

BOARD MEETING AGENDA

**Oregon Board of Pharmacy
800 NE Oregon Street
Portland, OR 97232
June 8-9, 2016**

1891- Celebrating 125 Years of Excellence - 2016

The mission of the Oregon State Board of Pharmacy is to promote, preserve and protect the public health, safety and welfare by ensuring high standards in the practice of pharmacy and by regulating the quality, manufacture, sale and distribution of drugs.

**Wednesday, June 8, 2016 @ 8:30 AM, Conference Room 1A
Thursday, June 9, 2016 @ 8:30 AM, Conference Room 1A**

≈ If special accommodations are needed for you to attend or participate in this Board Meeting, please contact Loretta Glenn at: (971) 673-0001. ≈

WEDNESDAY, JUNE 8, 2016

I. 8:30 AM OPEN SESSION, Roberto Linares, R.Ph, Presiding

- A. Roll Call
- B. Agenda Review and Approval *Action Necessary*
- C. Compliance and Delegated Grid Processes – *Miner* (20 min)

II. Contested Case Deliberation pursuant to ORS 192.690(1) - **Not Open to the Public**

III. EXECUTIVE SESSION – NOT OPEN TO THE PUBLIC, pursuant to ORS 676.175, ORS 192.660 (1) (2) (f) (k).

- A. Items for Consideration and Discussion:
 - 1. Deliberation on Disciplinary Cases and Investigations
 - 2. Personal Appearances
 - 3. Warning Notices
 - 4. Case Review

IV. OPEN SESSION - PUBLIC MAY ATTEND - At the conclusion of Executive Session, the Board may convene Open Session to begin the scheduled agenda for June 8, 2016. Items that may be covered are marked with an asterisk *.

Adjourn

THURSDAY, JUNE 9, 2016

8:30AM

V. OPEN SESSION, Roberto Linares, R.Ph. Presiding

- A. Roll Call
- B. Motions for Contested Cases & Disciplinary Action *Action Necessary*

9:00AM

VI. GENERAL ADMINISTRATION

- A. Rules
 - 1. Review Rulemaking Hearing Report & Comments **#A** *Action Necessary*
 - 2. Consider Adoption of Temporary Rules - none
 - 3. Send Rules to Rulemaking Hearing - none
 - 4. Consider Adoption of Rules *Action Necessary*
 - a) Div 006 – Definitions **#A1**
 - b) Div 025 – CPT Biennial Licensure and Housekeeping **#A2**
 - c) Div 041 – Epinephrine **#A3**
 - d) Div 041 – Remote Distribution Facilities **#A4**
 - e) Div 043 – Community Health Clinics **#A5**
 - f) Div 110 – Update CPT Biennial /Workforce data collection fees etc. **#A6**
 - 5. Policy Issues for Discussion
 - g) Naloxone legislation rule discussion
 - h) Harvard Avenue Drug question – *Miner* **#A7** *Action Necessary*
 - i) Update on new rules being prepared for August
- B. Discussion Items
 - 1. Waiver/Exception/Extensions/New Application Requests – none
 - Kaiser Permanente sink waiver **#B** *Action Necessary*
 - Walgreens – waiver request **#B1** *Action Necessary*
 - 2. Technician Discussion – *Watt/Cowan/Miner/Karbowicz* (45 min)
 - 3. Requests for Immediate Inspection Fee discussion – *Watt/Miner* (15 min)
 - 4. Staffing Levels & Impact on Patient Safety Position Statement / Workplace Survey – *Watt* (15 min)
 - 5. Contraceptive Prescribing Survey – *Watt* **#B2-CONFIDENTIAL** *Action Necessary*
 - 6. Schedule of Fees – *Watt* **#B3** *Action Necessary*

12:00-1:00 Lunch

1:00PM

ANNUAL BOARD BUSINESS MEETING (1.25 hrs)

- A. Election of New Officers *Action Necessary*
- B. Approval of ACPE accredited schools & colleges of pharmacy **#C** *Action Necessary*
- C. Approval of ACPE Continuing Education Process **#C1, C1a** *Action Necessary*
- D. Update on Board appointments
 - a. Roberto Linares – reappointed, effective 7/1/16

Agenda – June 8-9, 2016

NOTE: The Board may rearrange its agenda to accommodate the Board or members of the public.

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b. Rachael DeBarmore – appointed, effective 7/1/16

- E. Review other Committee/Council appointments **#C2-C2a** *Action Necessary*
- a. *Rural Health Coordinating Council*
- i. Amy Baker **#C3**
 - ii. Hope Murphy **#C4**
 - iii. Dianna Pimlott **#C5**
 - iv. Evon Anukam **#C6**
 - v. Leanne Yantis **#C7**
 - vi. John Bergert **#C8**
- b. *Council on Optometric Non-Topical Formulary* *Action Necessary*
- i. Christopher de Guzman **#C9**
- F. Overview of Oregon Ethics and Conflict of Interest – Cowan **#C10-11**
- G. Approve current version of Fed. List of Controlled Substances **#C12** *Action Necessary*
- H. Review the TOEFL NABP updates **#C13** *no action necessary*
- I. Affirm use of 7/2014 Attorney General’s Model Rules of Procedure *Action Necessary*
- J. Delegation of Board Authority update **#C14** *Action Necessary*
- K. Review and approve Board Per Diem Policy **#C15** *Action Necessary*
- L. Board Best Practices Performance Measure review **#C16** *Action Necessary*
- M. Recognition of outgoing Board Member Brad Fujisaki *Action Necessary*

Resume outstanding Discussion items or move on to Issues and Activities

*VII. ISSUES/ACTIVITIES

*A. Reports:

1. Board President/Members
2. Executive Director
3. Board Counsel **#C18**
4. Compliance Director
5. Administrative Director
6. Pharmacist Consultant
7. Licensing Department Supervisor
8. Project Manager

*B. Board Member/Staff Presentations – Linares

- Pharmacy Coalition – 6/8/16
- Professional Practice Roundtable – 5/10/16
- Health System Outreach Meeting – 4/19/16

*C. Committees/Meetings

1. OSHP Annual Seminar, 4/22-24/2016, Sunriver, OR – Watt/Karbowicz/Wallace
2. NABP 112th Annual Meeting – 5/14-17/2016, San Diego, CA – James/Watt
3. NABP District 6,7,8 Meeting 9/11-14/2016, Portland, OR – Watt/MacLean
4. CAC/CLEAR Meeting, 9/17-18, 2016, Portland, OR – **#C17**
5. OSPA Annual Mtg. 10/21-23,2016, Clackamas, OR –

- 6. OSHP Mtg 11/5/2016, Portland, OR -
- 7. OSPA Lane Co. Mid-Winter Mtg, 2/17-19/2017, Eugene, OR – *Watt/Karbowicz*

***D. Board Meeting Dates**

- August 10-12, 2016* Portland (*3 day meeting planned*)
- September 11-14, 2016 Portland NABP District VI-VII annual meeting
- October 5-6, 2016 Portland
- November 2-3, 2016 Silverton (*Strategic Planning*)
- December 7-8, 2016 Portland
- February 16-17, 2017 Eugene
- April 5-6, 2017 Portland
- June 7-8, 2017 Portland
- August 9-11, 2017* Portland (*3 day meeting*)
- October 11-10, 2017 Portland
- November 8-9, 2017 TBA (*Strategic Planning*)
- December 13-14, 2017 Portland

***E. Rulemaking Hearing Dates**

- November 22, 2016
- May 25, 2017
- November 28, 2017

***F. Financial/Budget Report – *Watt/MacLean* #D-D2 (10 min)**

G. Legislative update – *Watt* (none)

H. Strategic Planning – *MacLean/Karbowicz*

- Review & status update re: 2014 plan #E
- Review & status update re: 2015 plan #E1 Action Necessary
- 2016 planning update

I. Approve Consent Agenda* *Action Necessary*

*Items listed under the consent agenda are considered to be routine agency matters and will be approved by a single motion of the Board without separate discussion. If separate discussion is desired, that item will be removed from the consent agenda and placed on the regular business agenda.

1. NAPLEX Scores – none
2. MPJE Scores – none
3. License/Registration Ratification - April 6, 2016 – June 7, 2016
4. Extension Requests March 15, 2016 – May 12, 2016 #F
5. Approval of Board Meeting Minutes – February 10-12, 2016
6. Approval of Board Meeting Minutes - April 6-7, 2016

VIII. OPEN FORUM At the completion of regular Board Business, any Board licensee or member of the public is invited to meet with the Board to discuss issues of interest (typically the last item of the meeting)

Adjourn



Oregon

Kate Brown, Governor

JUNE 2016 / A

Oregon Board of Pharmacy
800 NE Oregon Street, Suite 150
Portland, OR 97232
Phone: 971 / 673-0001
Fax: 971 / 673-0002

E-mail: pharmacy.board@state.or.us
Web: www.pharmacy.state.or.us

To: Board Members

From: Courtney Wilson, Hearing Officer

Date: May 24, 2016

Subject: Hearing Officer's Report for Proposed Rules in Division 006, 025, 041, 043 and 110.

General Background:

A public hearing was held at the Portland State Office Building, located at 800 NE Oregon St. Conference Room 1B Portland, OR 97232 on May 24, 2016 at 9:30am. The purpose of the hearing was to receive public comment on the following proposed rules:

- Div 019 Definitions: The proposed amendments add a definition for Quality Assurance Plan and move the definition of Unprofessional Conduct to its own section for agency recordkeeping purposes.
- Div 025 Pharmacy Technicians and Certified Oregon Pharmacy Technicians: Proposed amendments provide additional clarification and update requirements. The rules also propose that a Certified Oregon Pharmacy Technician license will be valid for up to two years and will be renewed biennially; rules also reflect a change in the date of expiration to June 30th in even numbered years. Amendments require Certified Oregon Pharmacy Technicians to complete 20 continuing education (CE) hours during the period from July 1 through June 30 of each biennial license renewal cycle as defined. This means that upon renewal in 2016, a Certified Oregon Pharmacy Technician licensed before July 1, 2016 will renew, complete CE and the license will expire June 30, 2018 in order to make this shift to biennial licensure. All CPT licenses issued beginning on July 1, 2016 will expire June 30, 2018. Rules also update requirements to reinstate a Certified Oregon Pharmacy Technician license.
- Div 041 Epinephrine: Rules are updated to establish requirements for entities to acquire epinephrine by prescription. Additionally the rule states how the medication may be labeled.
- Div 041 Remote Distribution Facilities: Amendments makes minor housekeeping changes and update an outdated reference to a rule number.
- Div 043 Community Health Clinic Drug Outlet: These rules combine elements of the Family Planning Clinic and County Health Clinic. A facility must register when medication dispensing is performed by a Registered Nurse. The new rules provide minimum requirements of operation and define requirements for personnel, policies and procedures, security, drug acquisition storage of drugs, labeling, dispensing and drug delivery, disposal of drugs and recordkeeping.
- Div 043 – County Health Clinics: These rules are being proposed to repeal.

- Div 043 – Family Planning Clinics: These rules are being proposed to repeal.
- Div 110 – Fees: Rules are amended to reflect the fee structure for Certified Oregon Pharmacy Technician licensure; note that the current fee of \$50.00 remains the same. The Certified Oregon Pharmacy Technician license will be valid for up to two years. A reduction in fees is also included for the initial Certified Oregon Pharmacy Technician license for those that are issued within 180 days of expiration. The workforce Data Collection fee has been reduced for Pharmacists and Certified Oregon Pharmacy Technicians. The Community Health Clinic license fee has been established and the name of the Remote Distribution Facility fee listed in rule has been corrected.

The Rulemaking Hearing deadline for comments as noticed in the May 2016 Bulletin was 4:30 p.m. on May 24, 2016 in order for comments to be taken into consideration.

The following Board Members were in attendance in person or by phone: President Roberto Linares, Vice President Kate James, Penny Reher, Brad Fujisaki, Heather Anderson, Dianne Armstrong, and Cyndi Vipperman. Staff Members present include: Executive Director Marc Watt, Administrative Director Karen MacLean, Compliance Director Gary Miner, Project Manager Courtney Wilson and Inspector Laura Elvers.

Summary of Oral Testimony:

No one presented oral testimony or comment on the proposed rules.

Summary of Written Comments:

The Board received three written comments. One comment was received from the Oregon Health Authority on proposed rules in Division 041. Two comments were received for proposed amendments in Division 025 from CVS Health and the National Association of Chain Drug Stores.

Written Comments:

Pursuant to proposed amendments in Division 041 the Oregon Health Authority, Public Health Division, Health Care Regulation and Quality Improvement Program suggested language be added to OAR 855-041-2320(3)(b) clarifying that:

- The prescription issued in the name of the entity should limit the amount of epinephrine prescribed to one child dose package and one adult dose package per the number of employees trained at a given training event; and
- The dose obtained can be stored and used at a single business location only.

With regard to OAR 855-041-2320(3)(b)(C) the Public Health Division believes that the prescription itself will serve as documentation that an employee of an entity attended a training and recommends deleting the documentation requirement. The Division believes that the entity should be required to keep a log of the employees trained including documentation of completion and that such logs be made available to the Oregon Board of Pharmacy or Oregon Health Authority for purposes of complaint investigations.

Pursuant to proposed amendments in Division 025 CVS Health requested that the Board consider additional certification exam options including the allowance for completion of a Board approved employer examination or other exam conducted by a state or national certifying body approved by the Board to demonstrate competency to qualify for licensure.

The National Association of Chain Drug Stores also encouraged the Board to recognize alternative certification exam options for Certified Oregon Pharmacy Technicians such as another exam conducted by a state or national certifying body approved by the Board.

The hearing was attended by 20 individuals. Receiving no oral testimony or comment, the hearing was closed at approximately 9:47 am; copies of written comment are included as part of the permanent rulemaking record.



