



Oregon State University
College of Pharmacy

Office of Continuing Pharmacy Education
 CPE Gap Analysis Worksheet

DATE OF COMPLETION: February 20, 2026

CPE PROGRAM: 2026 Annual Seminar

JOINT PROVIDER (if applicable): Oregon Society for Health-System Pharmacists

Standard 2: Gap Analysis

The provider must develop CPE activities based on an identified knowledge, skill, and/or practice gap. The provider should identify gaps between what pharmacists and pharmacy technicians currently know or do and what is needed and desired in practice.

Directions: Describe a current practice compared to best practice, thereby identifying the gap in knowledge and need for education. This information will be used to inform the activity type, learning objectives, active learning exercises, and outcomes for the activity.

Activity Title/Topic	Current Practice	Best/Better Practice	Educational Need	Identified By	Activity Type
1 Oregon Formulary Updates 4/24/26 1:05-2:05 pm Courtney Sellers Crystal Sharp	Clinical pharmacists reference Oregon PDL updates but may not systematically integrate changes into CDTM protocols. Prior authorization burdens affect clinic workflow.	Rapid incorporation of formulary updates into EHR order sets, protocol revisions, and patient outreach for therapeutic interchange when needed. Alignment with payer-driven quality measures.	CE on interpreting Oregon PDL changes, PA optimization strategies, therapeutic interchange best practices, and workflow redesign to reduce administrative burden.	<input checked="" type="checkbox"/> Practitioners <input type="checkbox"/> Legislative Changes <input type="checkbox"/> New Protocols <input type="checkbox"/> New/Updated Treatment Guidelines <input type="checkbox"/> Literature Review <input type="checkbox"/> Patient Outcomes <input type="checkbox"/> Other _____	<input checked="" type="checkbox"/> Knowledge <input type="checkbox"/> Application Rationale: Update pharmacists in best practices for use of the Oregon Formulary Protocol for pharmacists



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<p>2</p> <p>Don't Blame Me, Blame ChatGPT: Recognizing Cognitive Debt in Pharmacy Education</p> <p>4/24/26 2:10-3:10 pm Maddie Frye Ryan Gibbard</p>	<p>Learners increasingly rely on AI tools, clinical decision support, and digital resources for rapid answers, sometimes at the expense of deep processing and knowledge retention. Faculty may observe reduced clinical reasoning stamina, surface-level learning, and overconfidence but lack shared language or frameworks to describe "cognitive debt."</p>	<p>Educational best practice supports structured AI integration, deliberate practice in clinical reasoning, and metacognitive skill development to prevent excessive cognitive offloading. Programs should explicitly teach when to offload vs. when to engage effortful retrieval, scaffold independent thinking, and create assessments that reward reasoning over answer generation.</p>	<p>Faculty development on identifying cognitive offloading behaviors and learners at higher risk (e.g., overreliance on summaries, avoidance of ambiguity, decreased retrieval practice). Training in strategies to mitigate cognitive debt, including retrieval-based learning, progressive case complexity, AI transparency discussions, and assessment redesign, is needed.</p>	<p><input checked="" type="checkbox"/> Practitioners <input type="checkbox"/> Legislative Changes <input type="checkbox"/> New Protocols <input type="checkbox"/> New/Updated Treatment Guidelines <input type="checkbox"/> Literature Review <input type="checkbox"/> Patient Outcomes <input type="checkbox"/> Other _____</p>	<p><input checked="" type="checkbox"/> Knowledge <input type="checkbox"/> Application</p> <p>Rationale:</p> <p>Address knowledge gaps for pharmacist preceptors on cognitive debt among pharmacy learners who use AI tools</p>
<p>5</p> <p>Oregon Indian Country: Tribal Sovereignty's Impact on Health Care</p> <p>4/25/26 8:10-9:10 am Claymore Kills First</p>	<p>Clinical pharmacists may serve AI/AN populations but have limited formal training in Tribal sovereignty and Indian Health Service (IHS) systems. Understanding of referral pathways and payer structures varies.</p>	<p>Practice that acknowledges Tribal sovereignty in care delivery, formulary considerations, and reimbursement structures. Collaboration with Tribal health programs and culturally responsive medication management. Integration of traditional healing considerations when appropriate.</p>	<p>CE addressing Tribal governance in healthcare, IHS/Tribal formulary structures, culturally responsive care models, and strategies for building sustainable partnerships with Tribal clinics.</p>	<p><input checked="" type="checkbox"/> Practitioners <input type="checkbox"/> Legislative Changes <input type="checkbox"/> New Protocols <input type="checkbox"/> New/Updated Treatment Guidelines <input type="checkbox"/> Literature Review <input type="checkbox"/> Patient Outcomes <input type="checkbox"/> Other _____</p>	<p><input checked="" type="checkbox"/> Knowledge <input type="checkbox"/> Application</p> <p>Rationale:</p> <p>Address knowledge gaps for pharmacist in a vulnerable population</p>



