Summary Report:

Potential Merge to One Professional State Pharmacy Organization

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Executive Summary

It is with great pleasure that we present the "Summary Report on a Potential Merge to One Professional State Pharmacy Organization." The joint task force putting together this Summary Report is made up of three pharmacy leaders from the Oregon State Pharmacy Association (OSPA) and three pharmacy leaders from The Oregon Society of Health System Pharmacists (OSHP). Both governing boards have supported the creation of the taskforce in hopes of creating an unbiased and full assessment of a potential merge to one professional state pharmacy organization.

The purpose of this Summary Report is not to give a recommendation to merge or to stay separate, but to document facts and survey results from other state societies and provide a potential framework should both governing boards decide to move forward with a merge. Also, the Summary Report is intended to be shared widely with each organization's membership. Our hope is that this will create professional and healthy discussion on this topic so that each governing board can decide on a strategic plan moving forward.

Despite that much of the Summary Report is based on other states' past experiences, this Report is meant to generate thoughts and discussions on what would be best for Oregon pharmacists and the pharmacy profession in the future. Healthcare is complex and always quickly evolving. This Summary Report may be used to decide a path forward, as our state professional organizations must evolve to meet the needs of our memberships and profession.

The taskforce has spent greater than one hundred voluntary hours investigating, interviewing, discussing, and writing this Summary Report. Individuals may or may not agree with the different perspectives presented, but it is our hope that the reader remembers that taskforce members and their interviewees are always trying to do what they feel is best from their perspective.

One common theme observed throughout the investigation was that good pharmacy leadership is paramount to the future success of any state pharmacy organization (merged or separate). Oregon is lucky to have good pharmacy leadership in both state pharmacy organizations. Both organizations should be proud of their historical work in advancing the profession.

It is with great excitement that we present the "Summary Report on a Potential Merge to One Professional State Pharmacy Organization."

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Background of OSPA and OSHP Collaborations

The Oregon State Pharmacy Association (OSPA), established in 1889, and the Oregon Society of Health System Pharmacists (OSHP), established in 1953, each have a long legacy of leadership for the profession of pharmacy. Other professional pharmacy organizations representing more specialized practice or geographic areas have been active at different times in Oregon, but only OSPA and OSHP have sustained a statewide presence and accepted responsibility to represent a breadth of practice settings and concerns. Coalescence of representation has occurred, in part, as a result of industry diversification. Individual pharmacies, pharmacy corporations, and health systems have increasingly become involved in the provision of patient care across a variety of practice settings and patient care needs.

The missions of the respective organizations can be viewed as initially having a relatively narrow focus. OSPA largely represented community (and at one time, primarily Independent) pharmacy; while the OSHP mission and name called for a focus on hospital-based practice. Also evident between the two organizations was a difference in culture, addressed elsewhere, but seen structurally with OSPA historically adopting a model utilizing a paid Executive Director as part of its leadership team, while OSHP relied solely on volunteer leadership.

Relations between the two organizations, pre-1990's, was cordial, but not collaborative, in part reflecting their respective missions. Significant direct conflicts between the organizations, however, have been very limited. The most visible conflicts were the 'PRDA-sponsored' legal challenge in the mid 1970's, in which institutions were subsequently required to maintain separate inventories, and a joint OSHP/OSPA meeting near the turn of this century in which the meeting lacked a promised collaboration in its planning and conduct. Although now historical, these events were unfortunately highly visible and continue to be frequently cited as representative of potential organizational conflict.

The mission statements of the organizations have more recently evolved to be strikingly similar. This evolution appears to be coincident with an expanded scope of practice represented in both organizations and perhaps most visibly noted in the mid-1990's name change from 'hospital' to 'health systems' for OSHP. Taken from the respective websites:
OSHP Vision: Oregon will be a model of excellence for the practice of health-system pharmacy.
OSHP Mission: To promote the professional development of pharmacists and the advancement of pharmacy practice in Oregon through education, collaboration and advocacy.

OSPA Mission: Leading Pharmacy, Advancing Healthcare
Educate - Advocate – Empower – Engage *

* Recently changed; expanded descriptors are available in strategic planning discussions

Cultural differences between the organizations are still present in the conduct of business by the respective Boards of Directors, but similarities and collaboration have become increasingly evident. Both organizations have moved toward a common administrative structure with OSPA's decision to move away from an Executive Director in 2007. Both organizations now utilize (the same) external management firm to facilitate operations. All-volunteer boards make strategic decisions and provide direction to the management firm serving the needs of comparably sized memberships. Revenue generation differs to some degree between organizations, but budgets are comparable in size. Finally, each Board includes a representative from the other organization as a voting member of the Board or as a liaison.

Examination of programmatic topics at the respective educational meetings reveals organization-specific focus for most topics, but also significant overlap. During the past five years, pharmacists have been able to take advantage of education that crosses traditional boundaries as both organizations have extended member's rates to each other's members and allowed some degree of co-marketing. Most recently, select programs (educational and social) and committees have been developed with an expressed intent to serve members from each organization.

The Pharmacy Coalition is often held up as the most obvious collaborative success. The role of OSPA in advocacy, with an Executive Director to lead lobbying, was perhaps more apparent for many years. In the late 1990's, however, an unaffiliated Pharmacy Coalition emerged that included strong representation from both organizations. With the anticipated move away from the Executive Director structure, OSPA employed a lobbyist and within a very short time, both organizations began to share the costs for a dedicated lobbyist. Over the past three to four years, OSPA and OSHP have shared leadership responsibilities in setting the agenda for the Pharmacy Coalition and directing lobbying efforts. A direct correlation cannot be proven, but success in legislative advocacy appears to have paralleled a shared commitment to advocacy.

The backdrop of legislative successes, complementary and collaborative educational and professional development efforts, and similar organizational (if not cultural) administration for both OSHP and OSPA has led to increased consideration of opportunities that may be present with closer affiliation or an actual merger. These possibilities have been discussed informally for many years and more formally by OSPA in 2007/2008. Similar discussions have taken place across the country with mixed outcomes, but resulting in more than a dozen examples of merged professional organizations. The current effort to conduct an in-depth inquiry of the potential advantages or disadvantages was initiated with OSHP Board of Directors approval of the proposal of the following page, guided by the goals and inquiries shown below the Motion.