PUBLIC HEALTH DIVISION
Office of Health Care Regulation and Quality Improvement

Kate Brown, Governor

JUNE 2016 / A
Oregon
Health
Authority

800 NE Oregon Street, Suite 465
Portland, OR 97232
(971) 673-0540
(971) 673-2964

May 23, 2016

Karen MacLean
Board of Pharmacy
800 NE Oregon Street, Suite 150
Portland, OR 97232

Dear Ms. MacLean:

The Oregon Health Authority, Public Health Division, Health Care Regulation and Quality Improvement Program is a key partner in implementing the provisions of ORS 433.800 through 433.830 relating to training on lifesaving treatments and establishing a training protocol on the treatment of severe allergic reaction. The Division thanks the Board of Pharmacy for their efforts in changing rules to allow an entity to obtain and possess epinephrine for purposes of ORS 433.825.

The Division would suggest that language be added to OAR 855-041-2320(3)(b) clarifying that:

- 1) the prescription issued in the name of the entity should limit the amount of epinephrine prescribed to one child dose package and one adult dose package per the number of employees trained at a given training event; and
- 2) the doses obtained can be stored and used at a single business location only.

With respect to OAR 855-041-2320(3)(b)(C), the Division believes that the prescription itself will serve as documentation that an employee of an entity attended a training and would recommend deleting the documentation requirement. The Division believes that the entity should be required to keep a log of the employees trained including documentation of completion and that such logs be made available to the Oregon Board of Pharmacy or Oregon Health Authority for purposes of complaint investigations.

Thank you for allowing us the opportunity to comment on these proposed rules.

Sincerely,

Dana Selover, MD, MPH
Section Manager

May 24, 2016

Karen MacLean
Administrative Director, Rules Coordinator
Oregon Board of Pharmacy
800 NE Oregon St
Suite 150
Portland, OR 97232

Re: Proposed amendments to Oregon Administrative Rules Division 25 Pharmacy Technicians and Certified Oregon Pharmacy Technicians

Dear Administrative Director MacLean:

I am writing to you in my capacity as Director of Regulatory Affairs for CVS Health and its family of pharmacies located across the state of Oregon. CVS Health appreciates the opportunity to submit comments on the proposed amendments to Division 25 regarding Pharmacy Technicians and Certified Oregon Pharmacy Technicians. We would like to thank the Board for their continued vigilance to improve the laws and rules that guide pharmacists serving Oregon patients.

While CVS Health supports certification of Pharmacy Technicians, we request the Board consider adding additional certification exam options under 855-025-0012. In addition to nationally recognized programs, such as PTCB and NHA, we request that the board consider an allowance for completion of a Board Approved Employer Examination or other exam conducted by a state or national certifying body approved by the board to demonstrate competency to qualify for licensure. The training requirements to sit for nationally recognized exams are changing considerably and can be unpredictable. These additional options would allow the Board flexibility in regulation, while protecting public safety. Our suggested language is in red below.

855-025-0012

Licensure as a Certified Oregon Pharmacy Technician

(1) ~~To obtain a Certified Oregon Pharmacy Technician license, the applicant must demonstrate that the applicant qualify for licensure as a Certified Oregon Pharmacy Technician, the applicant must demonstrate that he or she has taken and passed a national pharmacy technician certification examination offered by:~~

(a) The Pharmacy Technician Certification Board (PTCB); or

(b) The National Healthcareer Association (NHA); or

(c) A Board Approved Employer Examination: or

(d) other exam conducted by a state or national certifying body approved by the board

If this change is adopted, the board will also need to update references throughout Division 25 that only refer to National Pharmacy Technician Certification Exams to include Board Approved Employer Examinations.

Lauren Berton, PharmD | One CVS Drive | Mail Code 2325 | Woonsocket, RI 02895 | T: 540-604-3661

CVS Health appreciates the opportunity to submit comments for the proposed amendment of this rule. If you have any questions, please contact me directly at 540-604-3661.

Sincerely,



Lauren Berton, PharmD.
Director, Pharmacy Regulatory Affairs
CVS Health



May 24, 2016

Karen MacLean
 Rules Coordinator
 Oregon Board of Pharmacy
 800 NE Oregon St., # 150, Portland, OR 97232
 Via email: Karen.S.MacLean@state.or.us

Re: Proposed Rule Changes Under Division 025 – Pharmacy Technicians
 (855-025)

Dear Ms. MacLean:

The National Association of Chain Drug Stores (“NACDS”) thanks the Oregon Board of Pharmacy (“Board”) for the opportunity to comment on the proposed rule changes under Division 025 addressing licensure requirements for pharmacy technicians and certified pharmacy technicians. We appreciate the Board considering our input.

Given that the Board has opened Division 025 for rulemaking, we encourage the Board to use this opportunity to recognize alternative certification exam options for certified pharmacy technician candidates. To that end, we ask the Board to amend 855-025-0012 (1) as follows:

(1) ~~To obtain a Certified Oregon Pharmacy Technician license, the applicant must demonstrate that the applicant qualify for licensure as a Certified Oregon Pharmacy Technician, the applicant must demonstrate that he or she has taken and passed a national pharmacy technician certification examination offered by:~~

(a) The Pharmacy Technician Certification Board (PTCB); ~~or~~

(b) The National Healthcareer Association (NHA); ~~or~~

(c) Another exam conducted by a state or national certifying body approved by the board.

While NACDS is supportive of the current rule providing certified pharmacy technician candidates with more than one option for meeting certification requirements, the addition of this language would provide pharmacy technicians with more flexibility in how they meet existing certification requirements.

This is especially important given the recent changes to the Pharmacy Technician Certification Board (PTCB) certification program that, beginning in 2020, will require certification candidates to complete an education program accredited by the American Society of Health System Pharmacists (ASHP). The ASHP accreditation

NACDS Regional Office

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standards create a “one size fits all” training model for all pharmacy practice settings with burdensome standards and requirement to complete a minimum of 600 hours (15 weeks at 40 hours/week) of training. Consequently, we have concerns about training capacity, geographic challenges in finding ASHP-accredited training programs, and the resulting increased costs for the healthcare system.

NACDS thanks the Board for considering our comments on this matter. Please do not hesitate to contact me with any questions or for further assistance. I can be reached at 360-480-6990 or lhouchen@nacds.org.

Sincerely,

Lis Houchen

Lis Houchen
Director, State Government Affairs

1 **855-006-0005**

2 **Definitions**

3 As used in OAR chapter 855:

4 (1) "Board" means the Oregon Board of Pharmacy unless otherwise specified or required
5 by the context.

6 (2) "Certified Pharmacy Technician" means a person licensed by the State Board of
7 Pharmacy who assists the pharmacist in the practice of pharmacy pursuant to rules of the
8 Board and has completed the specialized education program pursuant to OAR 855-025-
9 0005. Persons used solely for clerical duties, such as recordkeeping, cashiering,
10 bookkeeping and delivery of medications released by the pharmacist are not considered
11 pharmacy technicians.

12 (3) "Clinical Pharmacy Agreement" means an agreement between a pharmacist or
13 pharmacy and a health care organization or a physician that permits the pharmacist to
14 engage in the practice of clinical pharmacy for the benefit of the patients of the health
15 care organization or physician.

16 (4) "Collaborative Drug Therapy Management" means the participation by a pharmacist
17 in the management of drug therapy pursuant to a written protocol that includes
18 information specific to the dosage, frequency, duration and route of administration of the
19 drug, authorized by a practitioner and initiated upon a prescription order for an individual
20 patient and:

21 (a) Is agreed to by one pharmacist and one practitioner; or

22 (b) Is agreed to by one or more pharmacists at a single pharmacy registered by the board
23 and one or more practitioners in a single organized medical group, such as a hospital
24 medical staff, clinic or group practice, including but not limited to organized medical
25 groups using a pharmacy and therapeutics committee.

26 (5) "Compounding" means the preparation, mixing, assembling, packaging, or labeling of
27 a drug or device:

28 (a) As the result of a practitioner's prescription drug order, or initiative based on the
29 relationship between the practitioner, the pharmacist and the patient, in the course of
30 professional practice; or

31 (b) For the purpose of, or as an incident to, research, teaching, or chemical analysis and
32 not for sale or dispensing; or

33 (c) The preparation of drugs or devices in anticipation of prescription drug orders based
34 on routine, regularly observed prescribing patterns; or

35 (d) As a component of a Shared Pharmacy Service agreement as defined in section (21)
36 of this rule.

37 (6) "Confidential Information" means any patient information obtained by a pharmacist
38 or pharmacy.

39 (7) "Consulting Pharmacist" means a pharmacist that provides a consulting service
40 regarding a patient medication, therapy management, drug storage and management,
41 security, education, or any other pharmaceutical service.

42 (8) The "Container" is the device that holds the drug and that is or may be in direct
43 contact with the drug.

44 (9) "Dispensing or Dispense" means the preparation and delivery of a prescription drug
45 pursuant to a lawful order of a practitioner in a suitable container appropriately labeled

46 for subsequent administration to or use by a patient or other individual entitled to receive
47 the prescription drug.

48 (10) "Interpretation and evaluation of prescription orders" means the review of the order
49 for therapeutic and legal correctness. Therapeutic review includes identification of the
50 prescription drug ordered, its applicability and its relationship to the other known
51 medications used by the patient and determination of whether or not the dose and time
52 interval of administration are within accepted limits of safety. The legal review for
53 correctness of the prescription order includes a determination that the order is valid and
54 has not been altered, is not a forgery, is prescribed for a legitimate medical purpose,
55 contains all information required by federal and state law, and is within the practitioner's
56 scope of practice.

57 (11) "Labeling" means the process of preparing and affixing of a label to any drug
58 container exclusive, however, of the labeling by a manufacturer, packer or distributor of a
59 non-prescription drug or commercially packaged legend drug or device.

60 (12) "Monitoring of therapeutic response or adverse effect of drug therapy" means the
61 follow up of the therapeutic or adverse effect of medication upon a patient, including
62 direct consultation with the patient or his agent and review of patient records, as to result
63 and side effect, and the analysis of possible interactions with other medications that may
64 be in the medication regimen of the patient. This section shall not be construed to prohibit
65 monitoring by practitioners or their agents.

66 (13) "Medication Therapy Management (MTM)" means a distinct service or group of
67 services that is intended to optimize therapeutic outcomes for individual patients.
68 Medication Therapy Management services are independent of, but can occur in
69 conjunction with, the provision of a medication product.

70 (14) "Nationally Certified Exam" means an exam that is approved by the Board which
71 demonstrates successful completion of a Specialized Education Program. The exam must
72 be reliable, psychometrically sound, legally defensible and valid.

73 (15) "Non-legend drug" means a drug which does not require dispensing by prescription
74 and which is not restricted to use by practitioners only.

75 (16) "Offering or performing of those acts, services, operations or transactions necessary
76 in the conduct, operation, management and control of pharmacy" means, among other
77 things:

78 (a) The creation and retention of accurate and complete patient records;

79 (b) Assuming authority and responsibility for product selection of drugs and devices;

80 (c) Developing and maintaining a safe practice setting for the pharmacist, for pharmacy
81 staff and for the general public;

82 (d) Maintaining confidentiality of patient information.

83 (17) "Oral Counseling" means an oral communication process between a pharmacist and
84 a patient or a patient's agent in which the pharmacist obtains information from the patient
85 (or agent) and the patient's pharmacy records, assesses that information and provides the
86 patient (or agent) with professional advice regarding the safe and effective use of the
87 prescription drug for the purpose of assuring therapeutic appropriateness.

88 (18) Participation in Drug Selection and Drug Utilization Review:

89 (a) "Participation in drug selection" means the consultation with the practitioner in the
90 selection of the best possible drug for a particular patient.

- 91 (b) "Drug utilization review" means evaluating prescription drug order in light of the
92 information currently provided to the pharmacist by the patient or the patient's agent and
93 in light of the information contained in the patient's record for the purpose of promoting
94 therapeutic appropriateness by identifying potential problems and consulting with the
95 prescriber, when appropriate. Problems subject to identification during drug utilization
96 review include, but are not limited to:
- 97 (A) Over-utilization or under-utilization;
 - 98 (B) Therapeutic duplication;
 - 99 (C) Drug-disease contraindications;
 - 100 (D) Drug-drug interactions;
 - 101 (E) Incorrect drug dosage;
 - 102 (F) Incorrect duration of treatment;
 - 103 (G) Drug-allergy interactions; and
 - 104 (H) Clinical drug abuse or misuse.
- 105 (19) "Pharmaceutical Care" means the responsible provision of drug therapy for the
106 purpose of achieving definite outcomes that improve a patient's quality of life. These
107 outcomes include:
- 108 (a) Cure of a disease;
 - 109 (b) Elimination or reduction of a patient's symptomatology;
 - 110 (c) Arrest or slowing of a disease process; or
 - 111 (d) Prevention of a disease or symptomatology.
- 112 (20) "Pharmacy Technician" means a person licensed by the State Board of Pharmacy
113 who assists the pharmacist in the practice of pharmacy pursuant to rules of the Board but
114 has not completed the specialized education program pursuant to OAR 855-025-0012.
- 115 (21) "Practice of clinical pharmacy" means:
- 116 (a) The health science discipline in which, in conjunction with the patient's other
117 practitioners, a pharmacist provides patient care to optimize medication therapy and to
118 promote disease prevention and the patient's health and wellness;
 - 119 (b) The provision of patient care services, including but not limited to post-diagnostic
120 disease state management services; and
 - 121 (c) The practice of pharmacy by a pharmacist pursuant to a clinical pharmacy agreement.
- 122 (22) "Practice of pharmacy" is as defined in ORS 689.005.
- 123 (23) "Prescription released by the pharmacist" means, a prescription which has been
124 reviewed by the pharmacist that does not require further pharmacist intervention such as
125 reconstitution or counseling.
- 126 (24) "Prohibited conduct" means conduct by a licensee that:
- 127 (a) Constitutes a criminal act against a patient or client; or
 - 128 (b) Constitutes a criminal act that creates a risk of harm to a patient or client.
- 129 (25) "Proper and safe storage of drugs and devices and maintenance of proper records
130 therefore" means housing drugs and devices under conditions and circumstances that:
- 131 (a) Assure retention of their purity and potency;
 - 132 (b) Avoid confusion due to similarity of appearance, packaging, labeling or for any other
133 reason;
 - 134 (c) Assure security and minimize the risk of their loss through accident or theft;
 - 135 (d) Accurately account for and record their receipt, retention, dispensing, distribution or
136 destruction;