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<p>6</p> <p>Oregon Emergency Preparedness</p> <p>4/25/26 12:30-2:00 pm Amy Cervan Amber Taylor</p>	<p>Pharmacists are generally aware of emergency response roles but may have limited knowledge of Oregon-specific emergency authorities and scope expansions during disasters. Preparedness activities vary by setting.</p>	<p>Pharmacists understand state emergency laws, dispensing flexibilities, vaccination authority, and continuity-of-care expectations during declared emergencies. They are prepared to support medication access, public health response, and patient counseling during crises.</p>	<p>CE on Oregon emergency authority statutes, emergency dispensing and documentation requirements, vaccine/antiviral response protocols, and strategies for maintaining medication access and patient safety during disasters.</p>	<p><input checked="" type="checkbox"/> Practitioners <input type="checkbox"/> Legislative Changes <input type="checkbox"/> New Protocols <input type="checkbox"/> New/Updated Treatment Guidelines <input type="checkbox"/> Literature Review <input type="checkbox"/> Patient Outcomes <input type="checkbox"/> Other _____</p>	<p><input checked="" type="checkbox"/> Knowledge <input type="checkbox"/> Application</p> <p>Rationale:</p> <p>Address knowledge gaps for pharmacist in best practices during disasters</p>
<p>7</p> <p>PrEPared in Primary Care: Putting PrEP into Practice</p> <p>4/25/26 2:30-3:30 pm Jess Potter</p>	<p>Some pharmacists assist with HIV risk screening and medication counseling, but pharmacist-led PrEP services are inconsistent. Barriers include workflow, reimbursement, and lab coordination.</p>	<p>Pharmacist-led or collaborative PrEP programs with standardized screening, baseline/ongoing labs, adherence monitoring, and STI screening. Integration into primary care population health strategies.</p>	<p>CE on PrEP eligibility criteria, lab monitoring protocols (renal function, HIV testing), billing/reimbursement models, stigma-sensitive communication, and long-acting PrEP options.</p>	<p><input checked="" type="checkbox"/> Practitioners <input type="checkbox"/> Legislative Changes <input type="checkbox"/> New Protocols <input type="checkbox"/> New/Updated Treatment Guidelines <input type="checkbox"/> Literature Review <input type="checkbox"/> Patient Outcomes <input type="checkbox"/> Other _____</p>	<p><input checked="" type="checkbox"/> Knowledge <input type="checkbox"/> Application</p> <p>Rationale:</p> <p>Address knowledge gaps for pharmacist in utilizing PrEP</p>



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<p>8</p> <p>Rewriting Disease: Gene Therapy and Gene Editing in Today's Pharmacy</p> <p>4/25/26 2:30-3:30 pm Robert Sigrid Nicole Carter</p>	<p>Most pharmacists have limited direct exposure to gene therapies outside specialty clinics. Knowledge gaps exist around long-term monitoring and REMS requirements.</p>	<p>Active participation in patient identification, prior authorization support, safety monitoring, and education for gene therapies (e.g., hemophilia, sickle cell disease). Coordination with specialty pharmacies and infusion centers.</p>	<p>CE on mechanisms of gene editing, adverse effect monitoring, payer navigation, REMS programs, and ethical considerations in ambulatory practice.</p>	<p><input checked="" type="checkbox"/> Practitioners <input type="checkbox"/> Legislative Changes <input type="checkbox"/> New Protocols <input type="checkbox"/> New/Updated Treatment Guidelines <input type="checkbox"/> Literature Review <input type="checkbox"/> Patient Outcomes <input type="checkbox"/> Other _____</p>	<p><input checked="" type="checkbox"/> Knowledge <input type="checkbox"/> Application</p> <p>Rationale:</p> <p>Address knowledge gaps for pharmacist in Gene Therapy</p>
<p>9</p> <p>GDMT Without Gaps: Building and Maintaining Optimal Therapy Across the Patient Journey</p> <p>4/25/26 3:35-4:35 pm Alyssa Rabon</p>	<p>Pharmacists participate in HF management, but full implementation of quadruple GDMT inconsistent. Titration delays, therapeutic inertia, cost barriers, and fragmented transitions of care contribute to suboptimal dosing. Monitoring may focus on symptom management rather than rapid optimization.</p>	<p>Early, simultaneous or rapid-sequence initiation of all four pillars of GDMT with protocol-driven titration to target doses. Pharmacist who incorporate lab monitoring, diuretic optimization, adherence assessment, and transitions-of-care follow-up reduce hospitalizations and mortality.</p>	<p>CE on updated HF guidelines, sequencing and titration strategies, adverse effect management, and workflow integration of pharmacist-led GDMT optimization.</p>	<p><input checked="" type="checkbox"/> Practitioners <input type="checkbox"/> Legislative Changes <input type="checkbox"/> New Protocols <input type="checkbox"/> New/Updated Treatment Guidelines <input type="checkbox"/> Literature Review <input type="checkbox"/> Patient Outcomes <input type="checkbox"/> Other _____</p>	<p><input checked="" type="checkbox"/> Knowledge <input type="checkbox"/> Application</p> <p>Rationale:</p> <p>Address knowledge gaps for pharmacist in maximizing GDMT therapies</p>