A similar motion was subsequently presented to and approved by the OSPA Board of Directors. Josh Free, Kevin Russell and Gary DeLander were appointed by OSPA to the task force and work on the proposal began in March of 2016; targeting a delivery date of August 1.

OSHP Motion:

Motion for a task force (3 OSHP members, Zach, Jake, Kristy and 3 OSPA Board members) be put together to investigate a potential merge with OSPA. This task force would be responsible to produce a written summary to be presented to the OSHP Board during the OSHP annual retreat. When in development, the written summary would be confidential within the OSPA/OSHP taskforce. No action on the written summary would be taken without a vote by the OSHP Board for next steps.

Taskforce goals/tasks:

1) Explorer financial situation if organizations merged
2) Evaluate the cultural impact of the two organizations
3) Evaluate the membership and board structure of merger
4) Evaluate what the social and meeting structure could look like with merger
5) Explorer what ASHP or APhA would need/ask. How do we maintain voting delegation with ASHP
6) Get a current contact list of merged (and one's with failed merger) organization leadership
7) Get a contact list of key individuals when organizations merged
8) Survey merged organizations for key questions (may be done best by telephone)

Work of the Taskforce

Members of the taskforce determined the scope, content, and timeline for work to be completed. It was decided to study, as objectively as possible, the impact of merged and non-merged organizations from other states and the potential effect of an association merge in Oregon. This work was broken down as follows:

a) Biweekly meetings- the taskforce met starting Wednesday March 23rd, 2016 and continued biweekly into August. Meetings were via conference call and 30-60 minutes in duration.
b) Surveys and discussions with leaders from other states- all taskforce members were assigned to contact leadership from other states with merger experience to collect opinions and data.
    i) Survey Monkey was used to create a survey soliciting objective data, subjective information, and recommendations regarding merging organizations (see Attachment 2).
    ii) E-mails and personal phone calls were used to solicit surveys and to gain further information.
    iii) Targeted states were: currently merged, merged and now unmerged, and discussed merging but decided against it.
c) Taskforce members were assigned to determine steps and requirements of merging organizations in regards to relationship to ASHP and APHA.
d) Taskforce members were assigned to discuss a potential merger with Update Management and determine current contractual requirements and process for a potential new contract.
e) Current strategic goals of both associations were evaluated.
f) Current culture of each organization was summarized and then the cultural impact of a merge was considered.
g) Organizational structure and management of a merged organization was explored, including academies.
h) Financial outlook of a merged organization was studied using pro-forma financial statements and compared to current financial outlooks for respective associations.
i) The taskforce provided a final report (this report) to the Board of Directors of each respective organization summarizing the data and results of the analysis. Conclusions and recommendations were limited in scope to analysis of elements listed above. Overall conclusions are left to respective boards.

Summary of States Who Have Merged

This summary is intended to be a balanced representation of responses, not a detailed recapitulation; but in some instances specific responses are noted. Best efforts were made to avoid evaluation of speakers' comments.

Demographics:

Responses from sixteen individuals representing eleven states that have merged professional organizations completed at least part of our survey instrument. Individuals responding included a number of association executives, but also ranged from community to hospital to academic pharmacists. The states responding included Alaska, Arizona, Colorado, Indiana, Iowa, Michigan, Montana, Nebraska, North Carolina, Washington, and Wisconsin. With the exception of Alaska, which recently added a Health Systems academy, the great majority of associations have been merged for 10 – 15 years. Most include representation from APhA and ASHP state affiliates, and in a couple instances either ASCP or NCPA were represented.

A general summary of answer to specific questions we posed follows:

Please list two or three reasons that motivated a merger

The top two reasons by far were:

- Financial: Efficiencies and economies of scale in running an organization, noting increased dependence on dues as industry funding has decreased; allowing a decrease in duplicative efforts while still allowing for independence
- Having one voice for the profession: The unity is perceived as being powerful internally and externally; one respondent noted that the unity is important, but perhaps most important when there is disagreement because it forces a conversation and resolution.

Additional notes included:

- Stronger programming overall and less redundancy in programming
- Several states noted low volunteerism, decreasing membership, and unequal resources between associations. Although not characteristic of our situation where associations are roughly equal in resources, in most cases the weaker association was in the health systems. One state noted ASHP supported inclusion health systems in an umbrella as a way to meet the needs of health systems pharmacists (no previous health systems organization).

Would you recommend merger to other states? If so, have the advantages matched the motivating reasons to pursue a merger?

Not surprisingly, since this section reviews merged organizations, the overwhelming answer was yes: a merged organization is recommended.
There are cautions noting that this is a state-specific decision and a number of questions, most that we have anticipated, are posed to assure it is a good decision.

The greatest concern was typically balance of power and a perceived diminished attention to health systems. One respondent felt that the Health Systems pharmacists took a wait and see attitude. In one other state, there seemed to be a sentiment that there was a lack of full engagement by health systems pharmacists and the undesirable result was perceived to be that greater power was ceded to the executive and staff.

Did ASHP/APhA have specific concerns with a merger? How were these addressed?
All significant concerns cited were from ASHP; they have policy to assure that health systems pharmacists are adequately represented and have a voice. One respondent seemed to note that reporting requirements for affiliate designation by ASHP continue to make it difficult to act in a unified manner.

What processes, or steps, were followed to secure a decision to merge?
There is not a lot of memory in the respondents on this point and so any emotions involved in the process are not strongly represented.
Several cite the creation of a task force, similar to our process. A significant effort to educate general membership is also cited, followed by a vote of the membership.

How did you transition to one organization once you decided to merge? And how long was the transition period?
Again, there is not a lot of memory among respondents; the transition period ranged from 1 to 3 years.
A few respondents noted utilizing a facilitator to develop shared bylaws and other guidance.
The task force, in some cases, went on to also define the administrative structure.

How did you continue opportunities that interest both community and health-system practitioners?
It was noted by several respondents that this is a difficult effort that requires ongoing attention.
Maintaining some separation in the emphasis for specific meetings or the inclusion of a 'track' at the professional meetings is most commonly cited.
Separate continuing opportunities for leadership are noted and in one case it was observed that significant attention is placed on assuring that strong nominations from all practice settings are secured for elections.

How is your merged organization's leadership structured? and
How is your merged organization's membership structured?

