations, component identity, and measurements 2.1.3 verify the quality of final compounded preparations, including components, adherence to MFR/ CStPP, appearance, and accuracy and completeness of labelling and documentation of preparations compounded by other pharmacy professionals or nonregulated pharmacy personnel *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.*
2.2 maintain the quality and safety of compounded preparations prior to dispensing or release	2.2.1 ensure transportation and delivery of preparations as required to ensure their quality and safety 2.2.2 for preparations compounded on behalf of other pharmacies, package and transport preparations appropriately, and communicate required information to the pharmacy where the preparations will be dispensed 2.2.3 for preparations compounded by other pharmacies, receive, verify, store, and label preparations appropriately
3. Compounding pharmacy management: Pharmacy professionals participate in the management of the pharmacy to ensure the quality and safety of compounding. Compounding pharmacy professionals are able to:	
3.2 implement QA programs that ensure compliance with a pharmacy's compounding P&P	3.2.4 complete required QA verifications and determine the level of compliance to the pharmacy's compounding P&P as specified in the pharmacy's QA program *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 3.2.4a for sterile compounding: perform required personnel and facility/environmental QA testing (e.g., gloved fingertip and media fill tests, surface and air sampling) *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 3.2.5 take immediate action to minimize risks when potential non-compliance with the QA program is detected, including notifying the compounding supervisor
3.3 supervise other members of the compounding team	3.3.1 provide and document results of training and skills assessments to pharmacy personnel for compounding of preparations *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 3.3.2 supervise non-regulated pharmacy personnel when they are performing assigned compounding tasks
3.4 contribute to pharmacy compounding operations	3.4.1 complete required cleaning and maintenance of equipment and facilities, and document in general maintenance logs 3.4.2 document results of quality assurance verifications, including logs, reports, and follow-up
3.5 contribute to pharmacy inventory management	3.5.1 source required compounding components, materials, equipment, and supplies 3.5.3 manage recalled, returned, and expired components and compounded preparations

Module 2 – Sterile Non-hazardous compounding for compounding supervisors and pharmacy managers **(module 1 is a pre-requisite)**	
3. Compounding pharmacy management: Pharmacy professionals participate in the management of the pharmacy to ensure the quality and safety of compounding. Compounding supervisors and pharmacy managers are able to:	
3.1 develop, review, and update compounding P&P that operationalize the compounding standards of practice	3.1.1 develop and maintain P&P specifying the obligations and required conduct of compounding and cleaning personnel 3.1.2 develop and maintain P&P specifying the training and skills assessment programs required for compounding and cleaning personnel, including required documentation 3.1.3 develop and maintain P&P assigning the performance of compounding activities to other pharmacy professionals or nonregulated pharmacy personnel 3.1.3a for sterile compounding: develop and maintain P&P for assigning competency training to other pharmacy professionals, and training and assessment of personnel and environmental verification testing to third-party evaluators 3.1.4 develop and maintain P&P for assigning the performance of compounding management to another pharmacy professional and designating them as the compounding supervisor 3.1.6 develop and maintain P&P specifying required compounding facilities, equipment, references, scheduled cleaning, maintenance, certification, and documentation 3.1.7 develop and maintain P&P requiring evidence-based development and review of MFR/CStPP, including for determining and extending BUD 3.1.8 develop and maintain P&P specifying sourcing, supply, storage, traceability, disposal, safety data information, and documentation requirements of components 3.1.9 develop and maintain P&P specifying compounding procedure requirements, including required processes, techniques, use of PPE, verifications, and compounding records 3.1.10 develop and maintain P&P specifying the labelling, packaging, storage, and transportation requirements for compounded preparations 3.1.11 develop and maintain P&P managing returned and/or expired components and preparations 3.1.12 develop and maintain P&P ensuring traceability, managing recalled compounded components and preparations, and for post-recall analysis 3.1.13 develop and maintain P&P for acquisition of prescribed preparations for patients from other compounding pharmacies 3.1.14 develop and maintain P&P for compounding of prescribed preparations on behalf of other pharmacies
3.2 implement QA programs that ensure compliance with a pharmacy's compounding P&P	3.2.1 develop, review, update, and document a QA program, specifying the verifications of the facilities, equipment, personnel conduct/ skills, and compounding procedures to be completed to evaluate compliance with compounding P&P, the frequency of these verifications, corrective actions to be taken, and required documentation 3.2.2 ensure the compounding supervisor develops, maintains, documents, and makes available the required compounding P&P

	3.2.3 ensure the compounding supervisor develops, implements, and evaluates compliance with the required QA program, including investigating and acting upon deviations, and documenting results 3.2.6 analyze the results of the QA program verifications, take required corrective/ preventive actions and complete/retain documentation to ensure adherence to compounding P&P 3.2.6a for sterile compounding: analyze environmental sterility sampling results, responding as required to ensure sterility and completing required documentation 3.2.6b for sterile compounding: analyze aseptic technique QA results, responding as required to ensure sterility and completing required documentation
3.3 supervise other members of the compounding team	3.3.1 provide and document results of training and skills assessments to pharmacy personnel for compounding of preparations 3.3.1b for sterile compounding: perform and document results of initial and ongoing assessments of personnel's sterile compounding competency

Module 1 - Hazardous Compounding Add-on for pharmacists and pharmacy technicians (Pre-requisite – Non-sterile or sterile compounding courses)	
1. Compounding: Pharmacy professionals safely compound quality preparations by adhering to legislation, standards, policies, and procedures. Compounding pharmacy professionals are able to:	
1.1 perform the required preparatory steps prior to compounding preparations	
1.2 compound preparations according to the MFR/ CStPP and the prescription	1.2.3 combine components using evidence-based, systematic techniques that are consistent with the MFR/CStPP and prescription 1.2.3c for hazardous compounding: follow safe handling and containment strategies required for hazardous components throughout the compounding process 1.2.5 for hazardous compounding: follow emergency measures for managing accidental exposures and spills
1.3 finish preparations according to the MFR/ CStPP and the prescription	1.3.3 store the preparation as required to ensure quality 1.3.3a for hazardous compounding: package, label, and store hazardous preparations in the manner required to minimize safety risks
1.4 assure the quality of the preparations they have compounded	
1.5 clean and organize after compounding	1.5.1 clean the equipment and compounding area, using designated equipment and processes 1.5.1a for hazardous compounding: deactivate, decontaminate, clean, and disinfect premises and equipment 1.5.2 for hazardous compounding: destroy and/or dispose of hazardous waste in a manner that minimizes risks
1.6 complete documentation for compounding of each preparation	
2. Quality control of compounded preparations: Pharmacy professionals ensure the quality and safety of compounded preparations prior to dispensing or release. Compounding pharmacy professionals are able to:	
2.1 perform independent verification of the quality of preparations compounded by other pharmacy professionals or non-regulated pharmacy personnel	

2.2 maintain the quality and safety of compounded preparations prior to dispensing or release	2.2.1 ensure transportation and delivery of preparations as required to ensure their quality and safety 2.2.1a for hazardous compounding: ensure transportation and delivery of hazardous preparations as required to minimize risks
3. Compounding pharmacy management: Pharmacy professionals participate in the management of the pharmacy to ensure the quality and safety of compounding. Compounding pharmacy professionals are able to:	
3.2 implement QA programs that ensure compliance with a pharmacy's compounding P&P	3.2.4 complete required QA verifications and determine the level of compliance to the pharmacy's compounding P&P as specified in the pharmacy's QA program *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 3.2.4b for hazardous compounding: perform required facility/ environmental QA testing for chemical contamination *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.*
3.3 supervise other members of the compounding team	3.3.1 provide and document results of training and skills assessments to pharmacy personnel for compounding of preparations *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.* 3.3.1a for hazardous compounding: provide and document results of training to compounding and cleaning personnel regarding containment strategies for hazardous products, including prevention and management of spills and accidental exposure, and waste management *In Ontario, pharmacy technicians have the authority to perform the controlled act of compounding, under the supervision of a pharmacist.*
3.4 contribute to pharmacy compounding operations	3.4.2 document results of quality assurance verifications, including logs, reports, and follow-up 3.4.2a for hazardous compounding: complete required documentation, logs, reports, and analyses of spills and accidental exposures
3.5 contribute to pharmacy inventory management	3.5.2 for hazardous compounding: follow procedures and PPEuse required for receipt, unpacking, and storing of hazardous products

Module 2 – Hazardous Compounding Add-on for compounding supervisors and pharmacy managers **(module 1 is a pre-requisite)**	
3. Compounding pharmacy management: Pharmacy professionals participate in the management of the pharmacy to ensure the quality and safety of compounding. Compounding supervisors and pharmacy managers are able to:	
3.1 develop, review, and update compounding P&P that operationalize the compounding standards of practice	3.1.6 develop and maintain P&P specifying required compounding facilities, equipment, references, scheduled cleaning, maintenance, certification, and documentation 3.1.6a for hazardous compounding: develop and maintain P&P specifying deactivation and decontamination requirements 3.1.8 develop and maintain P&P specifying sourcing, supply, storage, traceability, disposal, safety data information, and documentation requirements of components 3.1.8a for hazardous compounding: develop and maintain P&P specifying receipt / unpacking, and hazardous waste management requirements 3.1.9 develop and maintain P&P specifying compounding procedure requirements, including required processes, techniques, use of PPE, verifications, and compounding records 3.1.9a for hazardous compounding: develop and maintain P&P specifying prevention, management, equipment, documentation, and reporting requirements for spills and accidental exposure to hazardous products 3.1.10 develop and maintain P&P specifying the labelling, packaging, storage, and transportation requirements for compounded preparations 3.1.10a for hazardous compounding: develop and maintain P&P specifying requirements for transport and management of spills and accidental exposure to hazardous preparations during transportation
3.2 implement QA programs that ensure compliance with a pharmacy's compounding P&P	3.2.6 analyze the results of the QA program verifications, take required corrective/ preventive actions and complete/retain documentation to ensure adherence to compounding P&P 3.2.6c for hazardous compounding: analyze environment testing for chemical contamination, responding as required to minimize or mitigate safety risks and completing required documentation
3.3 supervise other members of the compounding team	

BOARD BRIEFING NOTE

MEETING DATE: March 25, 2024

FOR INFORMATION

From: Angela Bates, Director, Conduct and Shenda Tanchak, Registrar and CEO

Topic: Discipline Committee Review Project – Phase II

Issue/Description: For Information - Update on Discipline Committee Review Project – Phase II

Public interest rationale: The effective and efficient operations of the OCP's statutory committees are necessary for the College to achieve its public protection mandate.

Strategic alignment, regulatory processes, and actions: The Discipline Committee considers allegations of professional misconduct and incompetence. Referrals of allegations to the Discipline Committee are serious by nature, as other concerns are dealt with through remedial outcomes. As such, the Discipline Committee's mandate is firmly aligned with the broader public protection mandate of the OCP.

Background: This review was conducted in concert with a broader review of the OCP's governance framework relating to its remaining statutory and standing Committees of the College, currently underway.

In 2018, the OCP undertook a governance initiative that resulted in several reforms, including the Board election process, the Committee appointment process, and a rule against professional Board members sitting on most Committees. This initiative did not include a review of Committee activities, processes or practices, or the governance policies or practices relating to the Committees themselves.

Since then, the Ministry of Health has implemented the College Performance Management Framework (CPMF), which obligates colleges to self-assess and report against the benchmarks set out in the CPMF. Domain 1 of the CPMF requires colleges to focus on good governance. Domain 6 deals with Suitability to Practice and includes benchmarks for Discipline Committee.

Periodic audits of College Committees help ensure that the practices and processes of Committees are consistent with applicable regulatory requirements and governance policies and best practices, and demonstrate effectiveness and efficiency to support the Committees' mandates.

The College is now in the process of developing options for Discipline Committee process and practice improvements for the Board to consider at its June 2024 meeting.