- 137 (e) Protect the health, safety and welfare of the pharmacist, pharmacy staff and the
 138 general public from harmful exposure to hazardous substances.
- 139 (26) **“Quality Assurance Plan” is a written set of procedures to ensure that a**
 140 **pharmacy has a planned and systematic process for the monitoring and evaluation**
 141 **of the quality and appropriateness of pharmacy services and for identifying and**
 142 **resolving problems.**
- 143 ~~(26)~~ **(27)** "Responsibility for advising, when necessary or when regulated, of therapeutic
 144 values, content, hazards and use of drugs and devices" means advice directly to the
 145 patient, either verbally or in writing as required by these rules or federal regulation, of the
 146 possible therapeutic response to the medication, the names of the chemicals in the
 147 medication, the possible side effects of major importance, and the methods of use or
 148 administration of a medication.
- 149 ~~(27)~~ **(28)** "Shared Pharmacy Service" means a written agreement, that has been approved
 150 in writing by the board, that exists for the processing by a pharmacy of a request from
 151 another pharmacy or a practitioner licensed to prescribe the drug, to fill or refill a
 152 prescription or a drug order, or to perform processing functions including but not limited
 153 to:
- 154 (a) Dispensing;
 - 155 (b) Drug utilization review;
 - 156 (c) Claims adjudication;
 - 157 (d) Refill authorizations;
 - 158 (e) Compounding by a pharmacy located in Oregon for a practitioner or dispenser located
 159 in Oregon for Oregon outlets and practitioners located in Oregon only; and
 - 160 (f) Therapeutic interventions.
- 161 ~~(28)~~ **(29)** "Specialized Education Program" means;
- 162 (a) A program providing education for persons desiring licensure as pharmacy
 163 technicians that is approved by the board and offered by an accredited college or
 164 university that grants a two-year degree upon successful completion of the program; or
 - 165 (b) A structured program approved by the board and designed to educate pharmacy
 166 technicians in one or more specific issues of patient health and safety that is offered by:
 - 167 (A) An organization recognized by the board as representing pharmacists or pharmacy
 168 technicians;
 - 169 (B) An employer recognized by the board as representing pharmacists or pharmacy
 170 technicians; or
 - 171 (C) A trade association recognized by the board as representing pharmacies.
- 172 ~~(29)~~ **(30)** "Supervision by a pharmacist" means being stationed within the same work area
 173 as the pharmacy technician or certified pharmacy technician being supervised, coupled
 174 with the ability to control and be responsible for the pharmacy technician or certified
 175 pharmacy technician's action.
- 176 ~~(30)~~ **(31)** "Therapeutic substitution" means the act of dispensing a drug product with a
 177 different chemical structure for the drug product prescribed under circumstances where
 178 the prescriber has not given clear and conscious direction for substitution of the particular
 179 drug for the one which may later be ordered.
- 180 ~~(31)~~ "Unprofessional conduct" means ~~conduct unbecoming a licensee or detrimental to~~
 181 ~~the best interests of the public, including conduct contrary to recognized standards of~~

182 ethics of pharmacy or conduct that endangers the health, safety or welfare of a patient or
 183 client. Unprofessional conduct includes but is not limited to:
 184 (a) Fraud or misrepresentation in dealings relating to pharmacy practice with:
 185 (A) Customers, patients or the public;
 186 (B) Practitioners authorized to prescribe drugs, medications or devices;
 187 (C) Insurance companies;
 188 (D) Wholesalers, manufactures or distributors of drugs, medications or devices;
 189 (E) Health care facilities;
 190 (F) Government agencies; or
 191 (G) Drug outlets.
 192 (b) Illegal use of drugs, medications or devices without a practitioner's prescription, or
 193 otherwise contrary to federal or state law or regulation;
 194 (c) Any use of intoxicants, drugs or controlled substances that endangers or could
 195 endanger the licensee or others;
 196 (d) Theft of drugs, medications or devices, or theft of any other property or services
 197 under circumstances which bear a demonstrable relationship to the practice of pharmacy;
 198 (e) Dispensing a drug, medication or device where the pharmacist knows or should know
 199 due to the apparent circumstances that the purported prescription is bogus or that the
 200 prescription is issued for other than a legitimate medical purpose, including
 201 circumstances such as:
 202 (A) Type of drug prescribed;
 203 (B) Amount prescribed; or
 204 (C) When prescribed out of context of dose.
 205 (f) Any act or practice relating to the practice of pharmacy that is prohibited by state or
 206 federal law or regulation;
 207 (g) The disclosure of confidential information in violation of Board rule;
 208 (h) Engaging in collaborative drug therapy management in violation of ORS Chapter 689
 209 and the rules of the Board;
 210 (i) Authorizing or permitting any person to practice pharmacy in violation of the Oregon
 211 Pharmacy Act or the rules of the Board;
 212 (j) Any conduct or practice by a licensee or registrant which the Board determines is
 213 contrary to accepted standards of practice; or
 214 (k) Failure to cooperate with the Board pursuant to OAR 855-001-0035.
 215 (32) "Verification" means the confirmation by the pharmacist of the correctness,
 216 exactness, accuracy and completeness of the acts, tasks, or functions performed by an
 217 intern or a pharmacy technician or a certified pharmacy technician.

218
 219 Stat. Auth.: ORS 689.205
 220 Stats. Implemented: ORS 689.005, 689.151, 689.155, 689.305, 689.405, & 689.455,
 221 689.645 & 2015 OL Ch. 362
 222

223 **855-006-0015**

224 **Additional Definitions**

225 (1) Electronically Transmitted Prescription:
 226 (a) Where used in this chapter, Electronically Transmitted Prescription (ETP) means a
 227 prescription for a drug or medical device issued by a practitioner, who is licensed and

- 228 authorized to prescribe pursuant to the laws of this state and is acting within the scope of
 229 his or her practice, which has been transmitted by an electronic means that may include
 230 but is not limited to:
- 231 (A) Transmission by facsimile or hand held digital electronic device to a computer or
 - 232 facsimile;
 - 233 (B) Transmission from a computer to another computer;
 - 234 (C) Transmission by facsimile to computer; or
 - 235 (D) Transmission from a computer to facsimile.
- 236 (b) ETP does not include an oral prescription that has been reduced to writing by a
 237 pharmacist pursuant to OAR 855-041-0085 and does not include prescriptions, or drug or
 238 device orders written for inpatient use in a hospital.
- 239 (c) For an ETP to be valid, it must contain the name and immediate contact information
 240 of the prescriber, and be electronically encrypted or in some manner protected by up-to-
 241 date technology from unauthorized access, alteration or use.
- 242 (2) Tamper-resistant Prescription:
- 243 (a) Where used in this chapter, Tamper-resistant Prescription means a form for the
 - 244 purpose of issuing a hand written or typed prescription, intended to be manually delivered
 - 245 to a pharmacy, which has been developed, produced and formatted to ensure security,
 - 246 integrity and authenticity using currently accepted technologies.
 - 247 (b) Formatted features may include but are not limited to characteristics such as:
 - 248 (A) The word "void" appears when photocopies are attempted;
 - 249 (B) Background ink which reveals attempted alterations;
 - 250 (C) Heat sensitive ink that changes colors;
 - 251 (D) Penetrating ink to prevent chemical alterations;
 - 252 (E) A watermark which cannot be photocopied;
 - 253 (F) Coin reactive ink that reveals word when rubbed with a coin;
 - 254 (G) Sequential numbering.

255
 256 Stat. Auth.: 689.205
 257 Stats. Implemented: ORS **689.005 and** 689.155

258
 259 **855-006-0020**
 260 **Unprofessional Conduct Defined**

261
 262 **"Unprofessional conduct" means conduct unbecoming a licensee or detrimental to**
 263 **the best interests of the public, including conduct contrary to recognized standards**
 264 **of ethics of pharmacy or conduct that endangers the health, safety or welfare of a**
 265 **patient or client. Unprofessional conduct includes but is not limited to:**
 266 **(a) Fraud or misrepresentation in dealings relating to pharmacy practice with:**
 267 **(A) Customers, patients or the public;**
 268 **(B) Practitioners authorized to prescribe drugs, medications or devices;**
 269 **(C) Insurance companies;**
 270 **(D) Wholesalers, manufactures or distributors of drugs, medications or devices;**
 271 **(E) Health care facilities;**
 272 **(F) Government agencies; or**
 273 **(G) Drug outlets.**

- 274 **(b) Illegal use of drugs, medications or devices without a practitioner's prescription,**
- 275 **or otherwise contrary to federal or state law or regulation;**
- 276 **(c) Any use of intoxicants, drugs or controlled substances that endangers or could**
- 277 **endanger the licensee or others;**
- 278 **(d) Theft of drugs, medications or devices, or theft of any other property or services**
- 279 **under circumstances which bear a demonstrable relationship to the practice of**
- 280 **pharmacy;**
- 281 **(e) Dispensing a drug, medication or device where the pharmacist knows or should**
- 282 **know due to the apparent circumstances that the purported prescription is bogus or**
- 283 **that the prescription is issued for other than a legitimate medical purpose, including**
- 284 **circumstances such as:**
- 285 **(A) Type of drug prescribed;**
- 286 **(B) Amount prescribed; or**
- 287 **(C) When prescribed out of context of dose.**
- 288 **(f) Any act or practice relating to the practice of pharmacy that is prohibited by**
- 289 **state or federal law or regulation;**
- 290 **(g) The disclosure of confidential information in violation of Board rule;**
- 291 **(h) Engaging in collaborative drug therapy management in violation of ORS**
- 292 **Chapter 689 and the rules of the Board;**
- 293 **(i) Authorizing or permitting any person to practice pharmacy in violation of the**
- 294 **Oregon Pharmacy Act or the rules of the Board;**
- 295 **(j) Any conduct or practice by a licensee or registrant which the Board determines is**
- 296 **contrary to accepted standards of practice; or**
- 297 **(k) Failure to cooperate with the Board pursuant to OAR 855-001-0035.**

298

299 **Stat. Auth.: 689.205**

300 **Stats. Implemented: ORS 689.005 and 689.155**

301

DIVISION 25

~~CERTIFIED PHARMACY TECHNICIANS AND CERTIFIED OREGON PHARMACY~~
TECHNICIANS

855-025-0001

~~Transition from Registration of Technician to Licensure of Technician~~ Purpose and Scope

The purpose of the Pharmacy Technician (PT) license is to provide an opportunity for an individual ~~person~~ to obtain competency in the role of as a Pharmacy Technician. ~~It~~ This license will allow ~~a person to have~~ an individual time to take and pass a national pharmacy technician certification examination, which is required to be eligible for licensure as a Certified Oregon Pharmacy Technician (CPT). ~~and~~ These rules facilitate the initial licensure of a nationally certified Pharmacy Technician seeking licensure in Oregon.

Stat. Auth.: 689.205

Stats. Implemented: 689.225, 689.486

855-025-0005

Qualifications for Licensure as a Pharmacy Technician or Certified Oregon Pharmacy Technician

(1) To qualify for licensure as a Pharmacy Technician or Certified Oregon Pharmacy Technician, an applicant must demonstrate that the applicant is at least 18 years of age and holds has obtained a high school diploma or GED.

(2) Section one does not apply to persons under the age of 18 licensed by the Board as a Pharmacy Technician prior to January 1, 2015.

(3) An applicant for licensure as a Pharmacy Technician or Certified Oregon Pharmacy Technician must complete an application for licensure, provide the Board with a valid e-mail address and furnish documentation required to conduct a criminal background check.

(4) No person whose license has been denied, revoked, suspended or restricted by any healthcare professional regulatory Board may be licensed as a Pharmacy Technician or Certified Oregon Pharmacy Technician unless the Board determines that licensure will pose no danger to patients or to the public interest.

Stat. Auth.: ORS 689.205

Stats. Implemented: ORS ~~689.155~~ 689.225, 689.486

37 **855-025-0010**

38 **Licensure as a Pharmacy Technician**

39 (1) The license of a Pharmacy Technician expires the second June 30 from the date of issue and
40 is not to exceed ~~more than~~ two years.

41 (2) The Pharmacy Technician license is not renewable, ~~except by petition to the Board.~~

42 **(3) A time limited extension of a Pharmacy Technician license may be granted once by**
43 **petition to the Board. The written completed petition must be received by the Board prior**
44 **to the expiration of the PT license.**

45 ~~(3)~~ **(4)** An individual may reapply for a Pharmacy Technician license if ~~his or her~~ **the** previous
46 **PT** license is lapsed for a period greater than five years ~~or by petition to the Board.~~

47 Stat. Auth.: ORS 689.205

48 Stats. Implemented: ORS ~~689.155~~ **689.225, 689.486**

49 **855-025-0012**

50 **Licensure as a Certified Oregon Pharmacy Technician**

51 ~~(1) To obtain a Certified Oregon Pharmacy Technician license, the applicant must demonstrate~~
52 ~~that the applicant~~ **qualify for licensure as a Certified Oregon Pharmacy Technician, the**
53 **applicant must demonstrate that he or she** has taken and passed a national pharmacy
54 technician certification examination offered by:

55
56 (a) The Pharmacy Technician Certification Board (PTCB); or

57
58 (b) The National Healthcareer Association (NHA).

59
60 (2) The license of a Certified Oregon Pharmacy Technician expires ~~September~~ **June 30 in even**
61 **numbered years and must be renewed biennially** ~~annually.~~

62
63 Stat. Auth.: ORS 689.205

64 Stats. Implemented: ORS ~~689.155~~ **689.225, 689.486**

65
66 **855-025-0015**

67 **Renewal of Licensure as a Certified Oregon Pharmacy Technician**

68 (1) A person who has taken and passed a national pharmacy technician certification examination
69 listed in OAR 855-025-0012(1)(a)-(b) may use the following title, ~~are~~ **and is** referred to in these
70 rules as, and ~~are~~ **is** licensed as a “Certified Oregon Pharmacy Technician.”

71 (2) An applicant for renewal of a Certified Oregon Pharmacy Technician license must:

72 (a) Pay the **biennial** license fee prescribed in OAR 855-110.