Administratively, for those that commented on paid staff, an Exec Director, Lobbyist, and several staff (2 – 4) are noted. One respondent noted that weak membership has led to a perceived autocratic leadership.
The most common structure involves academies that have representatives to a Board of Directors. The most common academies appear to be Community, Health Systems, and Consultants where each academy has a Chair, Chair-elect, Past-chair. Technician representation was inconsistently characterized. For some, interest groups such as students, *network* is the terminology used rather than *academy*.

Two associations did not create separate practice-based sections or academies as they were grandfathered in separately by ASHP.

The Board of Directors has the typical President, President-elect, Past-President and Secretary/Treasurer. (A couple of associations designate that the President position will rotate between health system, community +/- other academies.) Chairs of the academies are usually also represented on the Board. In some cases, the Board is filled out with regional representation, and in others through at-large members. Typical size appears to be about 16 Board members.

(A note from elsewhere in the document, concern was expressed that, due to an imbalance in membership, at large or regional delegates to Board can end up being all from one practice setting. This warrants attention in constructing any future structure.)

(A Committee observation: The structures do not seem to be in step with the current predominance of practice settings. The inclusion of Health Systems; Community; and Long term care, or consultant, are common, but none mention a separate academy or network for Ambulatory, perhaps because this broad inclusion could mean many settings, but members may tend to identify more with certain other groups – like health-systems or community.)

How have you worked to maintain a sense of identity for pharmacists in different practice settings?
Among the respondents, there is a striking lack of concern around this and several respondents appear to believe that the structure of the organization adequately addresses any concerns. Assuring a diversity of representation on all committees / task forces is highly recommended. One outlying respondent noted the perception that Community dominates and many Health Systems pharmacists opt to join only the national organization; in another state, respondents noted the perception that Health Systems and Academics dominate the association.

How did you transfer finances, what process did you use, and what did you learn from it? and

What are the estimated yearly costs of your management company (includes management company contract, internet, utilities, etc…)? Please report as dollar value and percentage of expenses if possible.

Information in this area was very spotty among respondents.

All appear to have a common budget for the entire organization; in some cases each section or academy prepares and submits a separate budgetary request. In one instance, NC, there was initially a set allocation to each section/academy; but this subsequently was not considered necessary and was not continued.

Specific costs were typically not identified, but NC notes that paid personnel encompass about 50% of the budget.

How does your merged organization participate with Political Action Committee (PAC)? Does it financially support a PAC?

There is a mix, but a slight predominance of associations having a PAC relationship. Efforts are made to be certain PAC leadership is representative and there is a commitment to be active in resolving any differences (which are reported to be rare). Similarly, most, but not all associations employ a lobbyist.

What are the most important lessons learned or insights you would share as a result of considering or completing a merge? and

What other information do you think our task force should consider?

The responses here are not surprising, but none-the-less cautionary.

Combining by itself does not make a merged engaged organization. It is important to have a strong sense of why a merger makes sense and to continue to communicate that even following a merger. If the answer is different for state vs. national, identify and communicate those reasons.

Be certain to think prospectively as to how representation can be balanced; how priorities will be developed and aligned; how difficult conversations will be handled. Key areas for conflict are governance, finance, and politics. All parties need a commitment to having “skin in the game.”

Understand and manage national organization expectations. Similarly, attempt to communicate directly with key persons in opposition.

Finally, the key words that arise are: Communication, Transparency, and Trust.

Summary of States Who Have Decided Against Merging

(previously merged and now separate, or have considered merging but decided against)

This summary is intended to be a balanced representative of responses, not a detailed recapitulation; but in some instances specific responses are noted. Best efforts were made to avoid evaluation of speakers' comments.
Note: only 4 of 38 "non-merged" states were surveyed or responded (Florida, Kansas, Minnesota, South Carolina – briefly); respondents were generally from the ASHP-affiliate.

Please list two or three reasons that motivated (discussion of) a merger (not the actual wording of survey question)
The top two (proposed) reasons (but ultimately not enough to lead to merge):
- Financial
- Having one voice for the profession

Additional notes included:
- Respondents from ASHP-affiliates in non-merged/un-merged states often feel desire to merge is driven by APhA/affiliates; some felt it was attempt at "power grab", others felt membership of ASHP-affiliate was appealing because often very engaged, including many new practitioners

Please list two or three reasons that motivated not/un- merging (not the actual wording of survey question)
- Mission and focus of a state society are very much on practice and policy needs for different practices; practices differ and so do member needs. Difficult for one organization to be all for all.
- In most instances, major loss of purpose and identity for some of the organizations in the merge; lack of dedicated resources/support for health-system issues.
- Declining membership of health-system academy (secondary to perceived "community pharmacy focus" and lack of respect for non-retail practices of parent organization).
- Already collaborate legislatively (though one example that "final straw" was agreeing to an initiative in the coalition only to change recommendation to legislature/others afterwards without discussion/buy-in by all).
- Observation by respondents that while some have truly merged/unified organizations, most have a "parent" organization that seems to be APhA (community practice) driven,

making health-system (and other organization/interest) practices a small subgroup within.
- States with strong health-system organizations do not want to lose this focus (educational programming, advancing health-system practice).
- Also causes potential concern on how to balance power within leadership structure and priorities (i.e., elections - if no structure to rotate leadership and one section has more members than another).

Would you recommend merger to other states? If so, have the advantages matched the motivating reasons to pursue a merger?

Not surprisingly, since this section reviews non-/un-merged organizations, the overwhelming answer was no; a merged organization is not recommended. (Also worth noting, we did not survey all 38 states with separate organizations, but those known to have had the discussion of merging; those that were surveyed, tended to be ASHP-affiliates)

The greatest concern was typically balance of power and a perceived diminished attention to health systems. Also concern about educational programming content being able to meet needs of all members; question if efficiencies are gained when there is a need to have multiple different tracks/meetings for different focus, especially if not a large organization as this can require additional resources.

Did ASHP/APhA have specific concerns with a merger? How were these addressed?

ASHP's mission is to support pharmacists and practice in hospitals and health-systems; often this is thought to be diluted in merged organizations.

What processes, or steps, were followed to secure a decision to merge?

Many states formed taskforces similar to ours to explore and present to BODs/HODs to vote. Others did not feel it even warranted a discussion/exploration.

How did you transition to one organization once you decided to merge? And how long was the transition period?