Attachments:

- Workplan – Discipline Committee Review Project – Phase II (updated as of February 23, 2024)

DC Review Phase II

Read-only view, generated on 01 Mar 2024

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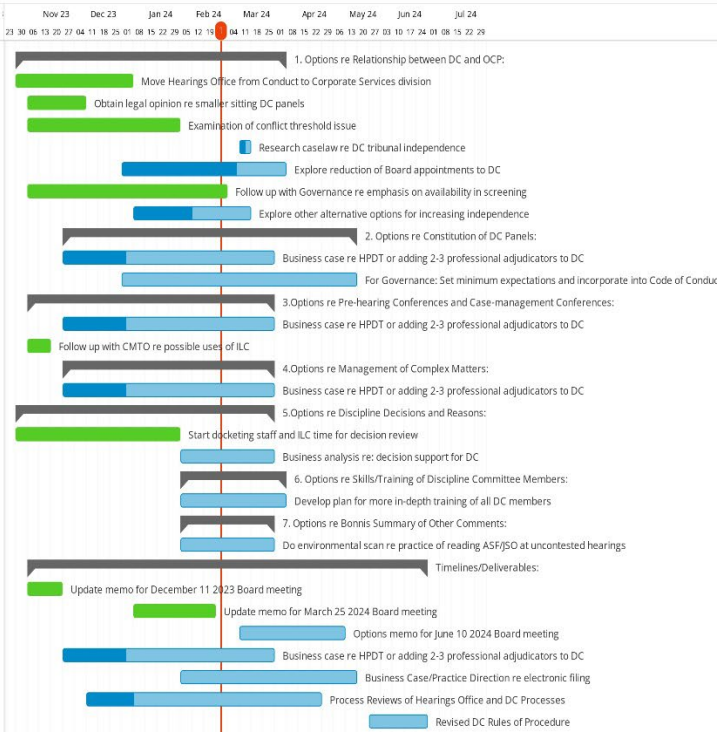
	ACTIVITIES	ASSIGNEE	START	DUE	STATUS	%
	1. Options re Relationship between DC and OCP:		01/Nov	01/Apr		86%
1	Move Hearings Office from Conduct to Corporate Services division	Shanda Tanchuk	01/Nov	02/Jan	Finished	100%
2	Obtain legal opinion re smaller sitting DC panels	Genevieve Plum...	06/Nov	04/Dec	Finished	100%
3	Examination of conflict threshold issue	Angela Bates	10/Nov	31/Jan	Finished	100%
4	Research caselaw re DC tribunal independence	Christine Pham	15/Mar	15/Mar	Started	50%
5	Explore reduction of Board appointments to DC	Angela Bates	02/Jan	01/Apr	Started	70%
6	Follow up with Governance re emphasis on availability in screening	Angela Bates	06/Nov	26/Feb	Finished	100%
7	Explore other alternative options for increasing independence	Angela Bates	08/Jan	15/Mar	Started	50%
	2. Options re Constitution of DC Panels:		30/Nov	13/May		14%
9	Business case re HPDT or adding 2-3 professional adjudicators to DC	Angela Bates	30/Nov	29/Mar	Started	30%
10	For Governance: Set minimum expectations and incorporate into Code of Conduct	Vera Patterson	01/Jan	13/May	Not started	0%
	3.Options re Pre-hearing Conferences and Case-management Conferences:		06/Nov	29/Mar		35%
12	Business case re HPDT or adding 2-3 professional adjudicators to DC	Angela Bates	30/Nov	29/Mar	Started	30%
13	Follow up with CMTO re possible uses of ILC	Angela Bates	06/Nov	13/Nov	Finished	100%
	4.Options re Management of Complex Matters:		30/Nov	29/Mar		30%
15	Business case re HPDT or adding 2-3 professional adjudicators to DC	Angela Bates	30/Nov	29/Mar	Started	30%
	5.Options re Discipline Decisions and Reasons:		01/Nov	29/Mar		62%
17	Start docketing staff and ILC time for decision review	Genevieve Plum...	01/Nov	31/Jan	Finished	100%
18	Business analysis re: decision support for DC	AB, ST	05/Feb	29/Mar	Not started	0%
	6. Options re Skills/Training of Discipline Committee Members:		05/Feb	05/Apr		0%
20	Develop plan for more in-depth training of all DC members	Genevieve Plum...	05/Feb	05/Apr	Not started	0%
	7. Options re Bonnis Summary of Other Comments:		05/Feb	29/Mar		0%
22	Do environmental scan re practice of reading ASF/JSO at uncontested hearings	CP, AB	05/Feb	29/Mar	Not started	0%
	Timelines/Deliverables:		06/Nov	28/Jun		25%
24	Update memo for December 11 2023 Board meeting	Angela Bates	06/Nov	20/Nov	Finished	100%
25	Update memo for March 25 2024 Board meeting	Angela Bates	08/Jan	23/Feb	Finished	100%
26	Options memo for June 10 2024 Board meeting	Angela Bates	11/Mar	06/May	Not started	0%
27	Business case re HPDT or adding 2-3 professional adjudicators to DC	Angela Bates	30/Nov	29/Mar	Started	30%
28	Business Case/Practice Direction re electronic filing	Angela Bates	05/Feb	13/May	Not started	0%
29	Process Reviews of Hearings Office and DC Processes	Angela Bates	11/Dec	26/Apr	Started	20%
30	Revised DC Rules of Procedure	Genevieve Plum...	27/May	28/Jun	Not started	0%



Ontario College of Pharmacists
Putting patients first since 1871

BOARD BREIFING NOTE

MEETING DATE: March 25, 2024

FOR INFORMATION

From: Shenda Tanchak, Registrar and CEO

Topic: Proposed by-law revision altering the compositional requirements of the Accreditation Committee to replace Public Directors with Lay Committee Appointees.

Issue/Description: The requirement to have Public Directors on the Accreditation Committee (AC) presents a barrier to forming Discipline Committee (DC) panels. This can lead to delays in addressing concerns about pharmacy professionals, potentially exposing the public to risk in the interim. Additionally, it places excessive demands on Public Directors appointed to DC. The burden on Public Directors, in turn, may have a negative impact on our ability to attract candidates for the Board.

Background: The composition of the Accreditation and Discipline Committees is informed by the following legislation and by-laws:

Discipline Committee

- Section 38 of the *Health Professions Procedural Code* (HPPC) specifically states that the DC panel must include a minimum of two Public Directors and that quorum is three members of a panel, with at least one of them being a Public Director. There are no exceptions.

Accreditation Committee

- Section 9 of the *Pharmacy Act* requires the College to have an AC and states that no member of the AC can serve on the DC.

- The composition of the AC is not addressed in the *Pharmacy Act*, but in College by-laws, which the Board may change. Article 9.17 of our by-laws outlines that the AC shall be comprised of 2 Public Directors; 3 or more Professional Committee Appointees (PCAs); and at the discretion of the Governance Committee, one 1 or more Lay Committee Appointees (LCAs).

- Section 139(4) of the *Drug and Pharmacies Regulation Act* says that the provisions in the HPPC related to the Registration Committee apply to the AC ***with necessary modifications*** (emphasis added).

- Section 17.2 of the HPPC states that Registration Committee panels must be composed of three persons, one of whom must be a Public Director.

Analysis: It is important to ensure that decision-making panels have public representation. While it might be ideal to draw on those appointed through Orders in Council, the reality is that our small board size leaves us with few Public Directors to manage the large workload. OCP has two more Committees (AC and Drug Drug Premises Preparation Committee (DPPC)) than other regulated colleges. As a result, the problem of scarcity of Public Directors is even more acute at OCP. We have experience with recruiting and training LCAs and are confident that they can represent the public voice in committee decision-making. We recommend amending the by-law so that AC is not required to have any Public Directors, but must have 2 or 3 LCAs, and 3 PCAs.

MOTION:

THAT the Board of Directors directs the Governance Committee to, in collaboration with legal counsel, develop by-law amendments, including a change to Article 9.17. Recognizing that DPPC and ACC have identical membership, the Governance Committee will additionally develop an amendment to Article 9.27.2 to align with the new 9.17.

Ontario College of Pharmacists
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BOARD BRIEFING NOTE

MEETING DATE: March 25, 2024

FOR DECISION

From: Governance Committee

Topic: Removing barriers to Board membership for pharmacy professionals from diverse populations, marginalized groups and individuals with disabilities.

Issue/Description: The Ontario College of Pharmacists has committed to promoting equity, diversity and inclusion (EDI) on the Board. OCP by-law 5.7.1 (f) excludes those who have been an employee, officer or director of a Professional Advocacy Association within the past three years. Some associations exist for the promotion of EDI. Should the Board remove this exclusion in relation to such associations, to remove barriers for candidates?

Background and Analysis: Good governance practices for regulators include imposition of a three-year cooling off period before officers or representatives from associations can serve with a regulator. This is reflected in measure 2.1 (b) of the College Performance Measurement Framework Reporting Tool that all health colleges are required by the Ontario Ministry of Health to complete annually.

The purpose of this requirement is captured nicely in the final report of *An Inquiry into the performance of the College of Dental Surgeons of British Columbia and the Health Professions Act*: "The College must be an independent regulator focused on its mandate to protect the public, respectful of many stakeholders but beholden to none. The College cannot be an effective independent regulator when it is...intertwined with (the Association)." [1] While the efforts and intentions of regulators and associations might frequently overlap, the potential for conflict of interest is high where the regulatory requirement of putting patients' interests first conflicts with the association mandate of advancing the interests of the profession.

Some associations, however, do not have the mandate to advance the whole profession, but to advance the interests of historically underrepresented groups within the profession. For example, the Indigenous Pharmacy Professionals of Canada (IPPC)'s vision is "We have connected all Indigenous Pharmacy Professionals in Canada and collaboratively transformed healthcare into a safe and holistic space for thriving communities." IPPC "serves to cultivate a thriving and empowered community of Indigenous Pharmacy Professionals to support safe and equitable care of patients, families, and communities. OBJ" The IPPC's mandate does not conflict with the College's. It aligns with OCP's own commitment to EDI; its strategic goal: The College uses its regulatory influence to ensure that all patients are treated with respect and without discrimination via positive changes in pharmacy practice; and its December 2023 decision to focus on Indigenous cultural humility and reconciliation in the College's EDI strategy.

Given that the reason the Association exists is because Indigenous pharmacy professionals are underrepresented in the profession, the population of professionals available to serve on the Association or the regulatory bodies across Canada is small. IPPC's membership numbers only 40 Indigenous pharmacists and pharmacy technicians nationwide, with 12 members on their Board. The application of our by-law 5.7.1 (f) to this association practically guarantees ineligibility for leaders in the small Indigenous pharmacy professionals' population.

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[1] Accessed March 9, 2024: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://static1.squarespace.com/static/5f8db86abcd26d38e120303f/t/5fc654514e98326c02e963da/1606833236959/190118++Cayton+Report+FINAL.pdf – this report formed the basis of significant reform to the health regulatory system in British Columbia.

IPPC is not the only example of an association to which the rationale for the cooling off requirement might not apply. These include but are not limited to the Black Pharmacy Professionals of Canada and the Chinese Canadian Pharmacists' Association.

As Indigenous and other diverse populations are increasingly employed by or participating in the leadership of Associations geared toward advancing their participation in the profession of Pharmacy, they will encounter difficulty amplifying their voice or increasing their impact on the profession through an inability to participate in leadership in the OCP. Conversely, as OCP strives to meet its commitment to Truth and Reconciliation and EDI, this requirement creates a barrier that may not serve the public interest.

Recommendation:

THAT By-law 5.7.1 be amended as follows (changes in red font):

> The Registrant is not and has not within the three (3) years immediately preceding the election been, an employee, officer or director of a Professional Advocacy Association, ***except for Associations whose purpose is to mitigate systemic barriers to access to the pharmacy profession for diverse populations, marginalized groups or individuals with disabilities.*** Additionally, nothing in this clause will prevent a Registrant who serves on an association or organization to which they have been appointed by the Board as a representative of the College, from running for election to be an Elected Director.

BOARD BRIEFING NOTE

MEETING DATE: March 25, 2024

FOR DECISION

From: Governance Committee

Topic: Election of a Public Director to the Executive Committee

Issue/Description: The Board will appoint a new public director to serve on the Executive Committee for the balance of the current term.

Background: Christine Henderson's resignation from the OCP Board has left a vacancy on the Executive Committee. The *Regulated Health Professionals Act* requires that the College have an Executive Committee. OCP By-law stipulates that the Committee must include two public directors.

The Board will elect a public director to serve on the Executive Committee beginning March 25, 2024 and ending September 16, when selection of the Executive Committee for the following year will take place.

The Chair of the Governance Committee will call for interest from the floor for this position. If more than one public director is interested in the role, an election will be held by secret ballot. The Registrar/CEO will collect the ballots and count the votes. If only one public member expresses an interest in the position, that person will be acclaimed.

If no public director identifies themselves as interested in the role, the Chair will appoint a public member of the Board to ensure compliance with the By-law and RHPA.

Decision for the Board

Motion: (To be identified) is elected to the Executive Committee for the term commencing March 25, 2024 and ending September 16, 2024.

Attachments:

- 15.1 – By law: 12.1.4 Executive Committee Election Process

OCP By-law

12.1.4 The Board shall elect the remaining members of the Executive Committee, in accordance with the composition requirements in paragraph 9.2. The election will be conducted in the following manner:

(a) The chair of the Governance Committee shall announce those who are willing to serve as and are qualified to be on the Executive Committee.

(b) The chair of the Governance Committee shall call for further interest from the floor, and those additional Directors who are interested in running for open positions on the Executive Committee shall be added as candidates for election.

(c) Should there be a sufficient number of candidates so that there would only be a total of two (2) Elected Directors or a total of two (2) Public Directors on the Executive Committee, such candidate(s) shall be declared appointed.

(d) Should the number of filled positions on the Executive Committee for either Elected Directors or Public Directors be less than two (2), elections shall be held, if necessary, so that there are two (2) filled positions in each category.

(e) Should there be more than one (1) remaining candidate for the fifth and last position on the Executive Committee an election shall be held.

(f) For any elections under this subparagraph 12.1.4, Directors shall mark their ballots for up to the number of candidates that matches the number of open positions in the category. The candidate who receives the fewest votes will then be removed from the ballot, and the voting will continue until the number of candidates remaining matches the number of open positions in the category, and such candidates shall be declared appointed. Directors may only cast one (1) vote per candidate on each ballot.

BOARD BRIEFING NOTE

MEETING DATE: March 25, 2024

FOR DECISION

From: Governance Committee

Topic: Assessment of 2024/25 Board Composition Needs

Issue/Description: The Governance Committee reviewed the skills matrix tool recently completed by Board members and found that the current Board is generally well-balanced with strong skills across the competencies It identified some opportunities to strengthen the Board further and these are presented.

Public interest rationale: Competency-based recruitment ensures the College Board has the skills, experience and competencies required to provide oversight and act in the public interest when making policy and strategic decisions.