73 (b) Satisfactorily complete a minimum of ~~120~~ continuing pharmacy educating hours during the
74 period from ~~September~~ **July 1** through ~~August 31,~~ **June 30**, of each license renewal cycle. These
75 hours must include:

76 (A) ~~One~~ **Two** hours of continuing pharmacy education in pharmacy law;

77 (B) ~~One~~ **Two** hours of continuing pharmacy education in patient safety or error prevention; and

78 (C) ~~Eight~~ **Sixteen** other hours of continuing pharmacy education hours or documented onsite
79 training, approved by the Board.

80 (c) OAR 855-025-0015(2)(b) does not apply to **a** Certified Oregon Pharmacy Technicians
81 applying for the first renewal of their license, if they have not been licensed by the Board for at
82 least one year prior to ~~October 1~~ **July 1** of the renewal period.

83 (d) Be subject to an annual criminal background check.

84 (3) The Board may randomly select and audit applications for renewal to verify completion of
85 ~~the~~ continuing education or documented onsite training reported on the application for renewal.
86 **A** Certified Oregon Pharmacy Technicians whose applications for renewal ~~are~~ **is** selected for
87 audit must provide documentation of completion of the continuing pharmacy education reported.

88 (4) Effective January 1, 2015, national certification is not required to renew a license as a
89 Certified Oregon Pharmacy Technician.

90 (5) A Certified Oregon Pharmacy Technician who fails to renew his or her license by the
91 expiration date and whose license has been ~~less than 180 days~~ **lapsed for less than one year** may
92 renew his or her license as follows:

93 **(a) Complete the renewal process;**

94 ~~(a)~~ **(b) Pay the biennial license fee as prescribed in OAR 855-110-; and**

95 ~~(b)~~ **(c) Pay a delinquent fee-; and**

96 **(d) Complete the required continuing education pursuant to OAR 855-025-0015(2)(b).**

97 ~~(6) A Certified Oregon Pharmacy Technician who fails to renew their license by the deadline and~~
98 ~~whose license has been lapsed 180 days may reinstate his or her license under OAR 855-025-~~
99 ~~0060(1).~~

100

101 Stat. Auth.: ORS 689.205

102 Stats. Implemented: ORS ~~689.155~~ **689.225, 689.486**

103

104

105 **855-025-0060**

106 **Reinstatement of a Certified Oregon Pharmacy Technician License**

107 (1) A Certified Oregon Pharmacy Technician who fails to renew their license by the deadline and
 108 whose license has been lapsed ~~180 days or longer~~ **for greater than one year** may reinstate their
 109 license as follows:

110 (a) Complete a new application for licensure and provide the Board with a valid e-mail address;
 111 ~~and~~

112 (b) Pay the **biennial** license fee as prescribed in OAR 855-110.; **and**

113 **(c) Submit to a national fingerprint background check;**

114 **(d) Provide certification of completion of 10 continuing education hours. These hours may**
 115 **not be counted toward renewal; and must include:**

116 **(A) One hour of continuing pharmacy education in pharmacy law;**

117 **(B) One hour of continuing pharmacy education in patient safety or error prevention; and**

118 **(C) Eight other hours of pharmacy technician-specific continuing education.**

119 (2) A Certified Oregon Pharmacy Technician whose license has been lapsed greater than ~~four~~
 120 **five** years must:

121 ~~(a) Complete an application for licensure, provide the Board with a valid e-mail address, and a~~
 122 ~~fingerprint card or other documentation required to conduct a criminal background check;~~

123 ~~(b) Pay the license fee as prescribed in OAR 855-110; and~~

124 ~~(e a)~~ Re-take and pass a national pharmacy technician certification examination offered by:

125 (A) The Pharmacy Technician Certification Board (PTCB); or

126 (B) National Healthcareer Association (NHA).

127 (b) Satisfy reinstatement requirements pursuant to OAR 855-025-0060(1).

128 Stat. Auth.: ORS 689.205

129 Stats. Implemented: ORS ~~689.155~~ **689.225, 689.486**

1 **855-041-2320**

2 **Epinephrine**

3 (1) A pharmacist may fill an order for epinephrine to be used by trainees to treat an anaphylactic
 4 reaction. Trainees must be 18 years of age or older and must have responsibility for or contact
 5 with at least one (1) other person as a result of the trainee’s occupation or volunteer status, such
 6 as, but not limited to, a camp counselor, scout leader, forest ranger, school employee, tour guide
 7 or chaperone.

8 (2) Individuals must successfully complete a training program approved by the Oregon Health
 9 Authority, Public Health Division. Upon successful completion, the trainee will receive the
 10 following certificates:

11 (a) Statement of Completion; and

12 (b) Authorization to Obtain Epinephrine.

13 (3) ~~(a) Distribution~~ **Acquisition** of epinephrine from a pharmacy to be used for the treatment of
 14 allergic emergencies may occur in the following manners:

15 ~~(b) (a) A trainee may obtain **acquire** epinephrine upon presentation of the Statement of
 16 Completion and Authorization to Obtain Epinephrine certificate to a pharmacy which:~~

17 **(b) (a) A trainee may obtain pharmacist may dispense epinephrine to a trainee upon
 18 presentation of the Statement of Completion and Authorization to Obtain Epinephrine certificate
 19 to a pharmacy which:**

20 (A) A pharmacist may generate a prescription for, and dispense an emergency supply of
 21 epinephrine for not more than one (1) child and one (1) adult in an automatic injection device, as
 22 specified by the supervising professional whose name, signature, and license number appear on
 23 the Authorization to Obtain Epinephrine certificate.

24 (B) The pharmacist who generates the hardcopy prescription for epinephrine in this manner shall
 25 reduce the prescription to writing, and file the prescription in a manner appropriate for a non-
 26 controlled substance.

27 (C) Once the pharmacist generates the epinephrine prescription, the pharmacist shall write in the
 28 appropriate space provided on the Authorization to Obtain Epinephrine certificate, the date and
 29 the number of doses dispensed, and return the certificate to the trainee.

30 ~~(4)~~ **(D)** The Statement of Completion and the Authorization to Obtain Epinephrine certificate
 31 may be used to obtain epinephrine up to four (4) times within three (3) years from the date of the
 32 initial training.

33 ~~(a)~~ **(E)** Both the Statement of Completion and the Authorization to Obtain Epinephrine
34 certificate expire three (3) years from the date of the trainee's last Oregon Health Authority
35 approved allergy response training.

36 ~~(b)~~ **(F)** Upon completion of the training, the trainee will receive a new Statement of Completion
37 and Authorization to Obtain Epinephrine certificate, with a valid duration of three (3) years.

38 ~~(b)~~ **An entity may acquire epinephrine if:**

39 **(b) A pharmacy may dispense epinephrine to an entity when:**

40 **(A) The epinephrine is acquired by a valid prescription presented to the pharmacy;**

41 **(B) The prescription identifies the entity as the patient for the purpose of prescribing;**

42 **(C) The pharmacist may dispense the epinephrine to the entity based on documentation**
43 **that the entity employs a person who has completed a completed training program**
44 **approved by the Oregon Health Authority for the treatment of allergic emergencies; and**

45 **(i) The pharmacist may shall use the name of the entity as the patient for the purpose of**
46 **labeling the prescription.**

47 **(ii) The prescription shall be limited to one adult and one child dose package per trained**
48 **employee per location.**

49 **(C) For the purpose of this rule, an entity conducts business at a single physical location.**

50 Stat. Auth: ORS 689.205

51 Stats. Implemented: ORS 689.155, 433.825

1 **Remote Distribution Facilities**

2 **855-041-4200**

3 **Remote Distribution Facility (RDF)**

4 (1) A pharmacy physically located in Oregon may make written application to operate an RDF.

5 (2) ~~At its discretion, the~~ The Board may approve an application for registration as an RDF which
6 includes the following:

7 (a) An operation plan;

8 (b) Policies and Procedures;

9 (c) A training plan;

10 (d) A quality assurance plan for ensuring that there is a planned and systematic process for the
11 monitoring and evaluation of the quality and appropriateness of pharmacy services and for
12 identifying and resolving problems; and

13 (e) The fee specified in **OAR 855-110** ~~OAR 855-110-0007 (14)~~.

14 (3) Notwithstanding the definition of “supervision by a pharmacist” in OAR 855-006-0005,
15 supervision in an RDF may be accomplished by a pharmacist via an audio-visual technology
16 from the applying pharmacy.

17 (4) Notwithstanding rules in this division and in Division 19 **and 25**, a Certified **Oregon**
18 Pharmacy Technician who works in an RDF may have access to the facility without the physical
19 presence of a pharmacist, but may only perform Board approved functions when under the
20 supervision of a pharmacist.

21 Stat. Auth.: ORS 689.205

22 Stats. Implemented: ORS 689.155

23

24

1 *These proposed rules repeal OAR 855-043-0110 thru 0130 **AND** OAR 855-043-0300 thru 0310 and adopt*
2 *a new section of rules to combine the County Health and Family Planning drug outlet registrations into a*
3 *single "Community Health Clinic Drug Outlet" with rules beginning at 855-043-0700.*

4
5 **County Health Clinics**

6 **855-043-0110**

7 **Purpose and Scope**

8 ~~(1) A Registered Nurse who is licensed with the Oregon State Board of Nursing, and who is an~~
9 ~~employee of a local health department established under the authority of a county or district~~
10 ~~board of health may dispense a drug or device to a client of the health department for purposes of~~
11 ~~earies prevention, birth control, or prevention or treatment of a communicable disease.~~

12 ~~(2) Such dispensing shall be pursuant to the order of a person authorized to prescribe a drug or~~
13 ~~device, and shall be subject to rules jointly adopted by the Board and DHS.~~

14 ~~Stat. Auth.: ORS 689.205~~

15 ~~Stats. Implemented: ORS 689.155~~

16
17 **855-043-0130**

18 **Drug Delivery and Control**

19 ~~(1) The health officer is responsible for the establishment of policies and procedures that include:~~

20 ~~(a) Procedures for drug dispensing, storage, security, and accountability;~~

21 ~~(b) Maintenance of all drug records required by federal and state law;~~

22 ~~(c) Procedures for procurement of drugs.~~

23 ~~(2) Dispensing:~~

24 ~~(a) A drug may only be dispensed by a practitioner who has been given dispensing privileges by~~
25 ~~their licensing board or by a Registered Nurse;~~

26 ~~(b) A drug must be dispensed in a container complying with the federal Poison Prevention~~
27 ~~Packaging Act unless the patient requests a non-complying container;~~

28 ~~(c) A Registered Nurses may only dispense a drug listed in, or for a condition listed in, the~~
29 ~~formulary;~~

30 ~~(d) Each drug that is dispensed must be labeled with the following information:~~

- 31 ~~(A) Name of patient;~~
- 32 ~~(B) Name of prescriber;~~
- 33 ~~(C) Name, address, and phone number of the clinic;~~
- 34 ~~(D) Date of dispensing;~~
- 35 ~~(E) Name and strength of the drug. If the drug does not have a brand name, then the generic~~
36 ~~name of the drug and the drug manufacturer must be stated;~~
- 37 ~~(F) Directions for use;~~
- 38 ~~(G) Initials of the person dispensing;~~
- 39 ~~(H) Cautionary statements, if any, as required by law;~~
- 40 ~~(I) Manufacturer's expiration date, or an earlier date if preferable, after which the patient should~~
41 ~~not use the drug.~~
- 42 ~~(e) A drug information fact sheet must accompany each drug dispensed from a county health~~
43 ~~clinic.~~
- 44 ~~(3) Repackaged Drugs. A drug repackaged for dispensing must be in a container meeting USP~~
45 ~~standards and labeled to identify at a minimum:~~
- 46 ~~(a) Brand name, or generic name and manufacturer;~~
- 47 ~~(b) Strength;~~
- 48 ~~(c) Lot number;~~
- 49 ~~(d) Manufacturer's expiration date or an earlier date if preferable. An internal control number~~
50 ~~which references manufacturer and lot number may be used.~~
- 51 ~~(4) Drug Security, Storage, and Disposal:~~
- 52 ~~(a) In the absence of a dispensing practitioner or a Registered Nurse, drugs must be kept in a~~
53 ~~locked drug cabinet or drug room which is sufficiently secure to deny access to unauthorized~~
54 ~~persons. Only dispensing practitioners and Registered Nurses may have a key to the drug cabinet~~
55 ~~or drug room. In their absence, the drug cabinet or drug room must remain locked.~~
- 56 ~~(b) All drugs must be stored in areas which will assure proper sanitation, temperature, light,~~
57 ~~ventilation and moisture control as recommended by the manufacturer.~~

58 ~~(c) Drugs which are outdated, damaged, deteriorated, misbranded, or adulterated must be~~
59 ~~quarantined and physically separated from other drugs until they are destroyed or returned to~~
60 ~~their supplier.~~

61 ~~(5) Drug Records;~~

62 ~~(a) A dispensing record must be maintained separately from the patient chart and kept for a~~
63 ~~minimum of three years. The record must show, at a minimum, the following:~~

64 ~~(A) Name of patient;~~

65 ~~(B) Brand name of drug, or generic name and name of manufacturer or distributor;~~

66 ~~(C) Date;~~

67 ~~(D) Initials of person dispensing the prescription.~~

68 ~~(b) All records of receipt and disposal of drugs must be kept for a minimum of three years;~~

69 ~~(c) All records required by these rules or by federal and state law must be readily retrievable and~~
70 ~~available for inspection by the Board.~~

71 ~~(6) Notwithstanding any other requirements in this rule, when a drug is dispensed in the practice~~
72 ~~of an Expedited Partner Therapy treatment protocol, the name of the patient may be omitted from~~
73 ~~the label, the patient's name may be omitted from the records and a drug may be dispensed to the~~
74 ~~patient to be given to the patient's partner even if the partner has not been examined by a~~
75 ~~licensed health care provider acting within their scope of practice.~~

76 ~~(7) Upon written request, the Board may waive any of the requirements of this rule if a waiver~~
77 ~~will further public health and safety. A waiver granted under this section shall only be effective~~
78 ~~when it is issued in writing.~~

79 ~~Stat. Auth.: ORS 689.205 & 689.605~~

80 ~~Stats. Implemented: ORS 689.155, 689.505 & 676.350~~

81

82 **Family Planning Clinics**

83 **855-043-0300**

84 **Purpose and Scope**

85 ~~(1) A practitioner who has been given dispensing privileges by their licensing board, or a~~
86 ~~Registered Nurse, who is an employee of a clinic that is registered with the Board and is~~
87 ~~supported by DHS for purposes of providing public health family planning services, may~~

88 dispense drugs or devices to clients for the purpose of birth control, the treatment of amenorrhea,
89 hormone deficiencies, urinary tract infections or sexually transmitted diseases.