N/A

The previously-merged, now un-merged organization recommending having clarification in by-laws on how to unmerge (finances, intellectual property, membership lists) if that had to happen (they did not have this, separation was contentious).

How did you continue opportunities that interest both community and health-system practitioners?

Since not-/un-merged, this is not a focus (since they can focus on specific practitioners); noted by most that this is a concern/struggle with merged organizations (perceived or experienced).

How is your merged organization's leadership structured? and
How is your merged organization's membership structured?
Again, respondents expressed concerns about balance of power (in elections and/or "direction" by some Executives) and if the health-system academy is "only" a subgroup of the larger "state association" organization rather than all practice areas having academies. (1 vote of X)
Variability in structure for technician & student chapters/academies/networks.
Some organizations seem to have many groups (health-system, community, owners/managers – unclear if different groups for different settings, managed care, academia, long-term care, students, new practitioners, techs), while others have only 2-3.

How have you worked to maintain a sense of identity for pharmacists in different practice settings?
Since not-/un-merged, this is not a focus (since practitioners join the organization(s) with whom they align).
Noted by many that this is a concern about merged organizations (since membership may not be equal, focus/efforts may not be equal or even proportionate).

How did you transfer finances, what process did you use, and what did you learn from it?
What are the estimated yearly costs of your management company (includes management company contract, internet, utilities, etc…)? Please report as dollar value and percentage of expenses if possible.
Respondents recommend clarifying how member dues and CE dollars would get distributed (general fund vs separate academies) as merged organization.
When separating, this was a challenge for one organization, so they ended up starting with nearly nothing (even though they had contributed going into the merger); for some states, dues for merged organization was higher than separate.

How does your merged organization participate with Political Action Committee (PAC)? Does is financially support a PAC?
Some use a joint PAC/lobbyist, others collaborate less formally.
Some respondents expressed concern (like with other areas) that loudest voice or most members in the room can drive agenda. Some experiences of community issues driving priorities.

What are the most important lessons learned or insights you would share as a result of considering or completing a merge?
What other information do you think our task force should consider?
Respondents recommended/noted:

- Review the purpose of society and your mission, and whether that can be supported to the same (or better) degree in a merged organization.

- Strongly consider the "why"; is it member-driven (all or vocal minority? Are there different views for "general" members vs. those in leadership?), financially driven? Is it wanted by both/all organizations or predominantly one-sided? Is one organization failing? Do you risk losing state members who may only remain active at national level if they don't feel like a professional home exists for them in-state?
- Ultimately organizations don't just want member numbers, but also want active and engaged members. Members need to feel that their professional home aligns with practice areas/interests (think about medicine colleagues).
- Are there the same opportunities for involvement, leadership if merged? Do you try to standardize the amount of volunteers? What happens if one academy doesn't fill their allotted positions?
- Consider remaining separate but collaborating where appropriate. It was noted that national organizations are collaborating more (especially ASHP and APhA), but they have no intention of merging. Part of that discussion is the question if one organization be everything to everyone.
- Merging and having an Executive Director are separate discussions, but often large merged states have an Exec (as do many states with large memberships in separate organizations), so that is often part of the appeal. However, smaller states may not be able to have Exec and enough staff to support all members/academies interests equitably which can lead to perceived "imbalances".
- Bylaws must be clear on processes and reviewed annually, and everything should be documented.

Strategic Goals of OSHP

In 2015, the OSHP Board agreed to align their activities around ASHP's Practice Advancement Initiative (PAI). While these recommendations are far-reaching and broadly-based, this past spring's Oregon PAI Summit identified two major goals to focus on as an organization:

1) Development of credentialing and privileging pathways for pharmacists
2) Advancement of technician roles

Details of how these goals are to be achieved in Oregon are yet to be worked through, but some general principles are noted here:
As health care continues to evolve, so do the opportunities for pharmacists to advance our practice. To provide optimal patient-centered care, pharmacists who provide clinical pharmacy services must attain and maintain appropriate competencies through training and/or commensurate experience, and credentials. The development of credentialing and privileging for pharmacists speaks to a pharmacist's specialization in different practice areas and/or settings. It is widely recognized that extra training and certification is required for a field such as nuclear pharmacy; as the health care system has evolved to become much more complex, different roles require different skill sets. In order to demonstrate competence to provide these specialized services, OSHP (and ASHP) have expressed the need for credentialing and privileging programs that include pharmacists. Such programs require that pharmacists demonstrate appropriate competence and credentials, which may (but not necessarily) include requirements of residency training, specialty residency training, board certification, etc. It is felt that these types of programs serve the institution of pharmacy well to advance practice and ensure that our patients have qualified pharmacy practitioners to provide their care.

To allow pharmacists to practice at the top of scope, and to continue to advance this scope of practice, the role of technicians also needs to advance. The advancement of technician roles is supported by a strong technician educational pathway, with nationally recognized certification standards that ensure a minimum level of education and competence upon entering the pharmacy technician field. With a qualified workforce, many medication distribution tasks may be reassigned to technicians with appropriate pharmacist oversight, making it possible to redeploy pharmacists' time to clinical activities. Examples of more advanced technician roles include the expansion of tech-check-tech programs and use of technicians in non-clinical roles with appropriate oversight (e.g. medication reconciliation data gathering). Nationally, this has also meant advocating for higher technician wages.

In addition to the PAI strategic goals, there are other areas that OSHP views as key to their strategy:

1) Legislative Activity – The Joint Legislative Council has been largely viewed as very successful.
2) Educational Programming – Membership tend to favor strong clinical programming absent of direct industry sponsorship. OSHP's two conferences represent about 65% of their anticipated income each year.
3) Professional engagement and development of membership (not only through leadership, but via recognition and networking at various events, as well as residency specific-programs)
4) A commitment to technician chapter and support of student chapters

Strategic goals of OSPA

OSPA focused efforts around several key initiatives in 2015-16:

1. Increasing the fiscal responsibility of events (as a main revenue driver)
2. Increasing service and presence in all geographic areas of the state through sponsoring smaller, regional events with a specific focus on pharmacist certificate programs (Cardio, MTM, Immunization, Diabetes, others)
3. Re-thinking the organizational mission and strategic objectives, where the following was adopted:
    a. Mission Statement:
        i. Leading Pharmacy. Advancing Healthcare
    b. Strategic Objectives:
        i. Educate
        ii. Advocate
        iii. Empower
        iv. Engage
4. Bringing pharmacists together through merger with PSOP and OSCP
5. Continued advocacy for legislative action which supports the pharmacist role in healthcare solutions while protecting the business interests of pharmacists
6. Supporting implementation of pharmacist prescribing of birth control
7. Promoting OSPA as a home for all pharmacy professionals

Cultural History of OSHP

OSHP was founded in 1953 after some hospital pharmacists in the Portland area attended an ASHP conference in California that same year. Even in the beginning, meetings typically included a short business agenda followed by a professional speaker (pharmacist or physician) who would speak on professional practice, research or medical issues. Formal affiliation with ASHP came in the 1960s.