Background: Pursuant to governance policy 1.4, the Governance Committee will use a skills and practice environment matrix tool to determine the gaps to be filled during the next election cycle. Annually the Governance Committee circulates a Board Member skills matrix tool to each Board Director. The matrix tool is used to evaluate the current and future gaps in the competencies and practice experience of the Board.

In 2023 the survey indicated significant gaps in six key areas including: Legal governance qualifications, Cybersecurity Expertise, Human Resources and Organizational Behaviour, Financial governance, Senior Leadership Roles and Governance experience. The 2024 Skills Attributes Survey identified that the current OCP Board is generally well-balanced with strong skills present across the competencies. In a year-over-year comparison, results indicate that measures taken in the 2023 election process to balance board skills and/or board training sessions have been successful.

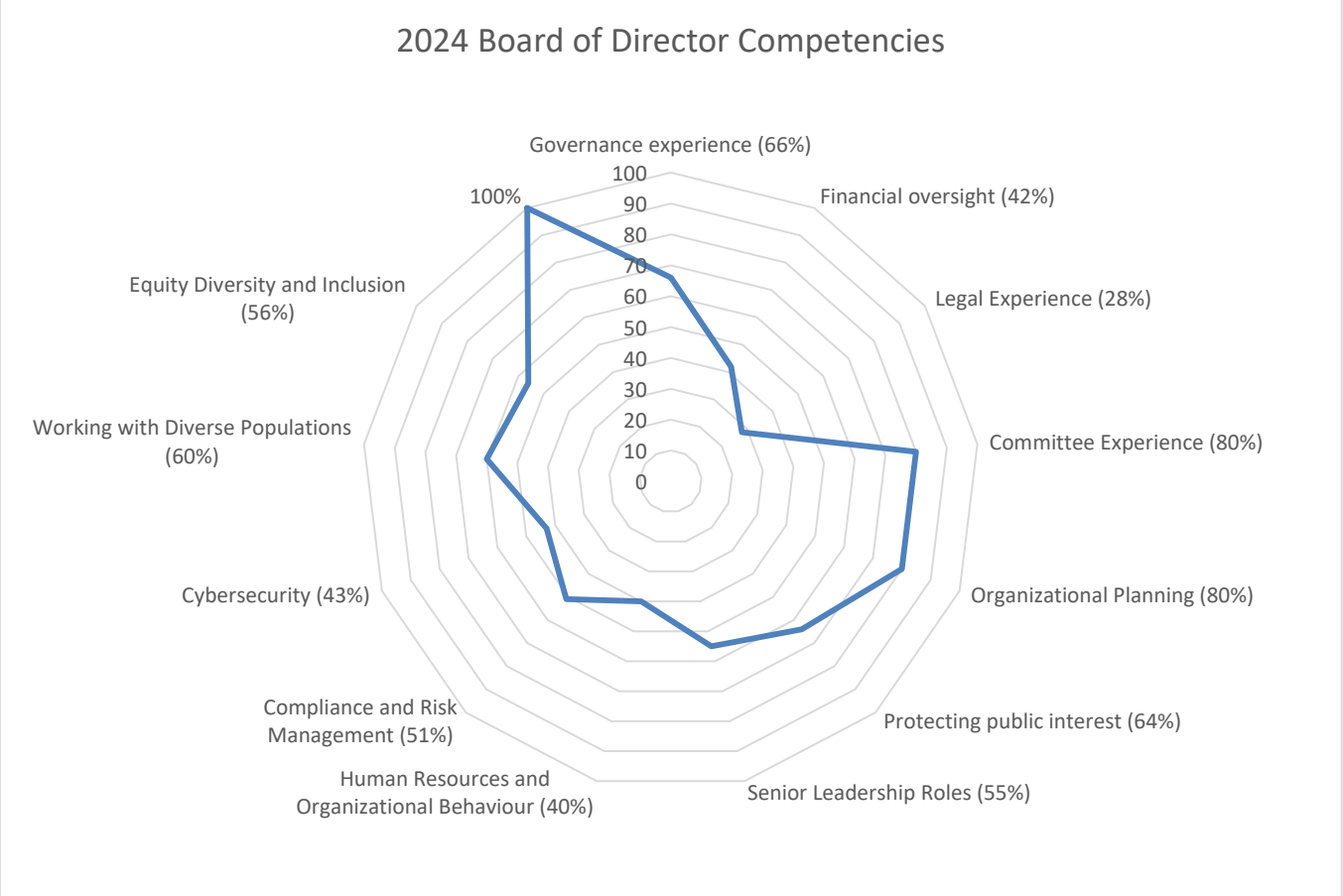
ANALYSIS:

Below is a summary of the raw data from the skills matrix tool.:

- Forty percent of the Directors are available one to three days per month.
  - Due to problems constituting Discipline Panels in particular, the Governance Committee has recommended that availability of a minimum of one to three days a month be mandatory for all election candidates.
- Ten percent of the Directors (2) are from a diverse population group and have actively worked in an organization with diverse populations to increase acceptance.
  - The Board may wish to ensure this number is not negatively affected in upcoming elections.
- Elected Directors who have served patients in remote northern areas stands at 3 Directors.
- Targeted recruitment three years ago increased the Board's ability to consider the needs of Northern Ontario residents. That seat is up for renewal this year.
- Twenty percent of Directors have limited or no knowledge of governance.
- Forty-five percent of the Board has strong financial oversight abilities.
- Forty percent of the board have relevant human resources experience.
- Fifteen percent of the board has had responsibility for developing a cybersecurity program.

- Less notably:
    - Seventy-five percent of the Board have general knowledge of legal issues.
    - Seventy-five percent of directors have experience chairing a committee.
    - Ninety percent of directors have experience developing and/or implementing operational plans.
    - Ninety-five percent of directors have a form of experience protecting and acting in the best interest of the public.
    - Ninety-five percent of directors have relevant senior leadership roles.
    - Fifty percent of the board have experience with compliance and risk management.

Concerning Legal Governance qualifications, in 2022, the Committee agreed that there are ample staff at the College with a legal regulatory background and requiring it of Board members was not essential.



The results indicate that while collectively all competencies are effectively represented on the Board, a couple of the competencies are concentrated in a low number of Directors. The preference would be to have a Board comprised of broader skill representation to support balanced consideration of issues.

Decisions for Board of Directors:

MOTION: THAT The Board of Directors approves the Governance Committee recommendation for the 2024 election: Availability of at least one to three days a month is mandatory for applicants. Candidates with competency in financial oversight and those who identify as coming from diverse populations, marginalized groups and/or individuals with disabilities, and/or those with experience working with diverse populations will be

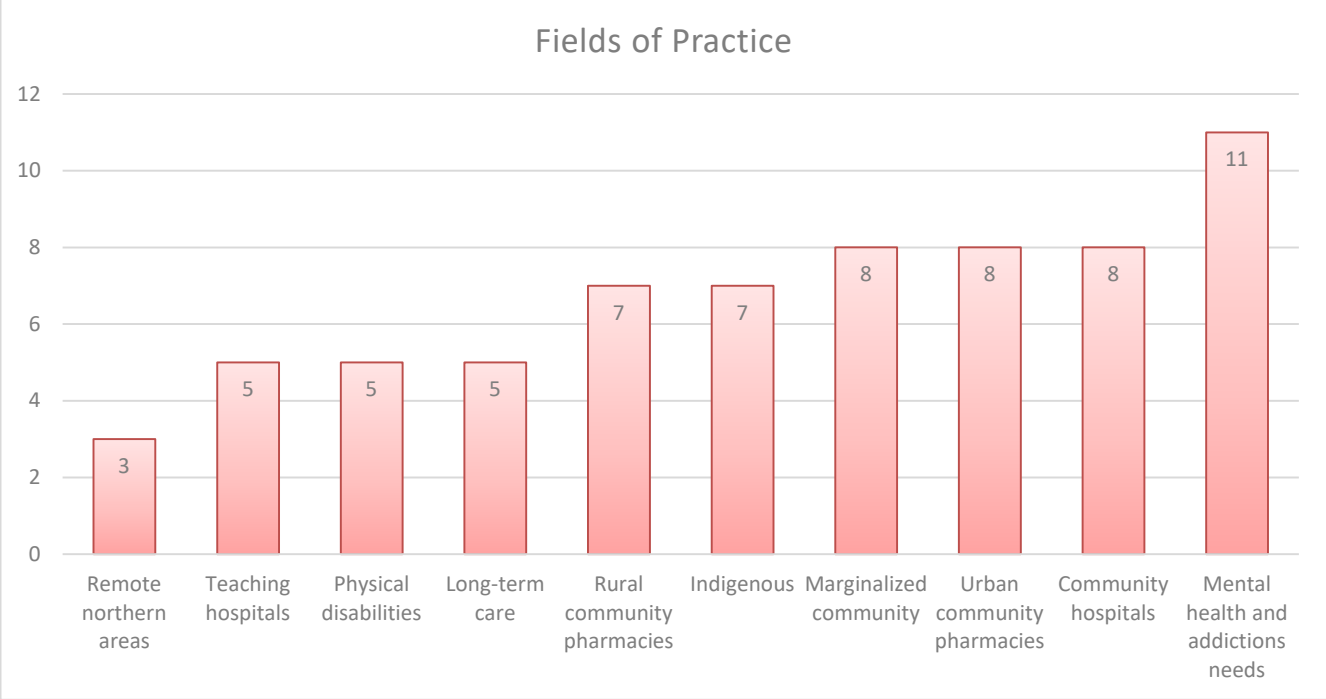
particularly encouraged to apply.

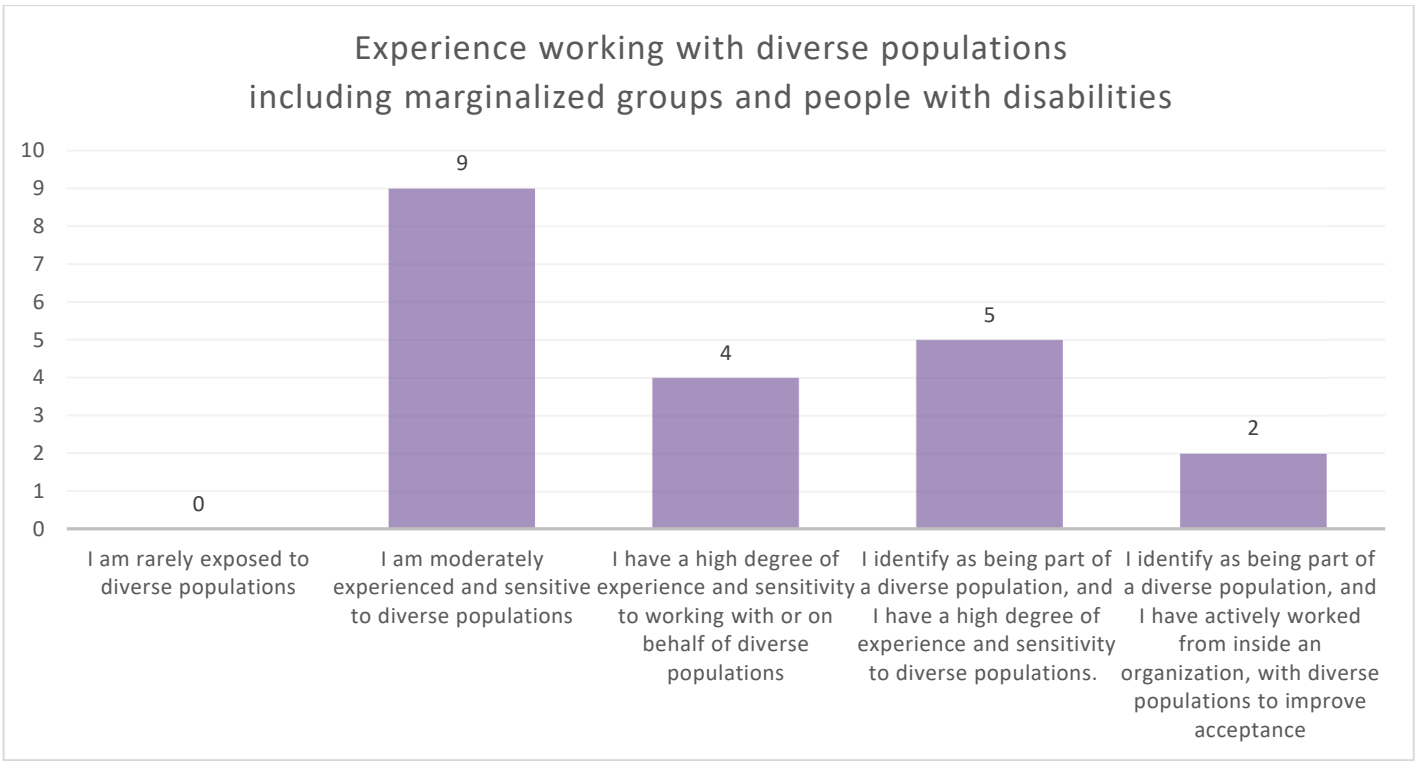
Attachments:

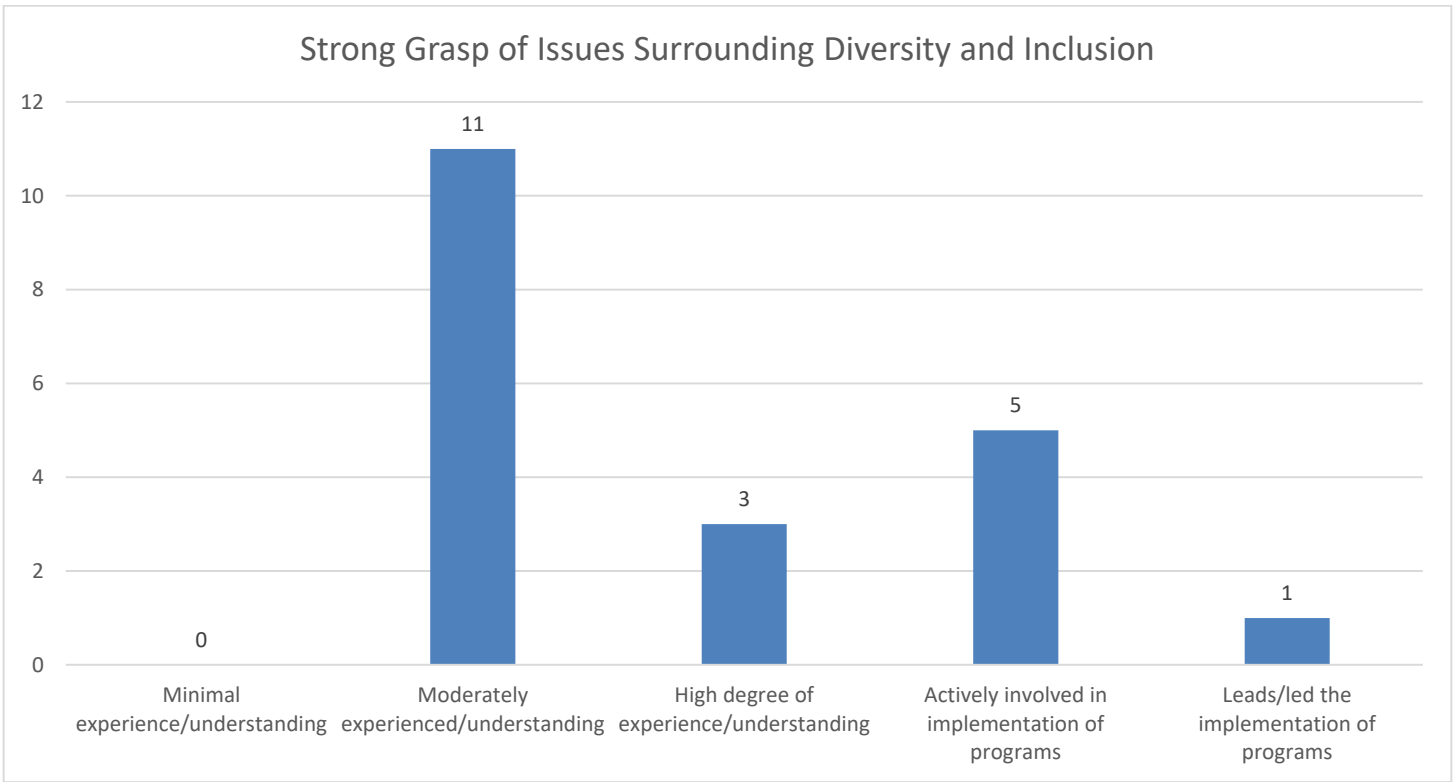
- 16.1 - Aggregated Board Matrix Tool Results
- 16.2 - Board Competencies with 3 Open Seats
- 16.3 - 2023 Skills Inventory

Appendix A

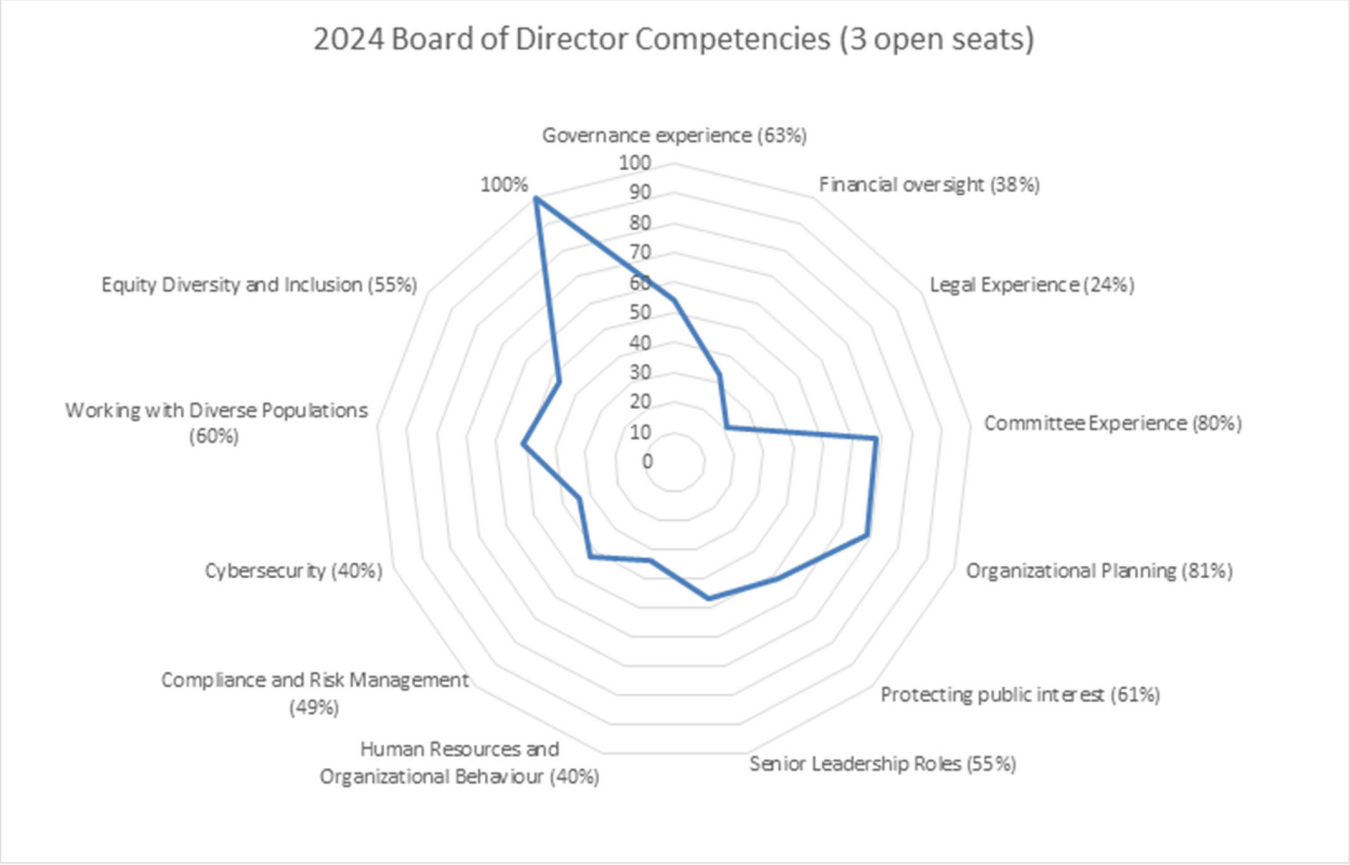

Available time commitment:
10
9
8
7
6
5
4
3
2
1
0
1
3
4
3
9
Irregular or not easily forecast
Less than one day per month, but at least quarterly
One to three days per month
Up to one day per week
More than one day per week, including several days in a row where occasionally required


Fields of Practice
12
10
8
6
4
2
0
3
5
5
5
7
7
8
8
8
11
Remote northern areas
Teaching hospitals
Physical disabilities
Long-term care
Rural community pharmacies
Indigenous
Marginalized community
Urban community pharmacies
Community hospitals
Mental health and addictions needs

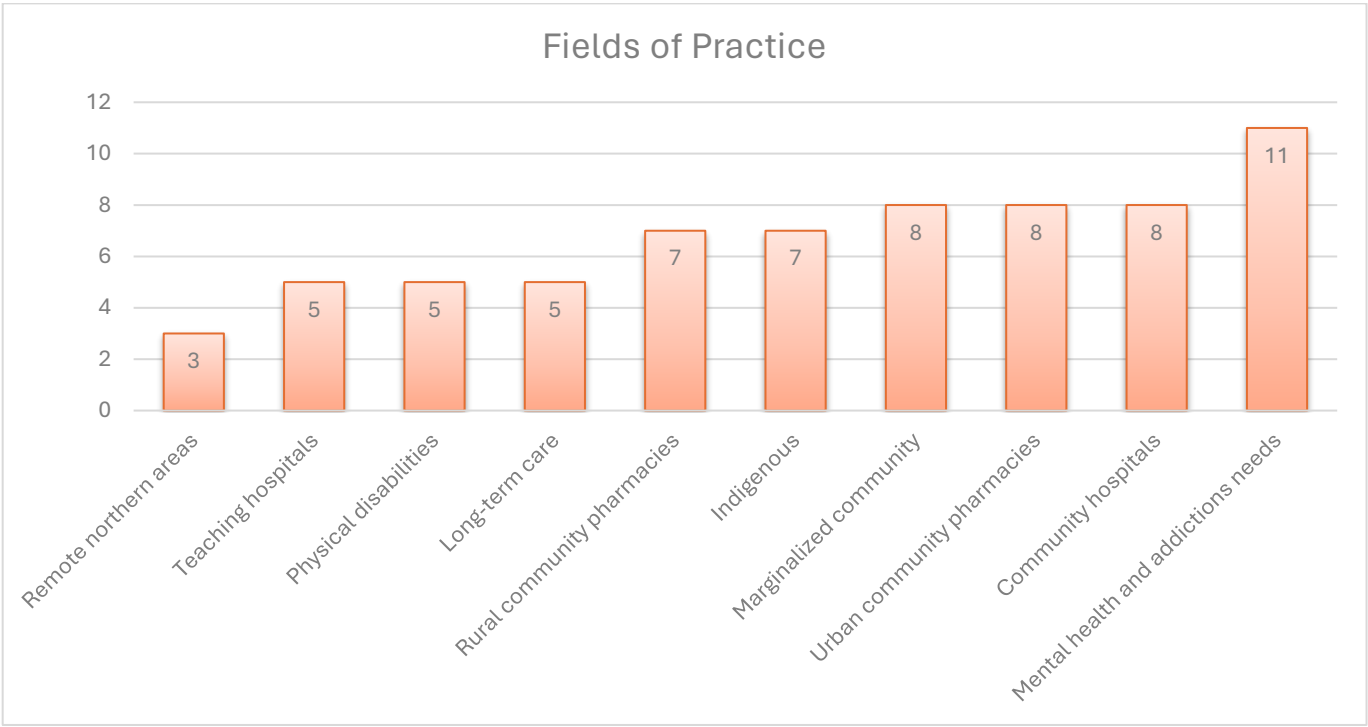

Experience working with diverse populations
including marginalized groups and people with disabilities
10
9
8
7
6
5
4
3
2
1
0
0
9
4
5
2
I am rarely exposed to diverse populations
I am moderately experienced and sensitive to diverse populations
I have a high degree of experience and sensitivity to working with or on behalf of diverse populations
I identify as being part of a diverse population, and I have a high degree of experience and sensitivity to diverse populations.
I identify as being part of a diverse population, and I have actively worked from inside an organization, with diverse populations to improve acceptance

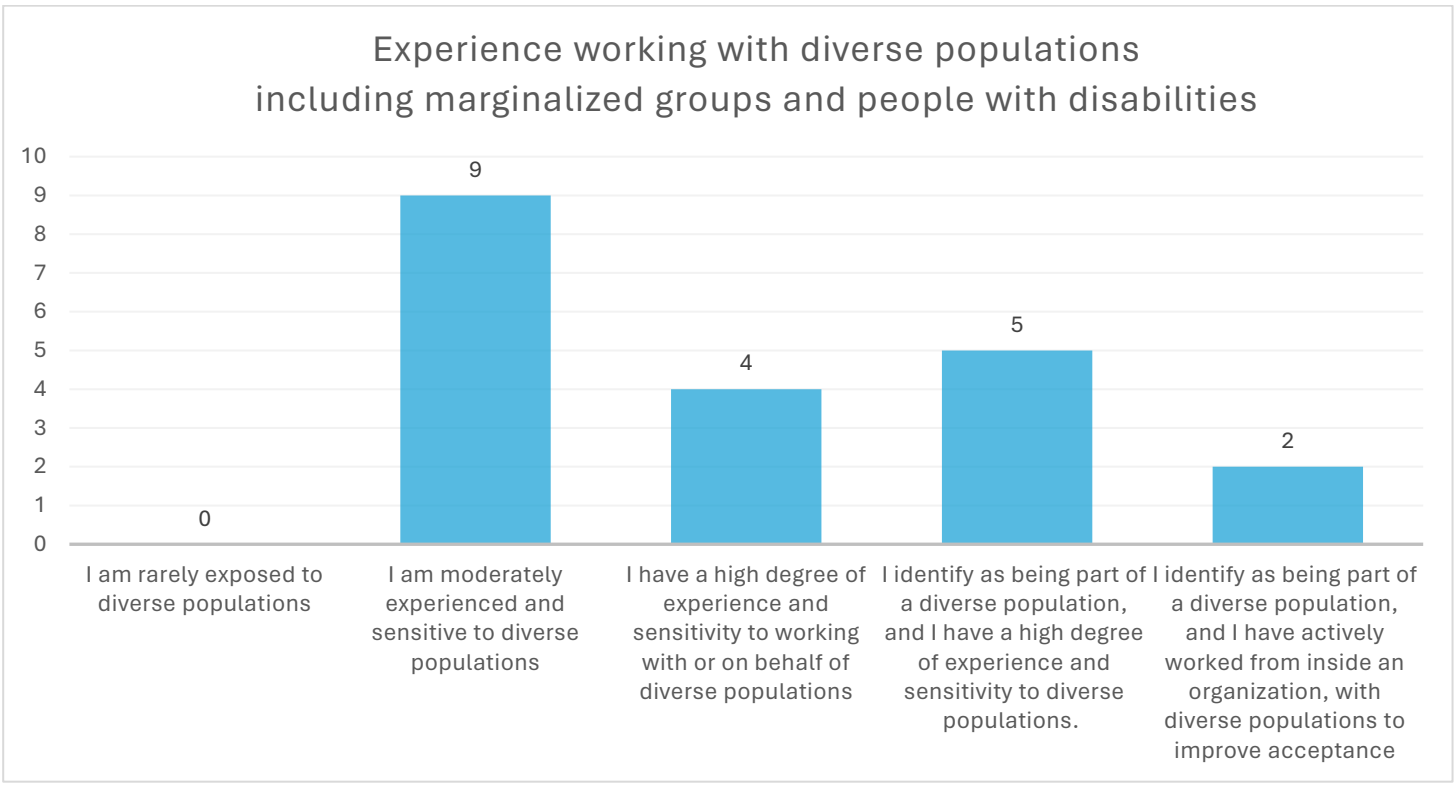

Strong Grasp of Issues Surrounding Diversity and Inclusion
12
10
8
6
4
2
0
0
11
3
5
1
Minimal experience/understanding
Moderately experienced/understanding
High degree of experience/understanding
Actively involved in implementation of programs
Leads/led the implementation of programs