90 ~~(2) Such dispensing must be pursuant to the prescription of a person authorized to prescribe a~~
91 ~~drug or device, and is subject to rules jointly adopted by the Board and DHS.~~

92 Stat. Auth.: ~~ORS 689.205~~

93 Stats. Implemented: ~~ORS 689.305~~

94 Hist.: ~~BP 4 2002, f. 6 27 02, cert. ef. 7 1 02; BP 1 2010, f. & cert. ef. 2 8 10~~

95 **855-043-0310**

96 **Drug Delivery and Control**

97 ~~(1) Policies and Procedures. The licensed facility is responsible for the following:~~

98 ~~(a) Maintaining written policies and procedures for drug dispensing, storage, security, and~~
99 ~~accountability;~~

100 ~~(b) Maintenance of all drug records required by federal and state law; and~~

101 ~~(c) Establishing procedures for procurement of drugs.~~

102 ~~(2) Dispensing:~~

103 ~~(a) Nonjudgmental dispensing functions may be delegated to staff assistants when the accuracy~~
104 ~~and completeness of the prescription is verified by a practitioner who has been given dispensing~~
105 ~~privileges by their licensing board, or by a Registered Nurse, prior to being delivered or~~
106 ~~transferred to the patient.~~

107 ~~(b) A drug must be dispensed in a containers complying with the federal Poison Prevention~~
108 ~~Packaging Act unless the patient requests a non-complying container.~~

109 ~~(c) A prescription must be labeled with the following information:~~

110 ~~(A) Name of patient;~~

111 ~~(B) Name of prescriber;~~

112 ~~(C) Name, address, and phone number of the clinic;~~

113 ~~(D) Date of dispensing;~~

114 ~~(E) Name and strength of the drug. If the drug does not have a brand name, then the generic~~
115 ~~name of the drug and the drug manufacturer must be stated;~~

116 ~~(F) Directions for use;~~

- 117 ~~(G) Initials of the person dispensing;~~
- 118 ~~(H) Cautionary statements, if any, as required by law; and~~
- 119 ~~(I) Manufacturer's expiration date, or an earlier date if preferable, after which the patient should~~
120 ~~not use the drug.~~
- 121 ~~(d) The prescriber must verbally counsel the patient concerning all new medications and a drug~~
122 ~~information fact sheet must accompany all drugs dispensed from a family planning clinic.~~
- 123 ~~(3) Repackaged drugs. Drugs repackaged for dispensing must be in a container meeting USP~~
124 ~~standards and labeled to identify at a minimum:~~
- 125 ~~(a) Brand name, or generic name and manufacturer;~~
- 126 ~~(b) Strength;~~
- 127 ~~(c) Lot number; and~~
- 128 ~~(d) Manufacturer's expiration date, or an earlier date if preferable. An internal control number~~
129 ~~which references manufacturer and lot number may be utilized.~~
- 130 ~~(4) Drug security, storage, and disposal:~~
- 131 ~~(a) In the absence of a physician, pharmacist, Registered Nurse, Clinical Nurse Specialist, or~~
132 ~~nurse practitioner, all drugs must be kept in a locked drug cabinet or drug room that is~~
133 ~~sufficiently secure to deny access to unauthorized persons. Only physicians, pharmacists,~~
134 ~~Registered Nurses, Clinical Nurse Specialists or nurse practitioners shall have a key to the drug~~
135 ~~cabinet or drug room. In their absence, the drug cabinet or drug room must remain locked.~~
- 136 ~~(b) All drugs must be stored in areas which will assure proper sanitation, temperature, light,~~
137 ~~ventilation, and moisture control as recommended by the manufacturer.~~
- 138 ~~(c) Drugs which are outdated, damaged, deteriorated, misbranded, or adulterated must be~~
139 ~~quarantined and physically separated from other drugs until they are destroyed or returned to~~
140 ~~their supplier.~~
- 141 ~~(5) Drug records:~~
- 142 ~~(a) A dispensing record must be maintained separately from the patient chart and kept for a~~
143 ~~minimum of three years. The record must show, at a minimum, the following:~~
- 144 ~~(A) Name of patient;~~
- 145 ~~(B) Brand name of drug, or generic name and name of manufacturer or distributor;~~

146 (C) Date of dispensing; and

147 (D) Initials of person dispensing the prescription;

148 (b) All records of receipt and disposal of drugs must be kept for a minimum of three years.

149 (c) All records required by these rules or by federal and state law must be readily retrievable and
150 available for inspection by the Board.

151 (6) A consultant pharmacist must conduct and document an annual inspection of the clinic in
152 accordance with the directions of the Board. The completed report form must be filed in the
153 clinic, and be available to the Board for inspection for three years.

154 (7) Notwithstanding any other requirements in this rule, when a drug is dispensed in the practice
155 of an Expedited Partner Therapy treatment protocol, the name of the patient may be omitted from
156 the label, the patient's name may be omitted from the records and a drug may be dispensed to the
157 patient to be given to the patient's partner even if the partner has not been examined by a
158 licensed health care provider acting within their scope of practice.

159 Stat. Auth.: ORS 689.205

160 Stats. Implemented: ORS 689.305, 2009 OL Ch 522

161

162 **Community Health Clinic Drug Outlet**

163 **855-043-0700**

164 **Purpose and Scope**

165 **(1) The purpose of 855-043-0700 to 855-043-0750 is to provide minimum requirements of**
166 **operation for a Community Health Clinic (CHC) which utilizes Registered Nurses to**
167 **dispense medications. A Community Health Clinic drug outlet registration replaces a**
168 **Family Planning or County Health Drug Outlet registration. A legend or non-prescription**
169 **drug may be dispensed to a client for the purpose of birth control, carries prevention, the**
170 **treatment of amenorrhea, the treatment of a communicable disease, hormone deficiencies,**
171 **urinary tract infections or sexually transmitted diseases by a practitioner who has been**
172 **given dispensing privileges by their licensing Board, or a Registered Nurse, who is an**
173 **employee of a clinic or local public health authority (LPHA), and is recognized by the**
174 **Oregon Public Health Division for the purposes of providing public health services.**

175 **(2) Such dispensing must be pursuant to the order or prescription of a person authorized**
176 **by their Board to prescribe a drug or established by the Medical Director or clinic**
177 **practitioner with prescriptive and dispensing authority.**

178 (3) Family Planning or County Health Drug Outlet registrations that currently expire
179 March 31, 2017 will be converted to the new category upon renewal in 2017, however these
180 new rules will take effect on July 1, 2016.

181 Stat. Auth.: ORS 689.205
182 Stats. Implemented: ORS 689.305

184 855-043-0705

185 Registration

186 (1) A Community Health Clinic drug outlet must register with the Board on a form
187 prescribed by the Board, and must renew its registration annually on a renewal form
188 prescribed by the Board.

189 (2) An initial application and renewal application must be accompanied by the fee
190 established in Division 110 of this Chapter.

191 (3) A certificate of registration will be issued upon Board approval of the application.

192 (4) A CHC drug outlet registration expires March 31, annually. If the annual renewal fee is
193 not paid by February 28 of the current year, the applicant for renewal must submit the
194 delinquent fee established in Division 110 of this Chapter with the renewal application.

195 (5) The registration is not transferable and the registration fee cannot be prorated.

196 (6) The registrant must notify the Board, within 15 days, of any substantial change to the
197 information provided on the registration application. A substantial change shall include
198 but not be limited to: a change of ownership; change of business address; change of normal
199 business hours; any disciplinary action taken or pending by any state or federal authority
200 against the registrant, or any of its principals, owners, directors, officers, or medical
201 director.

202 (7) A new registration form is required for a change of ownership or location and must be
203 submitted to the Board with the fees as specified in Division 110 of this Chapter within 15
204 days of the change.

205 (8) A CHC drug outlet may be inspected by the Board.

206 Stat. Auth.: ORS 689.205
207 Stats. Implemented: ORS 689.305

209 855-043-0710

210 Personnel

211 **(1) A Community Health Clinic drug outlet must employ a Medical Director who is an**
212 **Oregon practitioner with prescriptive and dispensing authority. The Medical Director shall**
213 **establish and enforce policies and procedures, drug dispensing formulary, and protocols**
214 **for the dispensing of drugs by authorized persons in the CHC.**

215 **(2) A CHC drug outlet must designate a representative employee who will act as the**
216 **Oregon Board of Pharmacy contact person. The designated representative must be on site**
217 **the majority of the CHC's normal operating hours.**

218 **(a) The Medical Director or designated representative must conduct and document an**
219 **annual review of the outlet on a form provided by the Board. The completed report form**
220 **must be filed in the outlet, retained on file for three years and be available to the Board for**
221 **inspection.**

222 **(b) The Medical Director shall develop policies and procedures for the outlet in**
223 **collaboration with the designated representative.**

224 **Stat. Auth.: ORS 689.205**
225 **Stats. Implemented: ORS 689.305**

226 **Policies and Procedures**

227 **855-043-0715**

228 **The Community Health Clinic must:**

229 **(1) Maintain written policies and procedures for drug management, including security,**
230 **acquisition, storage, dispensing and drug delivery, disposal, record keeping; and**

231 **(2) Establish procedures to train a Registered Nurse employed by the CHC to ensure**
232 **continued competence in the dispensing of drugs.**

233 **Stat. Auth.: ORS 689.205**
234 **Stats. Implemented: ORS 689.305**

235
236 **855-043-0720**

237 **Security**

238 **(1) All drugs must be kept in a locked drug cabinet or designated drug storage area that is**
239 **sufficiently secure to deny access to unauthorized persons. The drug cabinet or designated**
240 **drug storage area must remain locked and secured when not in use.**

241 **(2) Only a Physician, Clinical Nurse Specialist, Nurse Practitioner, or Registered Nurse**
242 **shall have a key to the drug cabinet or drug room. In their absence, the drug cabinet or**
243 **drug room must remain locked.**

244 **(3) Upon written request, the Board may waive any of the requirements of this rule if a**
245 **waiver will further public health or safety or the health and safety of a patient. A waiver**
246 **granted under this section shall only be effective when it is issued by the Board in writing.**

247 **Stat. Auth.: ORS 689.205**
248 **Stats. Implemented: ORS 689.305**

249

250 **855-043-0725**

251 **Drug Acquisition**

252 **The CHC must verify that all drugs are acquired from a registrant of the Board.**

253 **Stat. Auth.: ORS 689.205**
254 **Stats. Implemented: ORS 689.305**

255

256 **855-043-0730**

257 **Storage of Drugs**

258 **All drugs, including drug samples, must be stored according to manufacturer's published**
259 **guidelines and be stored in appropriate conditions of temperature, light, humidity,**
260 **sanitation, ventilation, and space.**

261 **Stat. Auth.: ORS 689.205**
262 **Stats. Implemented: ORS 689.305**

263

264 **855-043-0735**

265 **Labeling**

266 **(1) A prescription must be labeled with the following information:**

267 **(a) Unique identifier (i.e. prescription number);**

268 **(b) Name of patient;**

269 (c) Name of prescriber;

270 (d) Name, address, and phone number of the clinic;

271 (e) Date of dispensing;

272 (f) Name of drug, strength, and quantity dispensed; when a generic name is used, the label
273 must also contain the identifier of the manufacturer or distributor;

274 (g) Quantity dispensed;

275 (h) Directions for use;

276 (i) Initials of the practitioner who has been given dispensing privileges by their licensing
277 Board or the Registered Nurse;

278 (j) Cautionary statements, if any, as required by law; and

279 (k) Manufacturer's expiration date, or an earlier date if preferable, after which the patient
280 should not use the drug; and

281 (2) Notwithstanding any other requirements in this rule, when a drug is dispensed in the
282 practice of an Expedited Partner Therapy treatment protocol, the name of the patient may
283 be omitted from the label, the patient's name may be omitted from the records and a drug
284 may be dispensed to the patient to be given to the patient's partner even if the partner has
285 not been examined by a licensed health care provider acting within their scope of practice.

286 Stat. Auth.: ORS 689.205

287 Stats. Implemented: ORS 689.305, 689.505

288

289 855-043-0740

290 Dispensing and Drug Delivery

291 (1) A drug may only be dispensed by a practitioner who has been given dispensing
292 privileges by their licensing Board or by a Registered Nurse.

293 (2) A Registered Nurse may only provide over-the-counter drugs pursuant to established
294 CHC protocols.

295 (3) A Registered Nurse may only dispense drug listed in, or for a condition listed in, the
296 formulary.

297 (4) Nonjudgmental dispensing functions may be delegated to staff assistants when the
298 accuracy and completeness of the prescription is verified by a practitioner who has been

299 given dispensing privileges by their licensing Board, or by a Registered Nurse, prior to
300 being delivered or transferred to the patient.

301 (5) The CHC will provide appropriate drug information for medications dispensed to a
302 patient, which can be provided by the Registered Nurse or practitioner at the time of
303 dispensing.

304 (6) All drugs must be dispensed in a new container that complies with the current
305 provisions of the Federal Consumer Packaging Act (Public Law 91-601, 91st Congress, S.
306 2162) and rules or regulations and with the current United States Pharmacopoeia/National
307 Formulary monographs for preservation, packaging, storage and labeling.

308 (7) Drugs must be repackaged by the practitioner, Registered Nurse, a pharmacy; or a
309 manufacturer registered with the Board.

310 (8) A CHC may not accept the return of drugs from a previously dispensed prescription
311 and must maintain a list of sites in Oregon where drugs may be disposed.

312 (9) A CHC must have access to the most current issue of at least one pharmaceutical
313 reference with current, properly filed supplements and updates appropriate to and based
314 on the standards of practice for the setting.