Vision: Oregon will be a model of excellence for the practice of health-system pharmacy.
Mission: To promote the professional development of pharmacists and the advancement of pharmacy practice in Oregon through education, collaboration and advocacy.

<u>Key areas of our culture:</u>

Ongoing education/continuing professional development: In addition to the (spring) 3-day Annual Seminar and 1-day Fall Seminar, the Northern and Southern chapters offer numerous weekday evening CE events throughout the year. Members demand high quality, advanced, non-industry promotional (unbiased), clinical and practice management topics. During the larger meetings, there are often student and/or technician tracks with unique programming for their professional development needs.

Students: OSHP has 2 active student chapters (OSU and PU); OSHP has a strong commitment to student engagement in professional activities and providing opportunities for student professional development (e.g., poster presentations, financial support of students attending Clinical Skills Competition, etc.). Student chapter presidents are voting members of the BOD; both chapters are ASHP officially-recognized Student Societies of Health-System Pharmacy. Several local student leaders have been recognized by and involved with ASHP over the years. OSHP also invests in students through strong scholarship support (OSHP has been offering several thousands of dollars in scholarships each year for ~10 years).

Post-graduate training (residencies): Most health systems offer pharmacy residencies, with significant growth in numbers in recent years. This is in alignment with ASHP PAI recommendations to support a highly trained and competent workforce. OSHP promotes collaboration between health-systems in supporting residency development, accreditation standards, and residents. This includes networking, mentoring, and some precepting. Each year, one Northern Chapter and Southern Chapter meeting is dedicated to residency project presentations. Many residents are involved in committees. In absence of a residency by practicing/"seasoned" pharmacists, comparable experience in practice area/specialty is

recognized; non-traditional training experiences/residencies need to be developed to support those who want to change scope/setting of practice.

Advancing pharmacist practice (scope & settings): Members have long-standing involvement with advanced clinical practices (including robust CDTMs), both in ambulatory and acute care settings (broad definitions of both). Despite growth in ambulatory care settings (primary care as well as managed care, community, specialty, and home service settings), supporting pharmacists in "hospital" practice remains an organizational priority. Collaboration between community, primary care and acute care settings is optimal for patient care, but recognition of unique needs/priorities is also necessary. OSHP and its members are and have been involved in leading pharmacy practice and advancing healthcare across various practice environments; members are recognized leaders in accountability for medication outcomes, technology, progressive practices, sustainability, and integration in interprofessional teams. Discussion about reimbursement for cognitive/clinical services is of interest, but there is also recognition of changing payment models and emphasis on quality rather than activities/productivity (especially in Oregon's payment landscape).

Credentialing & privileging: This is a newer priority, aligning with PAI recommendations and preparation for provider status. The majority of health systems support a model that aligns with physician colleagues, facilitating advanced practice commensurate with appropriate experience and credentials.

Technicians: OHSP has a long-standing technician chapter (albeit with variable engagement/leadership from techs). Support and involvement of technicians has always been important; OSHP members were instrumental in bringing the PTCB exam to Oregon both by proctoring the exam and establishing training programs. Having a well-trained, certified and licensed technician workforce is needed to advance technician scope and practice, which (consistent with ASHP PAI recommendations) will allow pharmacist practice to continue to advance.

Industry: OSHP has a long-standing relationship with "ethical" drug manufacturers; industry representatives and medical liaisons work closely with health-system pharmacists to provide requested product information and (in more recent years) disease management programs and tools. This is, of course, in addition to sponsorship of OSHP educational programming through formal grant and exhibitor support. Exhibitor participation and interaction with members at the large meetings is strong and well regarded.

Advocacy: The Oregon Pharmacy Coalition (OPC) formed in 1998; key legislative efforts/priorities include pharmacist provider status, tech-check-tech, technician licensure, therapeutic drug interchange, and advancing the scope of practice of pharmacists and technicians. Focus on Pharmacy Benefit Management reimbursement is not a priority for the vast majority of OSHP members and can lead to frustration with OPC.

Networking: OSHP hosts social events and other networking opportunities for health-system pharmacists to connect, share practice pearls and ideas, collaborate on projects, and even seek new employment opportunities. Numerous mentor-mentee relationships have been formed across health systems. OSHP also has a message board, newsletter, member spotlight, and (newly formed) practice-area Sections/Specialty Interest Groups (Pharmacy Management; Ambulatory Care; Informatics, Technology & Research; Inpatient Practitioners & Clinical Specialists; and New Practitioners). Engaged members (just not number of dues paid), with diverse demographics, has always been a strength and priority for OSHP.

Volunteer leadership: OSHP has always been driven and led by member leaders; this remained a key cultural value of OSHP even with (and perhaps enhanced by) the hiring of Update Management in 2002 to support the day-to-day operations. OSHP has had an active committee structure and large (17 voting-member) Board of Directors, encouraging and providing opportunity for member involvement, and professional and leadership development. Leadership provided by practicing health-system pharmacists to guide practice and organizational goals is a priority.

Relationship with ASHP: Although affiliated with ASHP since the 1960s, the bi-directional involvement with and support for/from ASHP has dramatically increased in the last 15 (or so) years. ASHP staff and/or leaders attend Annual Seminar each year, we receive membership and publication support from ASHP. Donations from ASHP to the OSHP Student Scholarship Fund via the Not-So-Silent Auction are also greatly appreciated. OSHP presidential officers attend annual ASHP Presidential Officers Retreats for state affiliates, and ASHP members from Oregon are elected to serve as Delegates in the ASHP House of Delegates to vote on ASHP Policy. Leadership within ASHP through involvement on ASHP Councils, Commissions and Sections by OSHP members has been strong and consistent in the last 10 years.