Appendix B


2024 Board of Director Competencies (3 open seats)
Governance experience (63%)
Financial oversight (38%)
Legal Experience (24%)
Committee Experience (80%)
Organizational Planning (81%)
Protecting public interest (61%)
Senior Leadership Roles (55%)
Human Resources and Organizational Behaviour (40%)
Compliance and Risk Management (49%)
Cybersecurity (40%)
Working with Diverse Populations (60%)
Equity Diversity and Inclusion (55%)
100%
100
90
80
70
60
50
40
30
20
10
0

16.1 Aggregated Board Matrix Tool Results 2024




Experience working with diverse populations including marginalized groups and people with disabilities
10
9
8
7
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5
4
3
2
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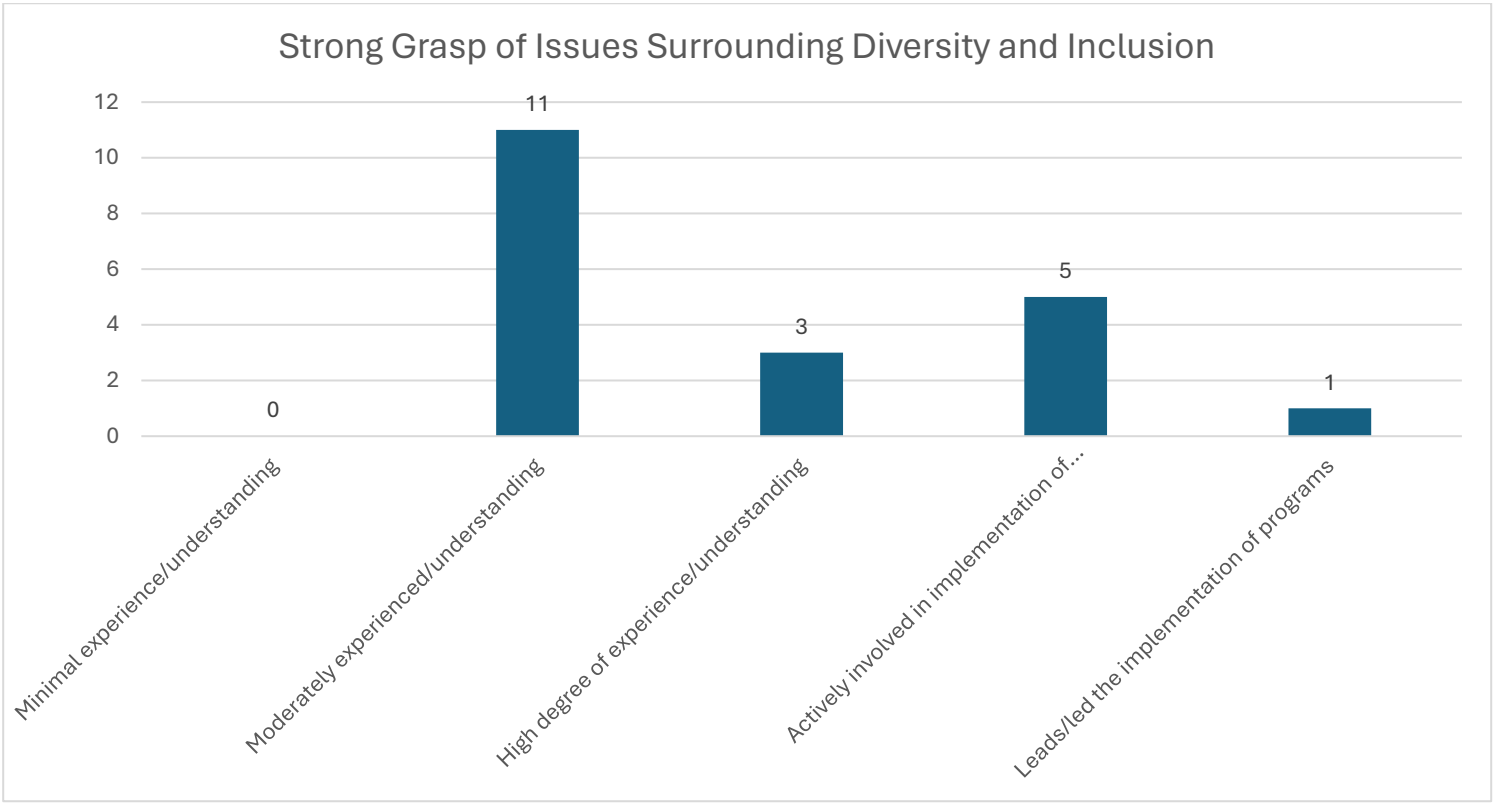
9
4
5
2
I am rarely exposed to diverse populations
I am moderately experienced and sensitive to diverse populations
I have a high degree of experience and sensitivity to working with or on behalf of diverse populations
I identify as being part of a diverse population, and I have a high degree of experience and sensitivity to diverse populations.
I identify as being part of a diverse population, and I have actively worked from inside an organization, with diverse populations to improve acceptance


Strong Grasp of Issues Surrounding Diversity and Inclusion
12
10
8
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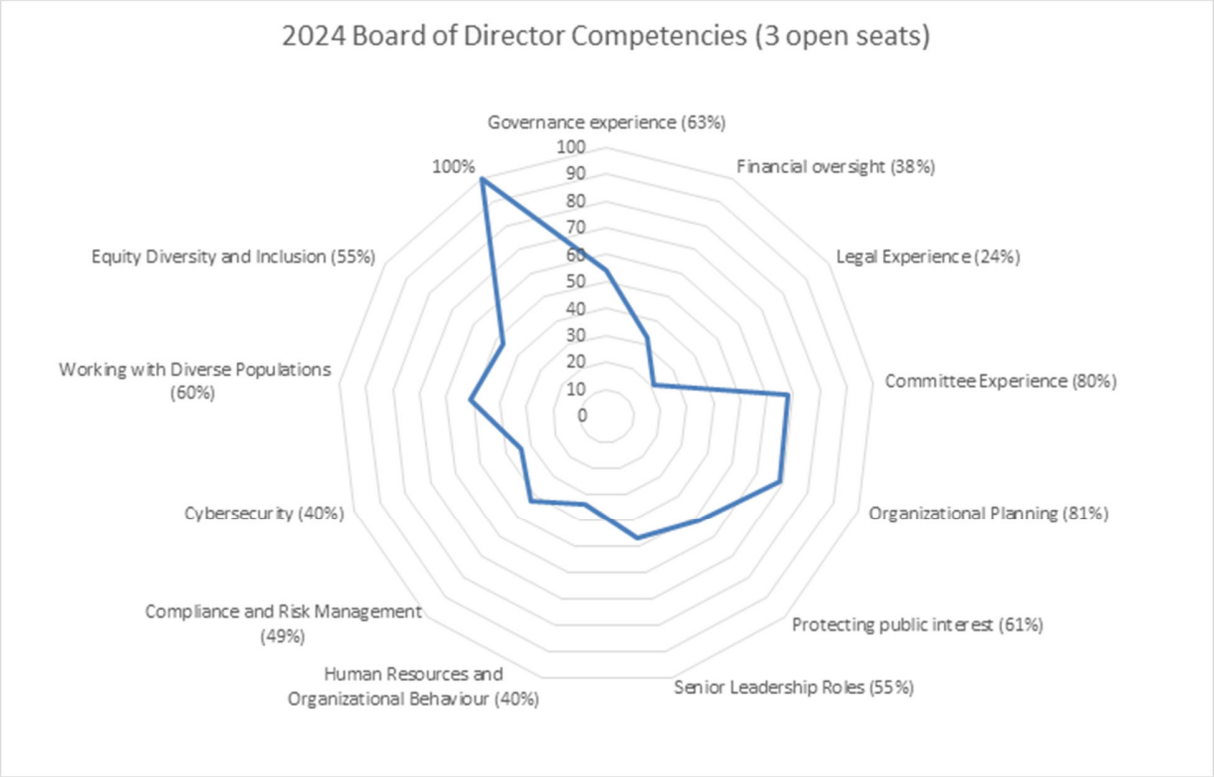
11
3
5
1
Minimal experience/understanding
Moderately experienced/understanding
High degree of experience/understanding
Actively involved in implementation of…
Leads/led the implementation of programs

16.2 Board Competencies with 3 Open Seats



Ontario College of Pharmacists
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BOARD BRIEFING NOTE
MEETING DATE: JUNE 2023

FOR INFORMATION

INITIATED BY: Billy Cheung, Interim Chair, Governance Committee

TOPIC: 2023 Skills Inventory

ISSUE: The results of the 2023 Skills Inventory are being shared with the Board for Information

Public interest rationale: The annual skills inventory is used to objectively assess the collective skills and experience of the Directors on the Board against the competencies set out in the College by-laws. The purpose of the inventory is to determine where the Board could be strengthened through targeted recruitment/selection of elected and appointed members and through training opportunities. The skills inventory results provide insights into the degree to which the Board's strengths support their mandate to provide oversight and set strategy for the College. Through this process the public can have confidence that the Board is comprised of a group of competent individuals who collectively possess the necessary skills and experience.

STRATEGIC ALIGNMENT, REGULATORY PROCESSES AND ACTIONS: The process for assessing and reporting on the Board's skills relates to the College's strategic priority to "strengthen trust and confidence in the College's role as a patients-first regulator."

BACKGROUND:

- Since 2020 when the by-laws were amended to enable the Board to screen for competency against a list of desired skills and competencies, prospective Boardapplicants are asked to self-identify their level of competence against the prescribed skills and competencies using a 5-point scale.

- In 2021, the College introduced the skills inventory survey to provide structured, clear, universally applicable criteria upon which Directors could objectively assess their level of expertise or exposure on each competency.

- The 2021 skills inventory survey results were used to develop two unique Director profiles for the 2021 Board Election, with one seat reserved for registrants with experience serving patients in remote and northern regions, and the other vacancies emphasizing competencies where gaps were evident.

- In response to feedback from the independent consultants who perform the initial screening of Board Applicants for election, the skills inventory survey was further refined in 2022 to address perceived bias toward incumbent applicants.

- The purpose and process for the annual skills inventory survey is set out in Board Policy 1.4 - Board Competencies, Skills, and Experience Inventory (Appendix 1).

ANALYSIS:

- The 2023 skills inventory survey results are being shared with the Board for information (Appendix 2). In addition, each Board member will receive a report on their own competency profile in relation to the collective board competency profile.

- The results indicate that while collectively all competencies are effectively represented on the Board, a couple of the competencies are concentrated in a low number of Directors. The preference would be to have a Board comprised of broader skill representation to support balanced consideration of issues.

- The Governance Committee has reviewed the 2023 skills inventory survey results and the core competencies and areas of practice where additional skills are required.

- The Governance Committee considered the various factors affecting the elections and agreed not to reserve seats for specific competencies this year, rather to emphasize within the 2023 Director Profile the additional strengths required on the Board.

- In addition to emphasizing the competencies where additional strength would be desired in the 2023 Director Profile for election, the College will communicate those areas to the Public Appointments Unit for consideration in future appointments to the Board.

- Information gathered from the survey will be used to identify training for the Board.

NEXT STEPS:

- Following the meeting each Director will be receiving an individual report.

ATTACHMENTS:

- Policy 1.4 - Board Competencies, Skills, and Experience Inventory
- 2022 Skills Inventory Results

Policy 1.4 Board Competencies, Skills and Experience Inventory

Purpose:

The Governance Committee will use a skills and practice environment inventory to determine the gaps for recruitment and to identify opportunities for additional training and development.

Application:

This process applies to:

- **Board Directors.**
- **The Screening and Governance Committees** who will use identified skills-gaps to inform the recruitment and selection/appointment processes and training/development programs.