315 Stat. Auth.: ORS 689.205
316 Stats. Implemented: ORS 689.305

317 855-043-0745

318 Disposal of Drugs

319 Drugs that are outdated, damaged, deteriorated, misbranded, adulterated, or identified as
320 suspect or illegitimate must be documented, quarantined and physically separated from
321 other drugs until they are destroyed or returned to the supplier.

322 Stat. Auth.: ORS 689.205
323 Stats. Implemented: ORS 689.305

324 855-043-0750

325 Record Keeping

326 (1) A dispensing record must be maintained separately from the patient chart and kept for
327 a minimum of three years. The record must show, at a minimum, the following:

328 (a) Name of patient;

329 **(b) Unique identifier (i.e. prescription number);**

330 **(c) Dose, dosage form, quantity dispensed and either the brand name of drug, or generic**
331 **name and name of manufacturer or distributor;**

332 **(d) Directions for use;**

333 **(e) Date of dispensing; and**

334 **(f) Initials of person dispensing the prescription.**

335 **(2) All records of receipt and disposal of drugs must be kept for a minimum of three years.**

336 **(3) All records required by these rules or by other State and federal law must be readily**
337 **retrievable and available for inspection by the Board.**

338 **Stat. Auth.: ORS 689.205**

339 **Stats. Implemented: ORS 689.305**

1 **855-110-0003**

2 **General**

3 (1) All fees paid under these rules are non-refundable.

4 (2) Fees cannot be prorated.

5 (3) Fees for initial licensure as a Pharmacist or Certified Oregon Pharmacy Technician may
6 be reduced to one half of a biennial rate, if the application is received or the mailing date of the
7 application is postmarked within 180 days of expiration.

8 (4) A delinquent fee must be paid:

9 (a) When an application is postmarked after the date specified in these rules; or

10 (b) When the Board requests additional information from an applicant and this information is not
11 provided within 30 days.

12 (5) A delinquent fee may be assessed when an application is submitted incomplete and the Board
13 requests the missing information.

14 Stat. Auth.: ORS 689.205

15 Stats. Implemented: ORS 689.135

16

17 **855-110-0005**

18 **Licensing Fees**

19 (1) Pharmacist license examination (NAPLEX) and re-examination fee — \$50.

20 (2) Pharmacist jurisprudence (MPJE) re-examination fee — \$25.

21 (3) Pharmacist licensing by reciprocity fee — \$200*. (*Temporary revenue surplus fee reduction
22 pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

23 (4) Pharmacist licensing by score transfer fee — \$200*. (*Temporary revenue surplus fee
24 reduction pursuant to ORS 291.055(3)).

25 (5) Intern license fee. Expires November 30 every two years — \$50.

26 (6) Pharmacist:

27 (a) Biennial license fee. Expires June 30 each odd numbered year. The biennial license fee is —
28 \$120. Delinquent renewal fee, (postmarked after May 31) — \$50.

29 (b) Electronic Prescription Monitoring Fund fee. Due by June 30 biennially— \$50. (This is a
30 mandatory fee, required by ORS 431.972 that must be paid with the pharmacist license renewal
31 fee).

32 (c) Workforce Data Collection fee. Due by June 30 biennially — ~~\$54~~. (This is a mandatory fee, ~~it~~
33 ~~may be charged annually at \$2.50 per year~~ as required by OAR 409-026-0130 that must be paid
34 with the Pharmacist license renewal fee.

35 (7) Certification of approved provider of continuing education course fee, none at this time.

36 (8) Pharmacy Technician license fee — \$50.

37 (a) A Pharmacy Technician license initially issued prior to January 1, 2015 to a person under 18
38 years of age expires June 30 in odd numbered years — \$50. Delinquent renewal fee,
39 (postmarked after May 31) — \$20.

40 (9) Certified Oregon Pharmacy Technician:

41 (a) ~~Biennial~~ License fee. Expires ~~September~~ June 30 each even numbered year annually —
42 \$50. Delinquent renewal fee, (postmarked after August 31) — \$20.

43 (b) Workforce Data Collection fee. Due by June 30 biennially — ~~\$54~~. (This is a mandatory fee,
44 ~~it may be charged annually at \$2.50 per year~~ as required by OAR 409-026-0130 that must be
45 paid with the Certified Oregon Pharmacy Technician license renewal fee.

46 Stat. Auth.: ORS 689.205, ~~&~~ 291.055 & 183.705

47 Stats. Implemented: ORS 689.135, 431.972 & 676.410

48

49 **855-110-0007**

50 **Fees for Registration, Renewal, and Reinspection of Drug Outlets**

51 (1) ~~County~~ Community Health Clinic (~~including family planning clinics~~). Expires March 31
52 annually — \$75*. Delinquent renewal fee (postmarked after February 28) — \$25. (*Temporary
53 revenue surplus fee reduction pursuant to ORS 291.055(3)). Fee reduction shall be effective
54 retroactive to July 1, 2013.

55 (2) Drug Distribution Agent. Expires September 30 annually — \$400. Delinquent renewal fee
56 (postmarked after August 31) — \$100.

57 (3) Drug Room (including correctional facility). Expires March 31 annually — \$75*. Delinquent
58 renewal fee (postmarked after February 28) — \$75. (*Temporary revenue surplus fee reduction
59 pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

- 60 (4) Manufacturers (including Manufacturer Class I, Manufacturer Class II and Manufacturer
61 Class III). Expires September 30 annually — \$400. Delinquent renewal fee (postmarked after
62 August 31) — \$100.
- 63 (5) Medical Device, Equipment & Gas Class C. Expires January 31 annually — \$50. Delinquent
64 renewal fee (postmarked after December 31) — \$25.
- 65 (6) Nonprescription Class A. Expires January 31 annually — \$50. Delinquent renewal fee
66 (postmarked after December 31) — \$25.
- 67 (7) Nonprescription Class B. Expires January 31 annually — \$50. Delinquent renewal fee
68 (postmarked after December 31) — \$25.
- 69 (8) Nonprescription Class D. Expires January 31 annually — \$100. Delinquent renewal fee
70 (postmarked after December 31) — \$25.
- 71 (9) Prophylactic and/or Contraceptive Wholesaler and/or Manufacturer — \$50*. Expires
72 December 31 annually. (*Temporary revenue surplus fee reduction pursuant to ORS
73 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.
- 74 (10) Re-inspection fee — \$100. Applies to any re-inspection of a drug outlet occasioned to verify
75 corrections of violations found in an initial inspection.
- 76 (11) Retail or Institutional Drug Outlet. Expires March 31 annually — \$175*. Delinquent
77 renewal fee (postmarked after February 28) — \$75. (*Temporary revenue surplus fee reduction
78 pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.
- 79 (12) Wholesalers (including Wholesaler Class I, Wholesaler Class II and Wholesaler Class III).
80 Expires September 30 annually — \$400. Delinquent renewal fee (postmarked after August 31)
81 — \$100.
- 82 (13) Remote Dispensing Machine or Remote Distribution Facility. Expires March 31 annually —
83 \$100. Due by February 28 annually.
- 84 (14) Charitable Pharmacy. Expires March 31 annually — \$75. Delinquent renewal fee
85 (postmarked after February 28) — \$25.
- 86 (15) Home Dialysis. Expires March 31 annually — \$175*. Delinquent renewal fee (postmarked
87 after February 28) — \$75. (*Temporary revenue surplus fee reduction pursuant to ORS
88 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.
- 89 (16) Supervising Physician Dispensing Outlet. Expires March 31 annually — \$175*.
90 (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)). Delinquent renewal
91 fee (postmarked after February 28) — \$75.

92 Stat. Auth.: ORS 689.205 & 291.055
93 Stats. Implemented: ORS 689.135, 689.774 & 2689.305

94

95 **855-110-0010**

96 **Fees for Registration for Controlled Substances under ORS 475.095**

97 (1) Animal Euthanasia controlled substance registration fee — \$50 annually.

98 (2) Drug Distribution Agent controlled substance registration fee — \$50* annually. (*Temporary
99 revenue surplus fee reduction pursuant to ORS 291.055(3)).

100 (3) Drug Room (including correctional facility) controlled substance registration fee — \$50*
101 annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

102 (4) Manufacturer controlled substance registration fee — \$50* annually. (*Temporary revenue
103 surplus fee reduction pursuant to ORS 291.055(3)).

104 (5) Retail or Institutional Drug Outlet controlled substance registration fee — \$50* annually.
105 (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

106 (6) Schedule II Precursor registration fee — \$50* annually. (*Temporary revenue surplus fee
107 reduction pursuant to ORS 291.055(3)).

108 (7) Wholesaler controlled substance registration fee — \$50* annually. (*Temporary revenue
109 surplus fee reduction pursuant to ORS 291.055(3)).

110 (8) Remote ~~Dispensing~~ **Distribution** Facility controlled substance registration fee — \$50*
111 annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

112 Stat. Auth.: ORS 689.205 & 291.055
113 Stats. Implemented: ORS 689.135 & ~~2013 OL Ch. 503~~

May 5, 2016

Harvard Ave Drugs clarification of rule

The functions allowed by the Board for clerks or non-licensed pharmacy personnel are only addressed in 855-025-0040. This rule does not specifically address the ability of a clerk to receive a prescription refill request but has been allowed by Board policy in the past. Functions of a clerk have been defined by a basic principle that a clerk cannot perform a task that will influence the outcome of a prescription. This has developed a cascade of allowable functions with the clerk only being able to take a prescription refill request by number, a technician can take the request based on the drug name and only a pharmacist can take the request base on a medical condition or disease state. Based on requests by pharmacists and PICs we have developed the “Non-Licensed Personnel – Clerks” Functions and Restrictions page posted on the website. This page clarifies functions a clerk can or cannot perform. This list is was developed base on the previously mentioned principle.

A pharmacy has been allowed use clerks (non-licensed personnel) for limited functions. The Board has no licensing or disciplinary authority over a clerk and therefore any regulation violation involving a clerk could be directed to any or all of Board’s licensees the outlet, the supervising pharmacist and PIC. A rule to create a “pharmacy clerk” would probably need statutory authority. This new allowance for the clerks would seem to create an additional level of supervision and awareness by the supervising pharmacist and PIC adding in to the workload in an already busy environment.

Recommendation:

The recommendation would be to reaffirm the principle and current application that we have used for defining clerk functions. We would recommend that if they want the clerks to take refill request by name then have them licensed as pharmacy technicians with the Board.

855-025-0040**Certified Oregon Pharmacy Technician and Pharmacy Technician Tasks and Guidelines**

(1) Non-licensed pharmacy personnel may enter non-prescription information into a computer record system and may perform clerical duties such as filing prescriptions, delivery, housekeeping, and general record keeping, but the responsibility for the accuracy of the non-licensed pharmacy personnel’s work lies with the Pharmacist.



Oregon

John A. Kitzhaber, MD, Governor

July 1, 2013

Oregon Board of Pharmacy

800 NE Oregon Street, Suite 150

Portland, OR 97232

Phone: 971 / 673-0001

Fax: 971 / 673-0002

E-mail: pharmacy.board@state.or.us Web: www.pharmacy.state.or.us

Non-Licensed Personnel—Clerks

Functions and Restrictions

This document is intended to assist PICs in providing non-licensed pharmacy personnel—pharmacy clerks—with an understanding of the capabilities and limits of their duties. The table is not all inclusive of the “DOs and DON’Ts” and does not provide all the necessary training for a clerk. The PIC and clerk should each initial each area reviewed and maintain this document on file available for Board inspection.

Non-licensed pharmacy personnel CAN enter non-prescription information into a computer record system and may perform clerical duties such as filing prescriptions, delivery, housekeeping, and general record keeping, but the responsibility for the accuracy of the non-licensed pharmacy personnel’s work lies with the pharmacist.¹

Non-licensed pharmacy personnel CANNOT engage in the duties of a pharmacy technician, or any function that can impact the outcome of a prescription.^{1, 3} Persons used solely for clerical duties, such as recordkeeping, cashiering, bookkeeping and delivery of medications released by the pharmacist are not considered pharmacy technicians.²

Clerks (<u>CAN</u>):	Clerks (<u>CANNOT</u>):	PIC & Clerk Initials
CAN send and receive orders to replenish the pharmacy’s stock, unpack and price the drugs, and place the drugs on the pharmacy’s shelves	CANNOT affix any labels upon a prescription	/
CAN perform inventory counts of pharmacy stock	CANNOT count, reconstitute, pack, pour, or place in a container for dispensing, sale, distribution, or transfer possession of any drug, medicine, poison, or chemical	/
CAN pull outdates from pharmacy stock	CANNOT pull stock for filling of prescriptions	/
CAN inform the patient of a change in medication appearance/manufacturer, if properly trained	CANNOT counsel on any medications	/
CAN answer non-professional telephone inquiries (Price Quotes)	CANNOT initiate or answer any professional questions (via telephone or otherwise)	/

CAN work as a cashier, enter patient demographics and billing information in to computer, and perform housekeeping and bookkeeping duties	CANNOT record patient or medication information (allergies, medical conditions, etc.) in computer systems	JUNE 2016 / A7 /
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Updated 7/1/13

CAN accept refill request by Rx number only	CANNOT accept or initiate refill requests pursuant to drug name and/or therapeutic class	/
CAN accept drop off Rx and hand off to pharmacist, Intern, or pharmacy technician for processing	CANNOT communicate or accept by oral communication a new or transferred prescription of any nature; and CANNOT accept oral or electronic refill authorizations	/
CAN deliver medications released by pharmacist (Home Delivery)	CANNOT perform any task that requires the professional judgment of the pharmacist	/
CAN file prescriptions in pharmacy	CANNOT perform functions that directly impact the outcome of any specific patient's specific prescription	/

I have read and understand Oregon Administration Rule Chapter 855 Division 025 and Rule Chapter 855 Division 006 section 0005.