Cultural History for OSPA

OSPA was founded in 1889 as a professional trade association representing its member community of pharmacists, pharmacy technicians, pharmacy students, and others who have an interest in advancing the practice of pharmacy through advocacy and education, and thereby improving the health of our fellow Oregonians.

Mission: Leading Pharmacy. Advancing Healthcare.

Key Areas of OSPA Culture

Professional education is a key component of the OSPA culture. Member and non-member pharmacists from throughout Oregon depend on OSPA to provide continuing education and certificate programs, which meet the needs of their practice. Objective, clinical, ACPE accredited CE is the core of educational programing. In addition, OSPA provides education on leadership, business, and professional advocacy topics to help pharmacists advance their practice.

Advocacy is a core role for the association. Pharmacists rely on OSPA to represent their professional and business concerns and to advocate for new professional opportunities. A significant amount of executive committee time and association resources are directed towards lobbying and policy efforts.

Professional networking is important to OSPA membership and the association seeks to provide opportunities for similar and diverse professionals to get together to converse about professional issues and establish business contacts.

National representation – OSPA represents pharmacists in Oregon at APhA meetings and appoints voting members to the APhA House of Delegates. Every year OSPA sends the President-Elect and Association Manager to the National Alliance of State Pharmacy Associations (NASPA) meeting where national issues are discussed and interstate networking connections are made. We also have members serving in leadership roles in other national associations such as NCPA and NABP.

Students – OSPA supports two student chapters at OSU and Pacific and contributes to outreach events, extra curricular programs, and mentoring.

Technician involvement has historically been a challenge, but OSPA felt strongly enough about it to change the organization's name from Oregon State Pharmacists Association to Oregon State Pharmacy Association to be more inclusive of pharmacy technicians. One of the priorities for this year is to provide benefits and educational opportunities for pharmacy technicians to provide membership value.

Governance and Volunteerism

As with the history of most state pharmacy associations, OSPA's main focus in the 20th Century was addressing the business interests of independent pharmacies in Oregon. The business of the association was largely conducted by paid executive directors, guided by the Board of Directors, which was largely made up of independent pharmacy owners.

In the 1990s and 2000's there was a cultural change as pharmacist practice settings shifted towards chain pharmacy. Membership and association revenue declined during this period resulting in the association deciding it could no longer support a paid executive director and association office space. In 2008, OSPA contracted with Update Management to manage the daily business of the association. Members of the Board of Directors, in particular the Executive Committee, took on a more active role in directing and conducting association business.

In the last 10 years, membership and leadership in the association has become more diverse, with representation from all practice settings, ages, and demographics. Increasingly, younger professionals are seeking involvement and demonstrating engagement. The cultural and business focus of association has shifted towards advancing pharmacy practice, through integration with health systems in Oregon, as providers of healthcare.

Some OSPA members and leaders have expressed that the scope and impact of OSPA has been limited without a dedicated executive director. With a limited number of volunteers and hours, issues and projects must be prioritized and timelines lengthened. A dedicated executive working on association business every day could allow OSPA to be more effective and provide a greater benefit to members.

Cultural Impact of a Merger with the Oregon Society of Health System Pharmacists

A merger with OSHP would align with the new mission and goals of OSPA (as referenced elsewhere). OSPA currently advocates for a greater medication management role for pharmacists and integration with other members of the healthcare team. The sudden increase in health-system pharmacist membership would greatly accelerate the ambulatory care shift at OSPA. The organization would need to find a new cultural identity representing all pharmacy professionals and their interests

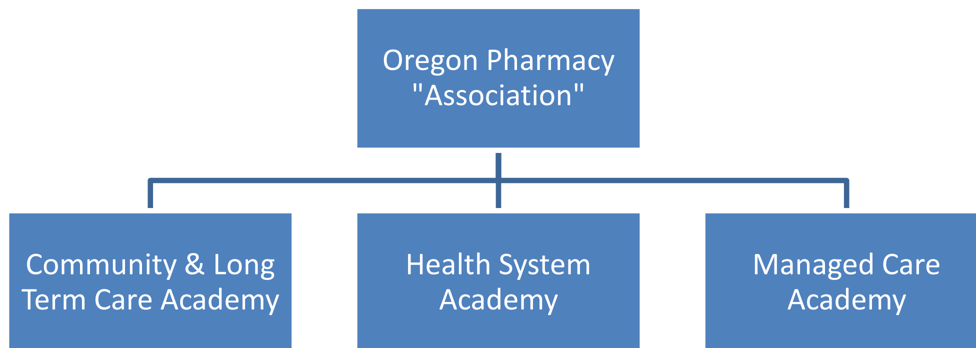
Governance culture would likely change from an association largely run by 3-4 elected Executive Committee members to one run by elected representatives of specialty academies (with or without an executive director).

Potential Membership and Board Structure

Based on the states responding to the survey conducted by the Task Force, there are a variety of structures in place to ensure adequate representation from various pharmacy practice settings, in both the membership and governance structure. There is no unanimous structure for success, but this section of the summary is meant to be a suggestion of what a structure could potentially look like. This potential structure is meant to be a starting point for discussion should a merger take place. The specific academies and reporting structure in the example are only intended to be illustrative of what has been observed in the Task Force's research, and are not intended to constrain full consideration of possibilities that would need to be explored were a merger to be proposed.

Membership

The membership could be structured to have one overarching organization ("One Voice", "Association") with multiple academies of interest underneath the umbrella organization. Members of the "Association" must pick at least one academy to belong to, but could belong to more than one Academy. Each academy could have its own Chair, Chair-Elect, and Immediate Past-Chair. Each Academy would meet separately to develop a strategy to best support its membership interests.



Each Academy could also have their own Section/Specialty Interest Groups (SIGs). These could be developed to support the various practice areas that align with the key interests of the Academy. Each SIG would have a Chair and Chair-elect, who would vote on decisions for each Academy. Each Academy would receive funding to develop activities for their Academy (proportional to its membership numbers). Furthermore, each Academy could have a separate track of CE offerings throughout the year and at the major "Association" meetings.