Process:

Annually the Governance Committee will circulate the Board Member skills matrix tool to each outgoing and returning Board Director.

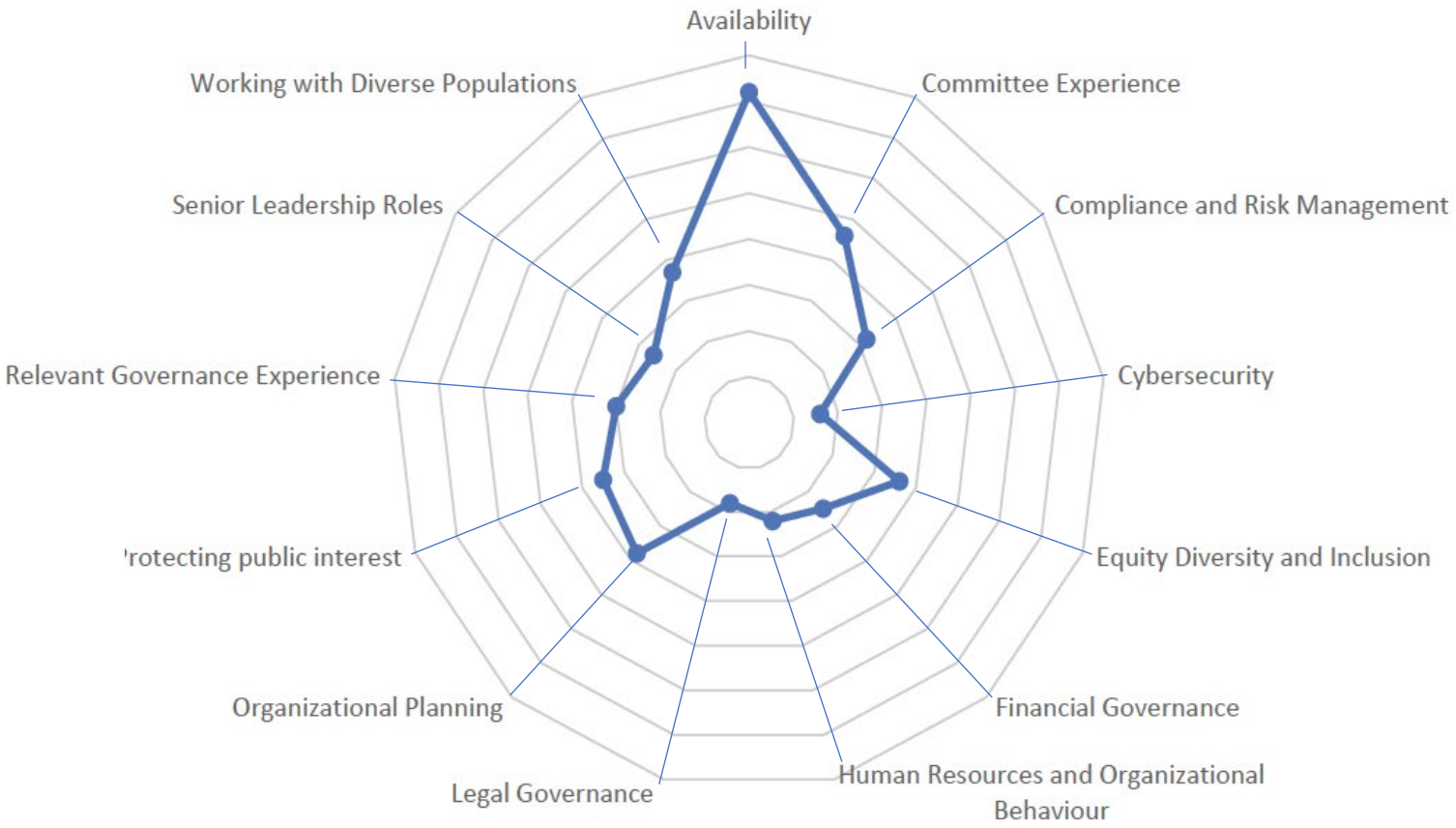
The inventory of skills[1] gathered will be used to evaluate the current and future gaps in the competencies and practice experience required to round out the Board. Annually this information will be used to create the Board Director Profile for the election and will also be used in the consideration of long range plans for the Board and for training opportunities.

The Governance Committee will also use the results of the inventory to assist in building Board member and Board capacity in governance or other areas, as identified by the Board from time to time.

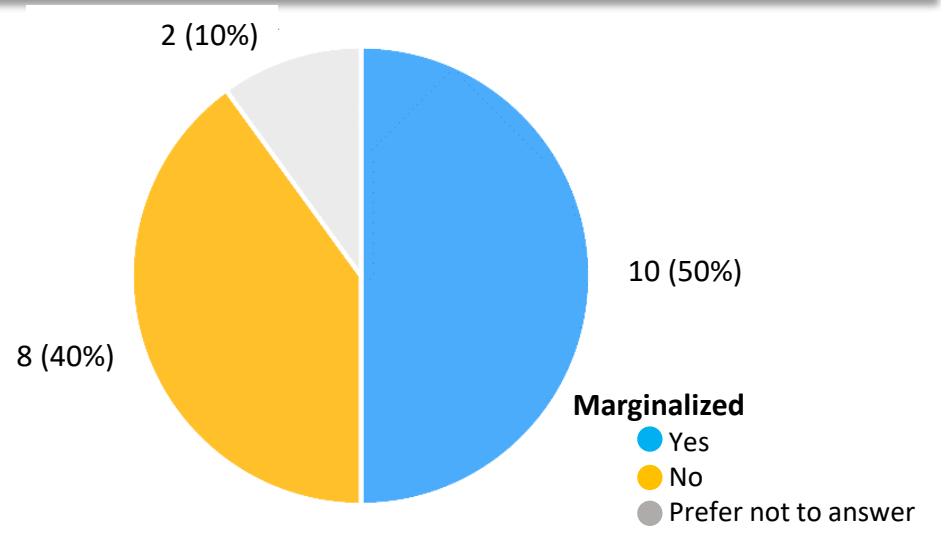
Amendment: The Board may amendthis policy.
Approval Date: December 7,2020
Last Review: December 7,2020
Last Revision: December7, 2020
Next Review Date:XXXX

[1] *The Skills Inventory is not a public document*

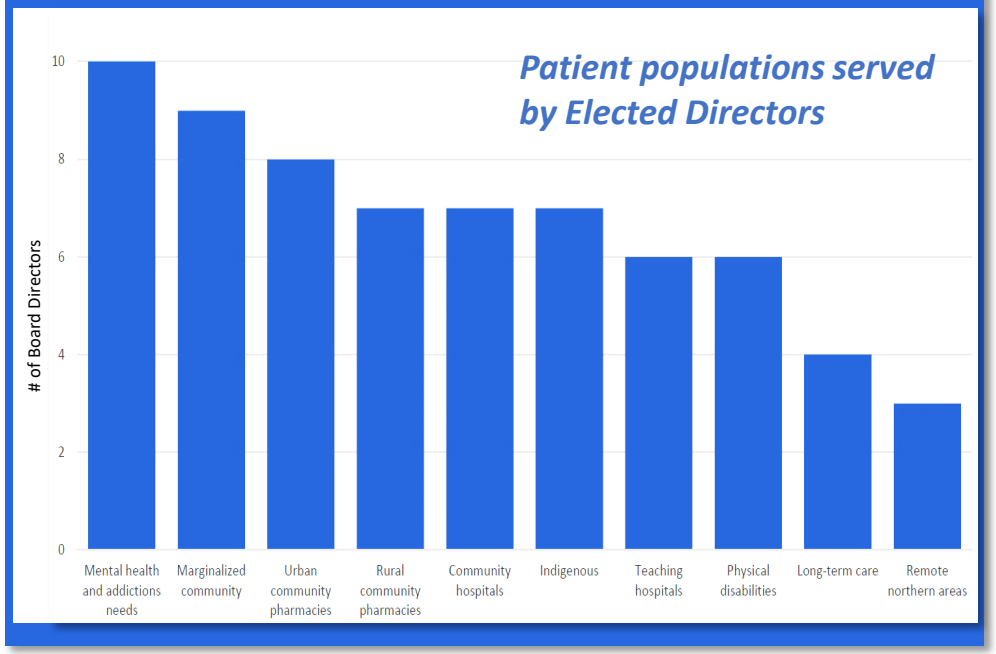
2023 OCP Board of Director Competencies - Weighted



Diversity on the Board



Areas of Service



BOARD BRIEFING NOTE

MEETING DATE: **March 25, 2024**

FOR DECISION

From: Executive Committee

Topic: Appointment of the 2024 Screening Committee

Issue/Description: Using established legislation and the identified skillsets required, the Screening Committee will screen for competence of individuals who wish to run for election to the Board as well as oversee college committee appointments for the 2024-2025 board year.

Public interest rationale: Ensuring there are robust and transparent governance practices setting out the process for screening candidates, including external unbiased individuals versed in governance principles, provides protection against both real and perceived bias.

Background: Annually before the Board election cycle, the Board appoints a Screening Committee to screen applicants for competency prior to running for election to the Board and being appointed to the College Committees. As per the by-laws, the Committee is comprised of a mix of Board Directors – both public and elected, as well as two Lay Committee Appointees with an understanding of regulatory governance.

The composition of the Screening Committees is set out in the by-laws as follows:

- Chair of the Governance Committee;
- Two (2) additional Directors, one or more of whom shall be a Public Director; and
- Two (2) or more Lay Committee Appointees. Provide a succinct background to the issue for consideration.

Lay Committee Appointees:

We are happy to recommend reappointing the following Directors to the Screening Committee:

- **David Collie, FCPA, FCMA, C.Dir, MBA**
  David has extensive Board, governance, and regulatory experience. As the former President and CEO of The Electrical Safety Authority Dan has served on the NAPRA Board as a public member and was a CPMF Working Group Member. In addition to the Ontario College of Pharmacists, David also sits on many Boards including the Ontario Health Association and Hamilton Health Sciences.

- **Megan Sloan, RPN, BScN, MA**
  Megan is currently the Assistant Clinical Manager at Children's Hospital of Eastern Ontario and a healthcare leader with experience in quality improvement, project management, regulation, governance, and strategy. Megan was a member of the Council at the College of Nurses of Ontario for 6 years and served on the task force established to review to all aspects of its governance — from the basics of how Council is formed, to how it operates. The task force reviewed global governance trends, best practices and expert advice. It also shared how to apply these to the College's governance. The findings and recommendations were published in a report called *Final Report: A vision for the future*.

OCP Board Representatives:
Elected Ontario College of Pharmacists Board Directors are eligible to serve on the Screening Committee unless one or more of the following is true: their term is expiring, and they intend to run for re-election in 2024; they are a member of the Governance Committee - excepting the Chair of Governance who is cross-appointed as provided in by-law section 9.23.

- **Dan Stapleton**
  Daniel Stapleton has had senior roles in several organizations, including VP Corporate Services at the Real Estate Council of Ontario, the regulator for Ontario's real estate profession, where he had responsibility for Communications, Finance, HR, IT, Insurance, Legal, and the Discipline & Appeals Tribunal. He was also CEO of: Human Resources Professionals Association; Canadian Physiotherapy Association; and Ontario Community Support Association. Prior to that he was in hospital administration for several years as Assistant VP Patient Services at Princess Margaret Hospital, and Director, Social Work at Michael Garron Hospital. He has a MSW and BSc from U of T and a certificate in health services management from the Canadian Healthcare Association. In addition to the Ontario College of Pharmacists, his governance experience includes serving on the boards of a large condominium corporation in Toronto, a national professional association, and an arts organization.

- **Shari Wilson**
  Shari Wilson is currently a contract mediator with Parity Consulting. She has extensive governance and financial oversight experience garnered through more than 24 years of experience as Board Chair, Co-Chair and/or Board Treasurer at Kensington Health (formerly Second Mile Club), York Raquet Club and Baycrest Aces for Alzheimer's. Shari also brings strong marketing, branding, and international business skills developed through work as the International Marketing Manager, with Belvedere Marketing and Brand Manager with Carlton Cards. Shari has demonstrated a keen interest in serving the community as demonstrated through volunteer work with The Canadian Breast Cancer Foundation and Friends of Simon Wiesenthal Center. Shari has a Master of Business Administration (MBA) and Bachelor of Business Administration (BBA) from York University - Schulich School of Business.

Motion: That the Board approve the appointments of the 2024 Screening Committee as follows:

- Governance Committee Chair
- Public Director – Dan Stapleton
- Public Director – Shari Wilson
- Lay Committee Appointee – David Collie
- Lay Committee Appointee – Megan Sloan

BOARD BRIEFING NOTE

MEETING DATE: March 25, 2024

FOR DECISION

From: Katya Masnyk, Director, Policy, Engagement and Strategy Implementation

Topic: Preferred Provider Networks (PPNs)

Issue/Description: The Board is asked to provide direction on a possible regulatory response to address risks of patient harm associated with PPN practices.

Public interest rationale: The potential risks to patient safety and wellbeing associated with PPN practices include limiting patient choice and autonomy, increasing patient inequities, disruption of continuity of care and limiting access to care.

Strategic alignment, regulatory processes, and actions: Providing direction and guidance on PPN practices is aligned with the College's 2024-2028 strategic goal #1: "Regardless of pharmacy setting, management and business exigencies do not compromise the health and well-being of pharmacy professionals or impede their ability to adhere to the Standards of Practice and Code of Ethics."