Pharmacy Clerk Signature Date

Pharmacist-in-charge Signature License # Date

¹ OAR 855-025-0040 (1). Portland (OR): OBOP; 2013 Jan. Oregon Board of Pharmacy Laws & Rules. 15 Jan. 2013 [20 Jun. 2013]. Available from: http://www.oregon.gov/pharmacy/Imports/Laws_RulesPDF/OBOP_Laws_Rules_FiledThrough1.13.pdf

² OAR 855-006-0005 (2). Portland (OR): OBOP; 2013 Jan. Oregon Board of Pharmacy Laws & Rules. 15 Jan. 2013 [20 Jun. 2013]. Available from: http://www.oregon.gov/pharmacy/Imports/Laws_RulesPDF/OBOP_Laws_Rules_FiledThrough1.13.pdf

³ Oregon Board of Pharmacy PIC Training. Portland (OR): OBOP; 2012 Jan., Slide 32 [20 Jun. 2013]. Available upon request from the Board.

Updated 7/1/13

Harvard Ave Drugs

JUNE 2016 / A7

1175 W. Harvard Ave.
Roseburg, OR 97471

Last of the Old Fashioned Drug Stores

541-672-1961 phone
541-672-9314 fax

RECEIVED

MAR 24 2016

OREGON BOARD OF PHARMACY

March 21, 2016

Dear Gary Miner and Oregon Board of Pharmacy Board Members,

I have recently encountered a conflict with Oregon rules vs. a worksheet describing duties allowed and not allowed by Pharmacy Clerks. I would like to request that the board addresses this issue with further clarification, and possibly a new designation of Pharmacy Clerk versus Clerk.

Our Pharmacy utilizes Pharmacy Clerks that are trained to work specifically in the pharmacy and do not work in the Gift portion of the store as Clerks. Our Pharmacy Clerks answer the phone, wait on customers and check in the order as well as put the drugs away correctly on the shelf. They are, therefore, well versed in the names (Brand and Generic) of the drugs, as our shelves are stocked by Brand Name, with the generic beside it.

We employ pharmacy clerks for the specific tasks listed above to reduce interruptions, errors and improve work flow so that our prescriptions are typed, filled and checked without error and as quickly as our customers need them. I have read through the Pharmacy Rules and Laws, and can't find where it says that the Pharmacy Clerks cannot take the phone calls from the patients requesting their refills by name. This is only addressed on the training sheet. Many times patients don't have the bottle beside them and/or they are in the car and the bottles aren't even with them. They do however, know their prescriptions and pills by name. There are far more errors in the elderly trying to read numbers and not being able to see the small print and therefore seeing 3's instead of 8, or 6 or 9, or even 0. Since the Pharmacy Clerks do not run the refills, having incorrect numbers may fill someone else's prescription, and/or requires additional work for the technicians to figure out what the intended prescription was. Our pharmacy clerks, of course, always defer to the technicians or pharmacist when there is a distinct problem with pronunciation or a patient is confused about the process, but keeping these down to a minimum is very important to the workflow in our pharmacy.

We are asking the Board to eliminate this line on the Pharmacy Clerk training form, creating two forms, if necessary, to differentiate between Pharmacy clerks and store clerks. To reduce errors in refilling the wrong medication or refilling for the wrong person, when the number is wrong; to reduce interruptions and therefore reduce errors by our technicians, and to better serve our customers by decreasing their hold time on the phone and getting them the correct medication, it is requested that our Pharmacy clerks be able to take refills by RX number and/or name of the drug.

Thank you for your consideration of this issue,

Jeannie Hooten, R.Ph.

Jeannie Hooten, RPh
Pharmacist in Charge
#7143

May 5, 2016

Exception and Waiver Request
Kaiser Permanente Mail Order Pharmacy

- Request – For a waiver from 855-041-1035(5) a sink with hot and cold water.
- The compounding functions have been moved to the Home Infusion pharmacy.
- This change has removed the direct need to a sink and there are other sinks available to the pharmacy if needed.
- Historically the Board has granted a waiver to pharmacies.
- Staff recommendation is to grant the waiver for the requirement of a sink in the pharmacy.

855-041-1035

Minimum Equipment Requirements (Both Retail and Institutional Drug Outlets)

The minimum equipment requirement to open and operate a retail drug outlet and institutional drug outlet in the state of Oregon shall consist of not less than the following:

(1) The most current issue of at least one pharmaceutical reference with current, properly filed supplements and updates appropriate to and based on the standards of practice for the setting.

(2) Current and properly filed Oregon Revised Statutes, Chapters 689, and 475; current and properly filed Oregon Administrative Rules, chapter 855; and a minimum of three years of the Board of Pharmacy quarterly newsletters maintained in house or other readily retrievable means.

(3) Official Poison and Exempt Narcotic Register if poisons and exempt narcotics are sold or distributed.

(4) Suitable refrigeration.

(5) A sink with running hot and cold water.

(6) Equipment and supplies appropriate to and based on the standards of practice for the setting as determined by the Pharmacy and Pharmacist-in-Charge.

(7) Failure to have and use equipment necessary to your practice setting constitutes unprofessional conduct for purposes of ORS 689.405(1)(a).

(8) If an outlet files original prescriptions electronically, then the outlet must have a computer and software capable of storing and accessing electronically filed original prescriptions. Exceptions to the above list may be approved by the Board of Pharmacy.

Stat. Auth.:ORS 689.205 & 689.508

Stats. Implemented: ORS 689.205 & 689.508

Hist.: 1PB 2-1979(Temp), f. & ef. 10-3-79; 1PB 2-1980, f. & ef. 4-3-80; 1PB 1-1981(Temp), f. & ef. 4-1-81; 1PB 2-1981, f. & ef. 8-20-81; 1PB 4-1986, f. & ef. 12-8-86; PB 8-1987, f. & ef. 9-30-87; PB 12-1989, f. & cert. ef. 8-11-89; PB 4-1991, f. & cert. ef. 9-19-91; PB 1-1992, f. & cert. ef. 1-31-92 (and corrected 2-7-92); PB 4-1992, f. & cert. ef. 8-25-92; PB 1-1994, f. & cert. ef. 2-2-94; BP

855-041-0040

Minimum Equipment Requirements (Both Retail and Institutional Drug Outlets)

The minimum equipment requirement to open and operate a retail drug outlet and institutional drug outlet in the state of Oregon shall consist of not less than the following:

- (1) The most current issue of at least one pharmaceutical reference with current, properly filed supplements and updates appropriate to and based on the standards of practice for the setting.
- (2) Current and properly filed Oregon Revised Statutes, Chapters 689, and 475; current and properly filed Oregon Administrative Rules, chapter 855; and a minimum of three years of the Board of Pharmacy quarterly newsletters maintained in house or other readily retrievable means.
- (3) Official Poison and Exempt Narcotic Register if poisons and exempt narcotics are sold or distributed.
- (4) Suitable refrigeration.
- (5) A sink with running hot and cold water.
- (6) Equipment and supplies appropriate to and based on the standards of practice for the setting as determined by the Pharmacy and Pharmacist-in-Charge.
- (7) Failure to have and use equipment necessary to your practice setting constitutes unprofessional conduct for purposes of ORS 689.405(1)(a).
- (8) If an outlet files original prescriptions electronically, then the outlet must have a computer and software capable of storing and accessing electronically filed original prescriptions. Exceptions to the above list may be approved by the Board of Pharmacy.

4/5/2016

* * *

Sandra Teeny

Kaiser Permanente Mail Order Pharmacy
5725 NE 138th Ave
Portland, OR 97230

Oregon Board of Pharmacy
800 NE Oregon St., Suite 150
Portland, OR 97232-2162

Dear Board of Pharmacy Members,

The Kaiser Permanente Mail Order Pharmacy has moved away from locally compounding pharmaceuticals. Instead, any compounding needs are filled by the KP Home Infusion Pharmacy.

Because we are no longer doing any compounding, we would to request a waiver to eliminate the sink from the production floor. We have 4 sinks available for staff personal use in our lunch room and restrooms located on site.

Removal of the production floor sink will allow us to realign our shelving and provide additional prescription storage which will improve our production floor work flow.

I would be happy to answer any questions.

Thank you for your prompt consideration of this waiver request.

Respectfully,



Sandra Teeny
Pharmacy Director
Kaiser Permanente Mail Order Pharmacy

May 2, 2016

Walgreens Waiver request
OAR 855-041-1045 Return Drugs and Devices

The collection boxes will be placed in the building which has a pharmacy department. The drugs are not physically accepted and returned to the pharmacy department. The key access to the collection containers will be with the pharmacy and the container will be locked when the pharmacy is closed. The program will meet the DEA requirements. Based on the current rule and the location of the collection containers outside the secured parameter of pharmacy, our recommendation is that no waiver is necessary.

855-041-1045

Returned Drugs and Devices

(1) Pharmacists, pharmacies, pharmacy technicians, and certified pharmacy technicians may only accept the return of controlled substances upon receiving a waiver from the Board of Pharmacy.

(2) Pharmacists, pharmacies, pharmacy technicians, and certified pharmacy technicians may accept the return of drugs or devices as defined by ORS 689.005 once the drugs or devices have been removed from the pharmacy only if;

(a) The drugs or devices are accepted for destruction or disposal and;

(b) The drugs or devices were dispensed in error, were defective, adulterated, misbranded, dispensed beyond their expiration date, were unable to be delivered to the patient, or are subject of a drug or device recall; or

(c) After consultation, a pharmacist determines that, in the pharmacist's professional judgment, harm could result to the public or a patient if the drugs or devices were not accepted for return.

(3) Notwithstanding section 2 of this rule, drugs or devices previously dispensed or distributed may be returned and redispensed or redistributed provided all the following conditions are met:

(a) The drug is in an unopened, tamper-evident unit;

(b) The drugs or devices have remained at all times in control of a person trained and knowledgeable in the storage and administration of drugs in long term care facilities or supervised living groups using the services of a consultant pharmacist;

(c) The drug or device has not been adulterated or misbranded and has been stored under conditions meeting United States Pharmacopeia standards.

(4) Upon written request, the Board may waive any of the requirements of this rule if a waiver will further public health or safety or the health and safety of a patient. A waiver granted under this section shall only be effective when it is issued by the Board in writing.

Stat. Auth.: ORS 475 & 689

Stats. Implemented:

Hist.: 1PB 2-1979(Temp), f. & ef. 10-3-79; 1PB 2-1980, f. & ef. 4-3-80; 1PB 1-1981(Temp), f. & ef. 4-1-81; 1PB 2-1981, f. & ef. 8-20-81; PB 5-1989, f. & cert. ef. 1-30-89; PB 8-1990, f. & cert. ef. 12-5-90; BP 2-2006, f. & cert. ef. 6-9-06); Renumbered from 855-041-0080, BP 7-2012, f. & cert. ef. 12-17-12



Pharmacy Law - Operations
& Services
104 Wilmot Road, MS #1446
Deerfield, IL 60015

April 20, 2016

Oregon Board of Pharmacy
800 NE Oregon Street, Suite 150
Portland, OR 97232

Re: Waiver Request

· OAR 855-041-1045 Returned Drugs and Devices

Walgreens is seeking a waiver to place a safe medication collection kiosk at select Oregon locations for collecting unused or unwanted medications, both controlled and non-controlled drugs. We ask the Board to review the waiver request at the June 2016 Board meeting.

Walgreens is deeply committed to the safe disposal of unwanted, unused, or expired medications. This safe disposal method will help prevent unwanted medications from ending up in landfills affecting the environment or in the possession of unintended users.

The Walgreen locations would be registered with the DEA as a licensed collector for controlled drugs. These locations would have a kiosk placed outside the pharmacy area. The take back kiosks would be secure as they are bolted in place. The kiosks only allow placement of discarded medications by the public directly into the kiosk. The design of the kiosk would prevent removal of medication by unauthorized persons.

Kiosk and Program Features

- Each location will be a DEA licensed authorized collector.
- All procedures will be in full compliance with CFR Parts 1300, 1301, 1304
- The kiosk will be installed in proximity and view of the pharmacy.
- Collection will only occur during pharmacy operating hours and locked when the pharmacy is closed.
- The pharmacist would control the keys to the kiosks.
- Pharmacy staff will not have any contact with the contents of the discarded drugs placed in the kiosk. Collected items in the liner will not enter the pharmacy.
- Each kiosk has a liner that is serialized.
- Walgreens would contract with a DEA licensed waste collector, Stericycle.
- Stericycle would remove and seal the liner under the supervision of two pharmacy personnel.

EVERY DAY WE HELP PEOPLE GET, STAY AND LIVE WELL.

- The serial number of the liner would be recorded in a log that will be kept in the pharmacy. The log will record the day-date-time and serial number of the removed liner and the new liner placed in the kiosk.
- The liner will be packed by Stericycle for shipment to their licensed facility for destruction in compliance with CFR Parts 1300, 1301, 1304.
- The packed liner will be securely stored until pick-up for transporting to the licensed destruction site.
- Certain items will be excluded from placement in the kiosk such as illegal drugs, lotions, liquids, inhalers, needles, aerosol cans, thermometers, and hydrogen peroxide.

The proposed locations for kiosk placement are:

Walgreens #03838
1950 N.E. Burnside Road
Gresham, OR 97030

Walgreens #03890
940 S.E. 39th Ave.
Portland, OR 97214

Walgreens #06370
14600 S.W. Murray Scholls Dr.
Beaverton, OR 97007

Walgreens #07373
111 Union Ave.
Grants Pass, OR 97527

Walgreens #07971
1450 S. Highway 97
Redmond, OR 97756

Walgreens #09650
699 Wallace Rd., N.W.
Salem, OR 97304

Walgreens will ensure the drug takeback program will operate in full compliance of all applicable state and federal laws.

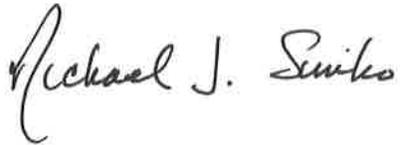
We respectfully ask the Board to grant Walgreens the waiver to collect both controlled and non-controlled drugs in these kiosks.

Please contact me if you have any questions or need any further information.

Walgreens will be present at the June meeting to address any concerns or answer questions the Board may have. We appreciate the Board's consideration and guidance in our request for this waiver.

Thank you.

Sincerely,

A handwritten signature in cursive script that reads "Michael J. Simko". The signature is written in black ink and is positioned below the word "Sincerely,".