Board of Governance

It is vital that the Board of the potential "Association" be equally represented across each Academy. The Board could include:

1) President (this would rotate one from each Academy every three years)
2) President-Elect
3) Immediate Past President
4) Secretary (Open)
5) Treasurer (Open)
6) 3 officers (Chair, Chair-Elect, Immediate Past Chair) of each Academy

Committee Structure

The "Association" could create a committee structure to ensure membership's voice is heard and to help strategically move the "Association." Both current organizations have well-functioning committees and would likely be used as a starting point for discussions. These Committees would be made up from any interested members of the various Academies.

Financial Analysis of a Merged Organization

Assumptions and relative information for financial projection:

Actual income and expense from 2015, with consideration for 2016 budgeting and known variances expected for 2017 were used in creating the attached financial models. In some cases, historical results were used beyond the most recent fiscal year to project expected financials of a merged organization. In general, most incomes and expenses were assumed additive and, taken individually; many of these line-items were inconsequential to the overall budget. There are, however, some assumptions made in the following areas that are likely to impact the outcome of the financial projections. These are described below.

Primary expenses of both organizations are linked to meetings and management. In order to project the financial impact of merging organizations, scenarios of meeting and management structure must also be projected. These are not intended as recommendations, simply likely potential options that should be examined.

Potential Meeting Structure

Meetings:

- Several regional small meetings and certificate programs would continue, hopefully benefiting from larger attendance. There would continue to be a Health System-focused annual meeting (may include a track that is inclusive of other groups); due to ASHP requirements, specific health-system programming would need to be regularly provided.
- One large Annual Convention (envisioned as a combined OSPA Annual + OSHP Fall Seminar with equal footing of all forums)
- Lane County – has been very profitable and well-attended for OSPA, and would continue
- A merged organization could improve the viability of delivering programming to rural areas, technicians, and students; this could further increase revenue as well as associated expenses.
- Social events would continue as is, again, hopefully benefiting from larger attendance; if more specified type of networking events were needed, SIG-type groups (or academies) could host their own events.
- In the financial projections, for untested conferences, assumed ~60% expense/income ratio (conservatively).

Potential management structure of a merged organization:
Three scenarios were evaluated, representing past and current experiences with leadership structure. Each comes with their own risks, benefits and financial implications.

> Option 1: Maintain management company and lobbyist structure that currently exists within both organizations. Anticipate that this structure would cost less than the additive amount both organizations are paying currently. Renegotiation of contracts would have to take place with Update Management and/or other interested parties (presumably through an RFP process).
>
> Option 2: Hire an executive director and release management company. This individual would manage day-to-day operations of the organization. Given the need for continuity of services, this individual would likely contract for outsourced telephone services and accounting services. Projections assume salary/benefit costs similar to those of a practicing pharmacist at an executive management level. (Currently about 20% of associations listed on the NASPA website are headed by individuals who identify themselves as pharmacists.) It is possible to reduce the cost of an executive director, however, by exploring partnership opportunities with other entities or hiring a non-pharmacist for this role.
>
> Option 3: Same as option 2, but assumes that the individual hired as an executive director also takes on the role of the lobbyist.

Potential membership revenue of a merged organization:

- Current pharmacist membership of OSHP is 370; OSPA is 400.
- Current pharmacist member rate for OSHP is $160; OSPA $195.
- In calculation of dues, anticipated as much as 10% attrition or gain; also looked at an average of the two dues structures or all moving to $195. Ultimately, settled on a projection that keeps dues revenue flat (additive of the two organizations).

<u>Summary</u>

Net Operating Margin

Attached financial projections sheets reflect the three management scenarios as described above. 2015 net operating margins of OSHP and OSPA are both 1% ($2,196 in net ordinary income) and 1% ($4,178 in net ordinary income) respectively. Net Operating Margin is used as the lead indicator for this proforma as it is reflective of excess monies that could be re-invested into the organization after expenses have been paid.

Option 1: Maintaining the current management structure and lobbyist model would result in a potential net margin of 17%, or $87,295 in net ordinary income.

Option 2: Hiring an executive director and keeping a separate lobbyist would result in a potential net margin of 4%, or $22,295 in net ordinary income.

Option 3: Hiring an executive director who would also fulfill the role of a lobbyist would result in a potential net margin of 12%, or $63,360 in net ordinary income.

Reserves

- OSHP reserves (minus scholarship accounts): $291,000 in assets.
- OSPA reserves (minus scholarship accounts): $139,000 in assets.
- OSHP currently has $53,000 in scholarship accounts.
- OSPA currently has $33,000 in a scholarship accounts and other educational funds

National Parent Organization Requirements for Merging State Affiliates

APhA Requirements of a Merged Organization

APhA does not have any requirements for merged organizations other than they need to know the criteria for selection of 3 state delegates to the APhA House of Delegates.

ASHP Requirements of a Merged Organization

ASHP specifically addresses state chapters merging with other organizations with the below statements:

- ASHP believes strongly that the practice of pharmacy in hospitals and health systems is a distinct area of practice and that practitioners in such practice have unique needs and interests.

- ASHP establishes formal relationships with affiliates who share this membership focus, vision, and commitment to concentrate on serving the unique needs of pharmacists in hospitals and health systems.

- ASHP's value and influence is extended through the development of mutually supportive relationships with organizations that mirror its purpose at the state level.

ASHP Benefits	State Affiliate Benefits
• Affiliates enhance ASHP's ability to understand and respond to issues affecting members	• ASHP supports the growth of its affiliates through programs aimed at assisting their development and improvement
• Affiliates support the growth of ASHP and advocate its policies at a state and local level	• ASHP provides information and tools regarding professional practice, practice standards, government affairs, and public relations
• Affiliates are invited to actively participate in shaping ASHP's national agenda for health-system pharmacy	

Obligations of ASHP	Obligations of State Affiliate
• Permit use of ASHP name & logo (according to ASHP policy)	• Support ASHP initiatives in public-policy advocacy and practice development
• Staff support to maintain & enhance ASHP-affiliate relationship	• Promote the standards and policies of ASHP within state
• Communicate ASHP policies, programs, initiatives; engage affiliates in	• Actively participate in ASHP events and programs (affiliate conferences;

development & implementation of these	recommending members for ASHP councils, commissions, committees, etc.; proposing policy issues; providing ASHP with advice/comment on initiatives and programs)
• Provide opportunities for shaping professional policies, programs, priorities	• Encourage the use of ASHP products and services.
• Provide tools & services to help affiliate carry out its mission and affiliate responsibilities	• Conduct the election of state delegates to the ASHP House of Delegates
• Promote membership in state affiliate	• Promote membership in ASHP.