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<p>10</p> <p>FDA-Approved Anti-Amyloid Therapy for Alzheimer's Disease</p> <p>4/25/26 3:35-4:35 pm Marketa Marvanova</p>	<p>Pharmacists on therapy expectations but are not consistently involved in eligibility screening or ARIA monitoring coordination. Workflow complexity limits engagement.</p>	<p>Pharmacist involvement in biomarker eligibility review, medication reconciliation to reduce ARIA risk (e.g., anticoagulants), patient/caregiver counseling, and MRI monitoring coordination.</p>	<p>CE on appropriate use criteria, ARIA risk mitigation, infusion logistics, Medicare coverage considerations, and interdisciplinary dementia care models.</p>	<p><input checked="" type="checkbox"/> Practitioners <input type="checkbox"/> Legislative Changes <input type="checkbox"/> New Protocols <input type="checkbox"/> New/Updated Treatment Guidelines <input type="checkbox"/> Literature Review <input type="checkbox"/> Patient Outcomes <input type="checkbox"/> Other _____</p>	<p><input checked="" type="checkbox"/> Knowledge <input type="checkbox"/> Application</p> <p>Rationale:</p> <p>Address knowledge gaps for pharmacist in new therapies for Alzheimer</p>
<p>11</p> <p>BOP Law Update</p> <p>4/26/26 8:05-9:05 am Gary Runyon</p>				<p><input type="checkbox"/> Practitioners <input type="checkbox"/> Legislative Changes <input type="checkbox"/> New Protocols <input type="checkbox"/> New/Updated Treatment Guidelines <input type="checkbox"/> Literature Review <input type="checkbox"/> Patient Outcomes <input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> Knowledge <input type="checkbox"/> Application</p> <p>Rationale:</p>



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<p>12</p> <p>Hypertension 2025 Guidelines Update</p> <p>4/26/26 9:10-10:10 am Abby Frye</p>	<p>BP diagnosis often relies on inconsistent office measurements with limited home/ambulatory monitoring and variable use of risk-based targets. Treatment is frequently initiated with single agents and slow titration, pharmacist roles differ by setting, and management of resistant or high-risk populations lacks standardization.</p>	<p>Emphasizes standardized BP measurement, routine out-of-office monitoring, and risk-based targets. Recommends early combination therapy, pharmacist-led titration within multidisciplinary teams, structured evaluation of resistant/secondary hypertension, and integration of remote monitoring to improve control and equity.</p>	<p>Education on accurate BP measurement and interpretation of home/ambulatory data, evidence-based combination of pharmacotherapy and rapid titration protocols, and optimization of collaborative practice models. Additional training on resistant hypertension workup, care transitions, and use of digital health tools to improve outcomes is needed.</p>	<p><input type="checkbox"/> Practitioners <input type="checkbox"/> Legislative Changes <input type="checkbox"/> New Protocols <input checked="" type="checkbox"/> New/Updated Treatment Guidelines <input type="checkbox"/> Literature Review <input type="checkbox"/> Patient Outcomes <input type="checkbox"/> Other _____</p>	<p><input checked="" type="checkbox"/> Knowledge <input type="checkbox"/> Application</p> <p>Rationale:</p> <p>Address updates in guidelines pertaining to pharmacists scope of practice.</p>
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<p>13</p> <p>Med Safety/Pt Safety: Deprescribing Therapy</p> <p>4/26/26 10:30-11:30 am Katherine Marks</p>	<p>Any pharmacists can conduct medication reconciliation and identify polypharmacy, especially in geriatrics and complex chronic disease. Deprescribing is often reactive and dependent on individual clinician comfort. Documentation and follow-up plans may lack standardization.</p>	<p>Proactive, protocol-driven deprescribing embedded in comprehensive medication management (CMM). Use of validated tools (e.g., Beers, STOPP/START) with shared decision-making and defined tapering plans. Structured follow-up to monitor withdrawal effects and clinical outcomes.</p>	<p>CE on systematic deprescribing frameworks, tapering protocols for high-risk classes (benzodiazepines, PPIs, insulin), documentation standards, and interprofessional communication strategies within team-based clinics.</p>	<p><input checked="" type="checkbox"/> Practitioners <input type="checkbox"/> Legislative Changes <input type="checkbox"/> New Protocols <input type="checkbox"/> New/Updated Treatment Guidelines <input type="checkbox"/> Literature Review <input type="checkbox"/> Patient Outcomes <input type="checkbox"/> Other _____</p>	<p><input checked="" type="checkbox"/> Knowledge <input type="checkbox"/> Application</p> <p>Rationale:</p> <p>Address knowledge gaps in deprescribing therapy's in vulnerable populations</p>
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