Background:

Preferred Provider Networks (PPNs) are contractual agreements between a specific payer (e.g. insurance companies, employers, etc.) and a group of providers (e.g. pharmacies) to provide services (e.g. dispensing prescriptions) to patients. Terms and conditions surrounding access to prescription drugs within a PPN is determined by contractual agreements between insurance companies and pharmacies. There are two types of PPNs – closed and open:

- Closed PPN – Insurance companies set the terms and conditions with a limited group of pharmacies and contractual agreements are not transparent.
- Open PPN – Eligibility to join the PPN is broader and conditions to join are transparent to pharmacies.
- Note: Regardless of whether it is an open or closed PPN, patients can choose a pharmacy outside of the PPN but the patient must pay a higher copay or deductible for prescriptions.

From a patient safety and quality of care perspective, closed PPNs have the potential to cause greater harm because they limit access and choice to a much larger degree than open PPNs.

During the December 2018 College Board meeting, background and concerns about PPNs were raised and discussed for decision (see Attachment 18.1a). The main points highlighted during the Board meeting included:

- The College does not have any legislative or regulatory jurisdiction over the practices of employers, insurance companies or pharmaceutical manufacturers.
    - Since PPNs are established by employers who negotiate and purchase group benefits plans from third parties on behalf of their patients, the College does not have the regulatory mechanism to restrict the use of PPNs.
- A thorough policy analysis on the potential risk of harm PPNs may have on the public identified three core

issues: Freedom of choice, disruption of continuity of care, and limited access to care.

- Since disruption of continuity of care and limiting access to care are risks to patient safety, these two issues were analyzed further. The conclusion was both issues could be managed within the College's existing regulatory framework.

During the 2018 discussion, the Board concluded that the College did not have the authority to intervene in the negotiation of PPN agreements between pharmacy owners and insurance providers. At the time, the Board directed the CEO and Registrar to raise Board concerns to the Minister of Health (see Attachment 18.1b). Despite the submission of this letter, no further action from the government was taken.

Since December 2018, PPN arrangements in the pharmaceutical sector have continued, bringing to light how PPNs are limiting patient choice, fragmenting care and limiting timely access to pharmacy services. While PPNs have been a topic of discussion and debate across pharmacy regulatory authorities, an updated 2024 jurisdictional scan concluded there have been no changes to the provincial or territorial regulatory oversight of PPNs since 2018 (see Table 1). Only three provinces have established a regulatory response: Nova Scotia through their Code of Ethics, Quebec through legislation, and Ontario through regulation.

Table 1: 2024 Jurisdictional scan of Canadian Pharmacy Regulatory Authorities on Regulatory Response to PPNs

Province	Has a regulatory response been established to prohibit PPNs?	Regulatory Response
Alberta	No	
British Columbia	No	
Manitoba	No	
New Brunswick	No	
Newfoundland & Labrador	No	
Nova Scotia	Yes	In the NSCP Code of Ethics, under Value III, Respect for Autonomy (third bullet point) it reads: *Registrants only enter into or engage in any arrangements, agreements or businesses that protect a patient's right to safe, accessible and professional health care services.*
Ontario	Yes	The Professional Misconduct and Conflict of Interest regulation under the *Pharmacy Act, 1991* in Ontario states: 2. (1) The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code: Business Practices 22. Entering into any agreement that restricts a person's choice of a pharmacist without the consent of the person.
Prince Edward Island	No	
Quebec	Yes	In *The Act respecting prescription drug insurance (chapter A-29.01)* in Quebec: **42.2.1.** No group insurance contract or employee benefit plan may restrict a beneficiary's freedom to choose a pharmacist.
Saskatchewan	No	

The most recent agreement between Shoppers Drug Mart and Manulife in January 2024, which has since been reversed, emphasized concerns raised about specialty drugs becoming less accessible to those in rural or remote regions and/or for patients enrolled in Manulife who didn't live near a Shoppers Drug Mart[1]. These concerns have

[1] Benchetrit, Jenna. "Manulife-Loblaw deal raises questions over ties between insurance companies, big drug retailers." CBC News. Is a https://www.cbc.ca/news/business/manulife-loblaw-deal-deliver-specialty-drugs-1.7098861

continued to highlight whether additional regulatory measures providing stronger oversight over PPN practices is warranted.

Analysis:

As a risk-based regulator, a decision regarding the College's regulatory response is based on a consideration of several key elements: the potential risk of harm to patients (likelihood and impact), current legislative frameworks and a consideration of whether others are also involved.

Is there a risk of harm to patients?

In addition to the problem described and risks identified in the December 2018 Briefing Note to the Board, which included infringement on freedom of choice, disruption of continuity of care, and limited access to care, two additional risks to patient harm are being considered:

1) **Patient Autonomy and Equity**

   PPNs limit patients' choices of pharmacists and pharmacy. Additionally, ethical and equity issues are raised when patients are forced to use specific pharmacies within the PPN, limiting patient autonomy – the right of patients to make decisions about their own health care. Patients are making decisions to cut ties with their current pharmacist to ensure their essential prescription drugs are covered. Even though employers may argue that it is the patient's "choice" to sever ties, patients are making the choice out of financial need, not due to informed decisions about the quality of care they receive.

   This creates an issue of equity. Those who can afford to pay the additional copay or deductible to receive care from their preferred pharmacist outside of their PPN are able to express patient autonomy and true consent – but at a price. Patients forced to receive pharmacy services within the PPN because of their financial circumstances, need to navigate restrictions on access (e.g. shipping requirements, rather than direct in-person access or travel a further distance to visit a preferred pharmacy). These restrictions result in inequities for those who can't afford to stay with their preferred pharmacist – the very group who may need ease of access most.

2) **Comprehensive Care**

   Pharmacists play a significant role in the patient's circle of care and over the past several years, have expanded their scope of practice to provide health services beyond dispensing. Pharmacists are playing an increased role as primary care providers, especially in more rural or remote areas, where primary care physicians or nurse practitioners are difficult to access. For these patients, pharmacists are essential health care providers. Fracturing the patient-provider relationship by mandating insurance company PPNs significantly impacts the delivery of comprehensive primary care. Research (Bes et al., 2017) has shown that PPNs have negative effects on the patient-provider relationship, such as lower trust and satisfaction when patients are restricted in their choice of provider[2]. Lower trust can lead to ineffective communication between patient and providers, which leads to poor patient outcomes and can impact patient safety[3]. With communication breakdowns being a leading source of medical errors, fracturing the patient-provider relationship points to a potential risk of patient harm.

Conclusion: The risks posed by PPNs which impact patient autonomy, equity and comprehensive care are at risk of harming patients.

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[2] Bes et al. Selective contracting and channelling patients to preferred providers: A scoping review. Health Policy 121 (2017) 504–514. http://dx.doi.org/10.1016/j.healthpol.2017.03.008

[3] Agency for Healthcare Research and Quality. Shared Decisionmaking To Improve Patient Safety, Education, and Empowerment. September 2016. Pub. No. 16-0053-1-EF. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/shareddec-1.pdf

Are the risks currently managed? Can they be solved locally?

Since the College does not have the regulatory mechanism to directly oversee PPNs, is there another external group handling these additional risks? Associations such as the Canadian Pharmacists Association (CPhA) and the Ontario Pharmacist Association (OPA) have issued position statements and papers on how PPNs compromise quality and accessibility of health care for patients. While they have called for restricting the formation of certain PPNs to allow for fair competition among pharmacies, there is no oversight over agreements between insurance companies and pharmacies. Media reports have highlighted how the terms and conditions of these agreements vary widely and remain private. As a result, associations are also calling for regulatory action to address the risks PPNs pose to patients.

The Professional Misconduct and Conflict of Interest regulation, *O. Reg. 130/17* under the *Pharmacy Act, 1991* includes s. 2(1)22, which states: "Entering into any agreement that restricts a person's choice of a pharmacist without the consent of the person" is considered professional misconduct. From a legal perspective, it can be argued that patients "provide consent" to joining the insurance company's PPN, including any terms and conditions, in order to participate in their employer's group benefits plan. However, as analyzed above, from an ethical and equity perspective, this is not true consent. Patients with financial limitations have no real option of opting out of the PPN[4].

Conclusion: The risks posed by PPNs are not being managed by another entity, thus a regulatory response is warranted.

What are OCP's regulatory options?

To address the risks PPNs pose to patient harm, several regulatory options exist:

1. **Status Quo**: As recommended in the December 2018 Briefing Note to the Board, continue to communicate the College's concerns about the impact of closed PPNs on the risks to patient safety and suggest government encourages employers and insurance companies to support open PPN models only.
   Benefit – Aligned with the Board's decision in 2018
   Risk – Doesn't address the risks to patient safety as discussed above

2. **Issue a Position Statement**: The Board can issue a position statement that highlights the ethical and equity issues that PPNs create, including the impacts on patient safety, quality of care and continuity of care.
   Benefit –
   - Rests squarely within the College's mandate and existing legislative framework.
   - Can be done within a short period of time and without additional funding.
   - Provides confirmation to patients and the public that the College recognizes the quality-of-care issues raised by PPNs.
   - Can be used as the foundational cornerstone for additional long-term work (i.e., could be step 1 of a comprehensive, phased approach).

   Risk –
   - Position statements do not have enforcement consequences associated with them.
   - May influence broader Government Relations strategy if the government takes a different approach to PPNs.

3. **Integrate approach to PPNs with project work related to Strategic Goal #1 of the 2024-2028 Strategic Plan**: Given the impact PPNs have on the management and business practices of community pharmacies, there are opportunities to align next steps with the work associated with managing the practice environment. These next steps would be shared in conjunction with work plans related to Strategic Goal #1. This would also increase Government Relations efforts behind Strategic Goal #1 and PPN agreements.

[4] This is known as a "Hobson's choice" where true "choice" is not possible because one of the possible choices (e.g., purchasing needed drugs outside the PPN) is highly undesirable.

Benefit –

- An aligned approach with an existing strategic goal would prioritize PPNs and ensure it is incorporated and coordinated with broader initiatives.
- Allows additional time to explore stronger enforcement options.

Risk –

- Longer timeline: Outcomes and next steps associated with addressing PPNs may not occur for the next few years as the College develops and implements project work related to Strategic Goal #1.
- A focus on PPNs within Strategic Goal 1 may take resources away from other Strategic Goal 1 priorities.

4. **Submit amendments to the Professional Misconduct and Conflict of Interest regulation (*O.Reg.130/17*), similar to Quebec's legislation**: This requires regulatory amendments and public consultation, College Board approval and Ontario government approval.

Benefit –

- Strongest regulatory response - makes it very clear that PPNs are restricted under regulations
- Clearly within the jurisdiction of the College.
- Based on existing precedent set with loyalty points when they were added to the professional misconduct regulations in 2004.

Risk –

- Timeline: amending misconduct regulations is a lengthy process.
- The final decision rests with the Ontario government and is outside the control of the College.

Operational implications

A number of key operational and financial implications exist:

- Depending on the option(s) selected, this work will be prioritized over other policy initiatives, which will impact the workload and timelines of initiatives being led by the Strategic Policy and Communications departments.
- If other initiatives identified need to move forward in addition to next steps associated with PPNs, will the Board consider adding funds to support additional resources?
- Additional funds or resources may be requested to support any Government Relations efforts as this is not part of the current budget.
- If Option 1 (status quo) is selected, the ongoing issue for both Conduct and Legal departments is the current ambiguity around PPNs makes it challenging to investigate and prosecute these cases, and these cases can be resource intensive.
- If Option 4 (amendments to Professional Misconduct and Conflict of Interest regulation) is selected and approved by the government, this will likely result in an increase in investigations and prosecutions relating to PPNs.

Recommendation: Move forward with a phased, multi-modal approach that includes options 2 through 4:

- Short-term: Issue a position statement, which will be reviewed and brought for approval during the June 2024 Board Meeting.
- Medium term: Integrate approach to PPNs with project work related to Strategic Goal #1 and continue to explore stronger regulatory responses.
- Long-term: Develop and propose amendments to the Professional Misconduct and Conflict of Interest regulations.

Motion: That the Board provides direction to College Management to move forward with a phased, multi-modal approach to addressing PPNs, including short-, medium-, and long-term regulatory responses, as described in the recommendation above.

Next Steps:

If approved, College staff will move forward with developing a draft position statement on PPNs for the Board's review and approval with the goal of issuing the position statement shortly after the June 2024 Board Meeting. Plans to incorporate PPNs into Strategic Goal #1 will be shared with and discussed during future Board meetings. College staff will seek advice from the Ministry of Health on proposing amendments to *O. Reg. 130/17*.

Attachments:

- 18.1a – December 2018 Council Briefing Note on Preferred Provider Networks
- 18.1b – January 2019 Letter to Minister Elliott on Preferred Provider Networks

Ontario College of Pharmacists
Putting patients first since 1871

COUNCIL BRIEFING NOTE
MEETING DATE: DECEMBER 2018

FOR DECISION	X	FOR INFORMATION

INITIATED BY: Executive Committee

TOPIC: Preferred Provider Networks (PPNs)

ISSUE: Consideration of the regulatory role related to preferred provider networks.

BACKGROUND Preferred provider networks have existed in both the public and private sector in a variety of industries for many decades. A **preferred provider network (PPN)** is a group of providers (e.g. pharmacies) that have come to an agreement with a specific payer (e.g. insurance company) to provide services (e.g. dispensing prescriptions) in accordance with certain pre-agreed terms (e.g. to dispense generic drugs only)[1].