Requirements of Affiliation

- Mission, scope & membership focus on health-systems
    - Autonomous governance
    - Autonomous finances
    - Independent authority to establish programs, professional polices, and priorities related to pharmacy practice in health systems

Specific requirements/instructions for "components of broader organizations" to initially apply for affiliation:

- Relevant policies defining the role and authority of the "component", in addition to Charter and Bylaws of parent organization
- Membership report, including membership categories of the "component"
- Roster of both BOD of the parent organization and the elected leadership of the health-system component, including CVs for both groups
- Budget and/or related policies which delineate financial autonomy of "component"

Comment letters from ASHP members in the petitioning state will be encouraged by the ASHP Board of Directors

Affiliate "levels": full, provisional, conditional, denial

Ongoing affiliation:

- Routine communication of programs, priorities, minutes, strategic plans, newsletters, member communications, etc.
- Periodic self-assessment (≤5 years)
    - Requirements for initial application as above
    - Demonstrated services to health-system pharmacists via

- Communication with key audiences in state about value of health-system pharmacists' professional contributions
- Participation in organizational/development activities by ASHP
- Compliance with ASHP practice standards
- Support/create pharmacy residency programs
- Establish/nurture SSHP chapters
- Promote involvement/leadership development of new practitioners

Attachment 1: Contact Information of State Organizations

Assigned	Need survey data	State	Merge	Director	State	Addresses	Organization	Website	Phone number	Organization email	Lead contact	Lead email
Kristy	No	North Carolina	**Yes**	Yes	14,478	10,971	North Carolina Association of Pharmacists	http://www.ncpharmacists.org/index.asp	984-439-1646		Fred Eckel	fred@ncpharmacists.org
Jake	No	Michigan	**Yes**	Yes	13,960	10,163	Michigan Pharmacists Association	http://www.michiganpharmacists.org/	517-484-1466	MPA@MichiganPharmacists.org	Richard Lucarotti	
Zach	Yes	Tennessee	**Yes**	Yes	10,693	7,542	Tennessee Pharmacists Association	http://www.tnpharm.org/?	615-256-3023	tpa@tnpharm.org	Micah Cost	micah@tnpharm.org
Zach	No	Arizona	**Yes**	Yes	10,678	6,640	Arizona Pharmacy Association	http://www.azpharmacy.org/	480-838-3385	admin@azpharmacy.org	Kelly Fine	kelly@azpharmacy.org
Gary	No	Indiana	**Yes**	Yes	10,600		Indiana Pharmacists Alliance	http://www.indianapharmacists.org/	317-634-4968	inpharm@indianapharmacists.org	Randy Hitchens	
Kevin	No	Washington	**Yes**	Yes	9,560	6,821	Washington State Pharmacy Association	http://www.wsparx.org/?	425-228-7171	askwspa@wsparx.org	Jeff Rochon	Jeff@wsparx.org
Jake	No	Wisconsin	**Yes**	Yes	7,546	5,587	Pharmacy Society of Wisconsin	http://www.pswi.org/	608-827-9200	info@pswi.org	Christopher Decker	cdecker@pswi.org
Josh	Yes	Colorado	**Yes**	Yes	7,303	5,145	Colorado Pharmacists Society	http://www.copharm.org/	303-756-3069	admin@copharm.org	Rebecca Moote	rmoote@regis.edu
Josh	No	Iowa	**Yes**	Yes	5,988	3,518	Iowa Pharmacy Association	http://www.iarx.org/	515-270-0713	ipa@iarx.org	Kate Gainer	kgainer@iarx.org
Gary	Yes	Puerto Rico	**Yes**	Yes	5,340	2,452	Colegio de Farmaceuticos de Puerto Rico	http://www.colegiodefarmaceuticospr.org/	(787) 753-7157		Milagros Morales	cfpr2000@coqui.net
Gary	No	Nebraska	**Yes**	Yes	4,290	2,408	Nebraska Pharmacists Association	http://www.npharm.org/	402-420-1500	info@npharm.org	Joni Cover	joni@npharm.org
Kevin	Yes	Hawaii	**Yes**	No	2,240	1,266	Hawaii Pharmacists Association	http://www.hipharm.org/				
Kevin	No	Montana	**Yes**	No	1,868	1,180	Montana Pharmacy Association	http://www.rxmt.org/	406-449-3843	info@rxmt.org	Stuart Doggett	stuart@montana.com
Kristy	No	Alaska	**Yes**	No	1,047	543	Alaska Pharmacists Association	http://www.alaskapharmacy.org/	907-563-8880		Ashley Schaber	arschaber@anthc.org
Kristy	No	Kansas	No		5,147	3,191						
Kristy	Yes	Minnesota	No		8,051	6,019						
Kristy	Yes	New Mexico	No		2,760	1,767						
Kristy	Yes	Florida	No		30,212	22,483						
		Alabama	No		9,000							
		Arkansas	No		5,217	3,335						
		California	No		42,425	36,868						
		Connecticut	No		5,545	3,374						
		Delaware	No		1,986	774						
		District of Columbia	No		1,704	633						
		Georgia	No		14,454	10,394						
		Idaho	No		2,265	1,376						
		Illinois	No		17,753	13,041						
		Kentucky	No		8,344	5,113						
		Louisiana	No		7,830	5,307						
		Maine	No		1,987	1,278						
		Maryland	No		10,047	6,439						
		Massachusetts	No		11,813	7,623						
		Mississippi	No		4,885	3,140						
		Missouri	No		9,426							
		Nevada	No		7,952	2,125						
		New Hampshire	No		2,572	1,291						
		New Jersey	No		16,043	11,562						
		New York	No		25,286	19,503						
		North Dakota	No		2,198	1,101						
		Ohio	No		18,556	13,536						
		Oklahoma	No		5,946	4,334						
		Oregon	No		6,145	3,699						
		Pennsylvania	No		23,107	16,725						
		Rhode Island	No		2,065	1,087						
		South Carolina	No		7,514	5,172						
		South Dakota	No		1,930	1,213						
		Texas	No		30,167	23,890						
		Utah	No		3,270							
		Vermont	No		1,357	722						
		Virginia	No		12,669	7,981						
		West Virginia	No		4,444	2,286						
		Wyoming	No		1,228	601						