Preferred provider networks are very prominent in the US in multiple forms within the healthcare industry[1]. Health Net, an organization that provides health benefits to over 5 million individuals across the US has a long-established PPN[2]. This PPN involves hospitals, health care providers and other relevant organizations to discount services by in-network providers.

There has been recent growth in PPNs in Canada as Canadian payers have identified PPNs as a financially sound model to control costs[1]. PPN structures are present in a variety of healthcare settings in Canada including optometry, physiotherapy, chiropractic care and pharmacy. Pt Health for example, an organization that provides services such as physiotherapy and chiropractic care in Canada, has established a PPN that allows network participants services at a discounted rate[3]. Rostering models in primary care (Family Health Organization, Family Health Group) would also be considered a type of PPN, as government must pay separately if patients seek services outside of their rostered clinician.

PPNs in Pharmacy

PPNs are gathering popularity in the pharmacy industry as insurance companies try to combat the rising cost of drugs. In 2017, PPNs comprised 85% of Medicare prescription drug benefit plans in the US[4]. Payers incentivize patients to use a pharmacy within the network through various channels such as subsidizing the prescription co-pay. In addition, payers often discourage patients from using out of network pharmacy providers through penalties such as a higher co-pay or even no drug coverage. PPNs often offer additional services to participating patients such as providing these patients with dedicated counselling sessions, adherence support services, and education for their conditions. Since the prevalence of PPNs is rising, pharmacies are pressured to participate in these networks in order to maintain their patient base. PPN models exist in many forms, including chronic medications PPNs, for example Express Scripts Canada mail-order pharmacy[5], medical marijuana PPNs, for example Manulife and Shoppers Drug Mart[6] and specialty drug PPNs (see below).

[1] https://ecatalyst.mckesson.ca/documents/1030040/1030056/6-en.pdf/ddad79bd-4a0a-483b-ba72-2da67faf49d5
[2] https://www.healthnet.com/
[3] https://www.pthealth.ca/ppn/
[4] https://www.drugchannels.net/2016/10/exclusive-preferred-pharmacy-networks.html
[5] https://wwwuat.express-scripts.com/index.html

Specialty Drugs PPNs
The pharmaceutical landscape is evolving with a rise in the number of specialty drugs in the market. Specialty drugs are medications with specific handling (e.g. refrigeration) or dosing form (e.g. injection) requirements and are typically a significantly higher cost than traditional small molecule oral drugs[6]. These specialty drugs can be critical in a patient's care, but are associated with a large financial burden. This model is also often driven by pharmaceutical manufacturers trying to maintain or increase market share. In Canada, the cost of specialty drugs is estimated to increase to 42% of total drug claim costs by 2020[7]. PPNs are increasingly becoming more prevalent in the area of specialty drugs as manufacturers and payers aim to reduce this financial burden. Insurance providers such as SunLife[8] and GreenShield[9] have introduced preferred provider (pharmacy) networks for specialty drugs in partnership with pharmaceutical manufacturers.

Nationwide response to pharmacy PPNs
Currently, no province or territory in Canada has regulations or guidelines in place to prohibit pharmacy preferred provider networks except for Quebec, where it was established and is enforced by the government, not the regulatory authority. The College of Pharmacists in Nova Scotia encompasses the issue of patient choice within their Code of Ethics. They have reminded members not to engage in arrangements that limit patient choice.

ANALYSIS:

Regulatory Jurisdiction
In considering this issue it is first necessary to acknowledge that the College does not have any legislative or regulatory jurisdiction over the practices of employers, insurance companies or pharmaceutical manufacturers. Preferred provider arrangements are established by employers who negotiate and purchase group benefit plans from third parties on behalf of their employees. Therefore, the College does not have a regulatory mechanism to restrict the use of PPNs.

Regulatory Role
Given the College does not have regulatory jurisdiction to restrict the use of PPNs, the fundamental question for the Council is whether the current preferred provider networks in pharmacy have an impact on the public's well-being such that there is any regulatory role for the College. In order to facilitate an efficient approach for this discussion, Harry Cayton's "Right Touch Regulation" assessment model has been used for the analysis. Right Touch Regulation uses a decision tree to help focus on the risk that is being managed and to assist in targeting a proportionate response by asking a series of questions. This approach has been applied previously when the College reviewed the ownership requirements for pharmacies.

What is the problem? Is the problem about risk? What are the risks?

In response to concerns raised previously by members of Council, the College's Executive Committee has considered the matter of PPNs and has identified three core issues: infringement on freedom of choice, disruption of continuity of care, and limited access to care.

Freedom of Choice
There is a view that preferred provider (pharmacy) networks have a negative impact on the public because patients are restricted in their choice of pharmacy provider in order to be eligible for

[6] https://business.financialpost.com/cannabiscannabis-business/manulife-joining-shoppers-drug-mart-in-medical-marijuana-program
[7] https://www.schueler.ca/combat-rising-drug-costs/
[8] https://www.sunlife.ca/Canada/smallbusiness/Focus+news/2012+issues/Sun+Lifes+Specialty+Drugs+Preferred+Provider+Network+is+coming?vgnLocale=en_CA
[9] https://www.providerconnect.ca/Carriers/GreenShield/Pharmacy/PharmacyManuals/en_CA/PharmacyClaimsManualOct2008.pdf

PPN benefits. If patients' regular pharmacies are not part of the preferred provider network, patients have no choice but to transfer their prescriptions to an in-network pharmacy if they wish to receive third party reimbursement for the medication.

Risk of disruption of continuity of care
Some patients have a PPN only for their specialty drugs, and another pharmacy for all other medications. Concerns have been raised with regards to the lack of continuity of care and increased risk of medication incidents when a patient uses more than one pharmacy. Since neither pharmacy has access (unless specifically requested) to the complete medication list of the patient, potential drug interactions could go unnoticed. If a patient transfers all their medications to an in-network pharmacy, the medical history (e.g. intolerances, lifestyle information) recorded with the previous pharmacy potentially could be lost during the transfer hence disrupting continuity of care. Patients may have formed a trusting relationship with their current pharmacist and be frustrated to transfer their care to another pharmacist whom they have never met.

Risk of limiting access to care
Lack of access is identified as a concern with PPNs, particularly in rural areas, whereby patients may have to travel long distances in order to access an in-network pharmacy, regardless of whether there is a pharmacy in the local community that can provide the required medication.

How great are the risks? Do the existing PPN terms result in a risk to members of the public? Are the risks currently managed?

Of the components described above, only two are considered to be risks to the patients associated with PPN practices: the risk of disruption of continuity of care and the risk of limited access to care. Each of these risks is managed through the existing regulatory framework which requires pharmacy professionals to practice according to the standards of care for the profession.

Disruption of continuity of care
Currently, it is well known that many patients do not obtain all of their medications from a single pharmacy. However, all pharmacists are required to adhere to the Standards of Practice to ensure optimal delivery of patient care. This would include ensuring a complete patient medical and medication history is obtained from all sources including previous pharmacies prior to providing care. Given this requirement, continuity of care should be ensured regardless of which or how many pharmacies patients use. Pharmacy professionals who provide specialty drugs to patients will have expertise in therapeutic knowledge with regards to these specialty products. When a patient has more than one pharmacy, collaboration is especially important and expected to ensure continuity of care and patient safety. Assuming pharmacy professionals uphold these practice standards and responsibilities, patients will receive a similar standard of care from their in-network pharmacy. If pharmacy professionals fail to uphold these standards, there is a mechanism in place to address the concern through the College's complaints process. Hence, the risk with regard to lack of continuity of care can be managed.

Lack of access to care
PPNs can increase access to specialty medications for patients who would otherwise not have been able to have the funds for the full cost of their medications. Delivery options exist and should be established in accordance with Standards of Practice, for example, the use of appropriate cold chain protocols to ensure that patients in both urban and rural settings continue to have uninterrupted access to care. In addition, mechanisms to ensure patients have access to a professional who is knowledgeable about their medications should be in place. Hence, if timely delivery mechanisms and a professional who can support the patient in their medication management is available, the risk with regard to access to care can generally be managed.

Are there any other factors, beyond risks to patients that should be considered?

Freedom of choice
Although not a risk to public safety, freedom of choice is a public interest issue, an important tenet of patient's first health care, and supported in regulation. The Professional Misconduct regulation prohibits "entering into any agreement that restricts a person's choice of a pharmacist without the consent of the person". PPN enrollment however, requires patient consent, and hence the PPN framework does not breach the Professional Misconduct regulation. Regardless, since many PPNs involve costly medications such as specialty drugs, some contend that patients cannot financially afford to decline consent for network participation, and hence do not truly have a choice but to transfer their specialty drugs to the in-network provider. In these situations, the tenet of freedom of choice is not upheld.

Affordability
The principle of affordability is linked to access to care. In 2017, the Canadian Institute for Health Information reported that drug costs accounted for the second largest share of health spending (16.4%), behind hospital costs (28.3%) and ahead of physician services (15.4%)[10]. Employers are not required to provide coverage for drugs but may choose to use PPNs to provide a financially viable method to ensure coverage of drugs as well as high cost drugs for their employees, thereby increasing access to care for their population. In accordance with the Code of Ethics, pharmacy professionals are expected to "make every reasonable effort to provide quality cost-effective pharmacy care and services to patients and society".

Is there a good regulatory solution? What is the suggested plan of action (from a regulatory perspective)? What consequences (intended and unintended) are likely to flow from any of the potential recommendations?

The concern regarding true freedom of choice is valid as is access to care. However, given the current economic environment and the public discourse on access to care, on balance, it would appear that the public interest would be better served by providing improved access. In addition to offering delivery options to patients, an open PPN model that allows any pharmacy willing to satisfy established criteria to be included in the PPN, would allow better access to care than the existing closed PPN models.

In addition, the identified risks associated with PPNs are addressed through the requirement to meet the standards of practice; and the College has not been presented with any evidence that would cause it to conclude that PPNs are in violation of any regulations or the Code of Ethics. However, as always, the College would have concerns should any established or emerging business model restrict, prevent or create new barriers to pharmacies or pharmacy professionals from being able to act on their professional obligations.

Although the College does not have legislative or regulatory jurisdiction to restrict the use of PPNs, communication to government about the impact on patients, and the potential to enhance access to care through an open PPN model, would be aligned with the College mandate to serve the public interest and improve patients' well-being. It would also be prudent for the College to remind members that they are expected to practice in accordance with the Standards of Practice and to ensure that continuity of care, access to care and patient safety is not compromised, regardless of whether there are multiple providers involved in the care of a patient.

[10] http://nationtalk.ca/story/cihi-total-health-spending-in-canada-reaches-242-billion

RECOMMENDATION: That Council direct the Registrar to formally communicate the College's concerns about the impact of closed PPNs on patient well-being and suggest government encourage employers and unions to support open PPN models.

EXECUTIVE COMMITTEE RECOMMENDATION AND COMMENTS (if any):

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

January 30, 2019

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
Hepburn Block, 10th floor
80 Grosvenor St
Toronto Ontario
M7A 2C4

Re: Preferred Provider Networks

Dear Minister Elliott:

At its December 2018 meeting, Council directed that the College convey to you its recent discussion regarding closed Preferred Provider Networks (PPNs) and the potential for such networks to have a negative impact on patient choice and continuity of quality pharmacy care. The College respectfully requests that the Minister encourage business to consider open PPN models as a matter of public interest. I have attached to this letter the briefing note that was presented at the December Council meeting for your information.

As the mandate of the College is to serve and protect the public interest and to ensure "access to adequate numbers of qualified, skilled and competent regulated health professionals," it does not have legislative or regulatory jurisdiction to restrict the use of PPNs and has not been presented with any evidence that would cause it to conclude that PPNs are in violation of any regulations or the Code of Ethics. However, the College would have concerns should any established or emerging business model negatively impact patient care and autonomy or restrict, prevent or create new barriers to pharmacies or pharmacy professionals from being able to fulfill their professional obligations.

PPN arrangements are established by employers who negotiate and purchase group benefit plans from insurers on behalf of their employees. An open PPN model allows any willing pharmacy to participate in the PPN if they are able to satisfy established criteria. Closed PPN models are prescriptive regarding which pharmacies can participate.

Benefits of PPNs for patients have been acknowledged, as have the potential risks associated with closed PPN models that may restrict a patient's choice of pharmacy or require patients to switch pharmacies to an in-network pharmacy, sometimes at great distances, in order to be reimbursed through their insurance plan for their medications. Open PPN models, on the other hand, could help limit the potential risks associated with disruptions in continuity of care and choice while still providing the economic benefits to both patients and employers.

Therefore, the College is formally expressing its view regarding the potential risks to the public interest and to quality patient care associated with closed PPNs. To mitigate any such risk,

employers and insurance providers should be encouraged to instead consider open PPNs models that promote greater patient autonomy and continuity of care.

In the meantime, the College continues to remind registrants that they are expected to practice in accordance with the Standards of Practice and to ensure that continuity of care, access to care and patient safety is not compromised, regardless of whether there are multiple providers or a single provider involved in the care of a patient.

Many thanks for your consideration.

Sincerely,

Nancy Lum-Wilson, R.Ph., B.Sc.Phm., MBA
CEO and Registrar

cc: Laurel Brazill, Director, Stakeholder Relations
Emily Beduz, Senior Policy Advisor