Michael J. Simko, Senior Counsel
Walgreens – Pharmacy Law
104 Wilmot Road
Deerfield, IL 60015
(847) 315-4344
michael.simko@walgreens.com

Oregon Board of Pharmacy

Schedule of Administrative Fees

In accordance with OAR 855-110-0015(4), the Board of Pharmacy establishes the following fees **effective 03/01/2010**: Upon request fees may be waived as specified in OAR 855-110-0015(7).

1. General:

Provide an estimate of costs for the services requested:	No charge
The first 30 minutes of staff time to provide the information requested:	No charge
After 30 minutes, staff time will be charged at:	
(i) Administrative staff time:	\$28 per hour in increments of 15 minutes;
(ii) Management or pharmacist time:	\$48 per hour in increments of 15 minutes;
(iii) IT Consultant time	\$100 per hour or part thereof;
(iv) Department of Justice (DOJ) attorney fees:	Actual costs as billed to the agency by DOJ.

2. Duplication and delivery of records:

The first 10 pages:	No charge.
Each page printed or copied after the first 10:	\$0.25 per page.
Records provided on digital media such as CD, or any other media:	\$5 / CD Other media at actual cost.
Facsimile within area code 503:	\$.30 / page. Maximum of 20 pages
Facsimile outside area code 503 (within USA):	\$.50 / page. Maximum of 20 pages
Facsimile to international numbers:	Actual cost.
Electronic mail message including attachments:	No charge, however staff time may apply.
Mail or other delivery service:	Actual cost.
Electronic lists of licensees and registrants:	\$80 per category
Electronic lists of <u>individual</u> licensees BASIC list (name, mailing address, issue/expiration date)	\$25 per category, this does not apply to outlets
Manual license verification:	\$10 per license number (including lapsed and inactive numbers).
Certified copies (two per page)	No charge for first page \$5 per additional page

3. Publications:

Copies of Laws and Rules (available free through the Board web site):	\$25 per CD or paper set for delivery within the USA; \$25 plus actual delivery costs for delivery outside the USA;
Board quarterly newsletter (available free through the Board web site):	Paper copies - \$5.00 per edition.
Duplicate wall certificates:	\$20 each;
Re-mailing of renewal forms or other documents when the applicant has failed to notify the Board of a change of address:	\$25 per set;
Duplicate sets of renewal forms:	\$5

855-110-0015

Administrative Fees

- (1) The Board of Pharmacy may charge a fee reasonably calculated to reimburse the agency for costs of providing and conveying copies of public records, and other administrative services.
- (2) All fees and charges must be paid before public records will be available for inspection or copies provided.
- (3) Costs include but are not limited to:
 - (a) The services and supplies used in making the records available;
 - (b) The time spent locating the requested records, reviewing the records, and redacting or separating material exempt from disclosure;
 - (c) Supervising a person's inspection of original documents;
 - (d) Copying records;
 - (e) Certified copies of records and licenses;
 - (f) Summarizing, compiling or organizing the public records to meet the person's request;
 - (g) Searching for and reviewing records even if the records subsequently are determined to be exempt from disclosure;
 - (h) Postal and freight charges for shipping the copies of the public records sent first class or bulk rate based on weight;
 - (i) Indirect costs or third party charges associated with copying and preparing the public records;
 - (j) Costs associated with electronic retrieval of records;
 - (k) Actual costs charged by the Attorney General's office for attorney's time spent in reviewing and redacting material from the records, and in separating material into exempt and nonexempt records. A fee may not be charged for the cost of time spent by an attorney in determining the application of the provisions of ORS 192.410 to 192.505;
 - (L) Staff time for performing the work;
 - (m) The cost of publications will be based on the actual costs of development, printing and distribution as determined by the Board;

(4) The Board shall establish and publish a list of fees used to charge requestors for the costs of preparing and making available the following and shall review the schedule at least once a biennium and any time an increase is proposed, to assure that the fees reflect current Board costs:

(a) Photocopies;

(b) Facsimile copies. The Board may limit the transmission to twenty pages;

(c) Electronic copies, CDs, DVDs, and other electronically generated materials including lists electronically mailed from the Board database. The Board shall determine what electronic media for reproduction of computer records may be used and whether the electronic media is to be provided by the Board or the requestor;

(d) Manual license verification;

(e) Publications including but not limited to:

(A) Copies of Laws and Rules;

(B) The newsletter.

(f) Licensee duplicate wall certificates;

(g) Duplicate renewal forms;

(h) Re-mailing of returned mail when a licensee or registrant has failed to notify the Board of a change of address.

(5) No additional fee may be charged for providing records or documents in an alternative format when required by the Americans with Disabilities Act.

(6) The Board shall notify requestors of the estimated fees for making the public records available for inspection or for providing copies to the requestor. If the estimated fees exceed \$25, the Board shall provide written notice and may not act further to respond to the request until the requestor notifies the Board, in writing, to proceed with making the records available.

(7) The Board or its designee may reduce or waive any of the above administrative fees when a determination is made that the waiver or reduction of fees is in the public interest. Factors that may be taken into account in making such a determination include, but are not limited to:

(a) The overall costs incurred by the Board are negligible; or

- (b) Providing the requested records or documents is within the normal scope of the Board's activity; or
- (c) Requiring payment would cause extreme or undue financial hardship upon the requestor; or
- (d) The request is a discovery request made as part of pending administrative, judicial or arbitration proceedings.

(8) If the Board denies an application for waiver or reduction of fees, the requestor may petition the Attorney General under the provisions of ORS 192.440(5) and 192.450.

(9) The Board establishes the following fees for inspection of out-of-state registrants. When an applicant for registration or renewal of registration requests an inspection, the Board shall execute an agreement with the applicant that must specify that the applicant shall pay:

- (a) The travel expenses of each Board staff person (inspector) by coach-class commercial air or by rental car;

- (b) The hotel costs of the inspector, subject to the applicant arranging accommodation in a hotel that is, whenever possible, on the federal per-diem list;

- (c) Rental car costs for the inspector unless the applicant provides adequate ground transportation;

- (d) The per-diem expenses of the inspector;

- (e) A fee for the Board's time and expenses calculated as:

- (A) The daily compensation of the inspector, plus the costs of any fringe benefits charged to the Board, multiplied by: one plus the number of days or partial days the inspector is away from their normal workplace; plus

- (B) An administrative fee of \$750.

(10) In addition to the reinspection fee specified in OAR 855-110-0007, the Board establishes the following administrative fees for a re-inspection of any Oregon drug outlet that is necessary to verify corrections of violations found on an initial inspection:

- (a) The travel, hotel and per-diem costs for the inspector; and

- (b) The hourly compensation of the inspector plus the cost of any fringe benefits charged to the Board multiplied by the number of hours necessary for the reinspection.

Stat. Auth.: ORS 689.205

Stats. Implemented: ORS 192.430 & 192.440

Hist.: PB 10-1990, f. & cert. ef. 12-5-90; PB 1-1996, f. & cert. ef. 4-5-96; BP 2-2010, f. 2-12-10, cert. ef. 3-1-10

**ACPE ACCREDITED PROFESSIONAL PROGRAMS OF COLLEGES AND SCHOOLS OF PHARMACY
LIST PULLED 05/11/16.**

You may press Ctrl and click on the link below or copy and paste this link into your web browser to sort this list by various statuses i.e. Accredited, Accredited with Probation.

https://www.acpe-accredit.org/shared_info/programsSecure.asp

**Preaccredited and Accredited Professional Programs of Colleges
and Schools of Pharmacy**

The Accreditation History link below each program includes Review Period, Review Type, Board Action, and Status. For clarification, additional explanation of the following terms is provided via the links below:

- [Review Type](#)
- [Board Action](#)
- [Status](#)
- [Programs Up For Review](#)

ACPE requires the programs it accredits to meet the expectations of all 30 standards of ACPE's accreditation standards. Any standard the board finds to be partially compliant or non-compliant can be seen by clicking on the *Detailed PharmD Accreditation History* link for each College or School. The program has two years to bring the standard into compliance as per US Department of Regulation if no standard is noted, the program is in compliance with all 30 ACPE Accreditation Standards.

Sort by State/Region ▼

Sort by Status ▼

ACCREDITED

**Albany College of Pharmacy and Health Sciences
Accredited**

106 New Scotland Avenue
Albany, NY 12208
Robert DiCenzo, PharmD, BCPS, FCCP
Interim Dean and Professor
Tel: 518-694-7200
FAX: 518-694-7063
E-Mail: Rob.DiCenzo@acphs.edu
Web Site: www.acphs.edu
[Detailed PharmD Accreditation History](#)
[Detailed BS Accreditation History](#)

[Branch Campuses](#)
Colchester (Burlington) VT

**Appalachian College of Pharmacy
Accredited**

1060 Dragon Road
Oakwood, VA 24631
Susan L. Mayhew, PharmD, BCNSP, FASHP
Dean
Tel: 276-498-4190
FAX: 276-498-4193
E-Mail: slmayhew@acpharm.org
Web Site: www.acpharm.org/
[Detailed PharmD Accreditation History](#)

**Auburn University Harrison School of Pharmacy
Accredited**

2316 Walker Building
Auburn University, AL 36849-5501
R. Lee Evans, Jr., PharmD

Dean & Professor
Tel: 334-844-8348
FAX: 334-844-8353
E-Mail: evansrl@auburn.edu
Web Site: pharmacy.auburn.edu/
[Detailed PharmD Accreditation History](#)
[Detailed BS Accreditation History](#)

Branch Campuses
Mobile, AL

**Belmont University College of Pharmacy
Accredited**

1900 Belmont Blvd.
Nashville, TN 37212
Philip E. Johnston, PharmD
Dean
Tel: 615-460-6000
FAX: 615 460 6741
E-Mail: phil.johnston@belmont.edu
Web Site: www.belmont.edu/pharmacy/
[Detailed PharmD Accreditation History](#)

**Butler University College of Pharmacy and Health Sciences
Accredited**

4600 Sunset Avenue
Indianapolis , IN 46208
Mary Graham, PharmD
Dean
Tel: 317-940-9735
FAX: 317-940-6172
E-Mail: mandritz@butler.edu
Web Site: www.butler.edu/cophs/
[Detailed PharmD Accreditation History](#)
[Detailed BS Accreditation History](#)

**California Northstate University College of Pharmacy
Accredited**

9700 W. Taron Drive
Elk Grove, CA 95757
Hieu Tran, PharmD
Dean
Tel: 916-631-8108
FAX: 916-631-8127
E-Mail: hieu.tran@cnsu.edu
Web Site: pharmacy.cnsu.edu
[Detailed PharmD Accreditation History](#)

**Campbell University College of Pharmacy and Health Sciences
Accredited**

PO Box 1090
205 Day Dorm Road Room 101
Buies Creek , NC 27506
Michael L. Adams, PharmD, PhD
Dean and Acting Vice President for Health Programs
Tel: 910-893-1686
FAX: 910-893-1943
E-Mail: adamsm@campbell.edu
Web Site: www.campbell.edu/pharmacy/
[Detailed PharmD Accreditation History](#)
[Detailed BS Accreditation History](#)

**Chicago State University College of Pharmacy
Accredited**

9501 S. King Drive
206 Douglas Hall
Chicago, IL 60628-1598
Carmita Coleman, PharmD
Interim Dean
Tel: 773-821-2500
FAX: 773-821-2595
E-Mail: ccolem30@csu.edu

Web Site: [www.csu.edu/collegeofpharmacy/
Detailed PharmD Accreditation History](http://www.csu.edu/collegeofpharmacy/Detailed%20PharmD%20Accreditation%20History)

**Concordia University School of Pharmacy
Accredited**

12800 N. Lake Shore Drive
Mequon, WI 53097
Dean L. Arneson, PhD, PharmD
Dean
Tel: 262-243-5700
FAX: 262-243-2754
E-Mail: dean.arneson@cuw.edu
Web Site: www.cuw.edu
[Detailed PharmD Accreditation History](#)

**Creighton University Medical Center School of Pharmacy and Health Professions
Accredited**

2500 California Plaza
Omaha, NE 68178
J. Chris Bradberry, PharmD
Dean
Tel: 402-280-2950
FAX: 402-280-5738
E-Mail: jbradberry@creighton.edu
Web Site: spahp2.creighton.edu/
[Detailed PharmD Accreditation History](#)
[Detailed BS Accreditation History](#)

**Drake University College of Pharmacy and Health Sciences
Accredited**

2507 University Avenue
Cline Hall Suite 106
Des Moines, IA 50311
Renaee J. Chesnut, EdD, MBA, RPh
Dean
Tel: 515-271-1814
FAX: 515-271-4171
E-Mail: renae.chesnut@drake.edu
Web Site: <http://www.drake.edu/cphs/>
[Detailed PharmD Accreditation History](#)
[Detailed BS Accreditation History](#)

**Duquesne University Mylan School of Pharmacy
Accredited**

306 Bayer Learning Center
Pittsburgh, PA 15282-1504
J. Douglas Bricker, PhD
Dean
Tel: 412-396-6377
FAX: 412-396-1810
E-Mail: bricker@duq.edu
Web Site: www.pharmacy.duq.edu
[Detailed PharmD Accreditation History](#)
[Detailed BS Accreditation History](#)

**D'Youville College School of Pharmacy
Accredited**

320 Porter Ave.
Buffalo, NY 14201
Canio Marasco, PhD
Dean
Tel: 716-829-8000
FAX: 716-829-7760
E-Mail: marascoc@dyc.edu
Web Site: www.dyc.edu/academics/pharmacy/
[Detailed PharmD Accreditation History](#)

**East Tennessee State University Bill Gatton College of Pharmacy
Accredited**

P.O. Box 70414

807 University Parkway
Johnson City, TN 37614
Larry D. Calhoun, PharmD
Dean
Tel: 423-439-6300
E-Mail: calhoun@etsu.edu
Web Site: www.etsupharmacy.com
[Detailed PharmD Accreditation History](#)

Ferris State University College of Pharmacy

Accredited
220 Ferris Drive
PHR 105
Big Rapids, MI 49307
Stephen W. Durst, BS, PharmD
Dean
Tel: 231-591-3780
FAX: 231-591-3829
E-Mail: Dursts@ferris.edu
Web Site: www.ferris.edu/colleges/pharmacy/
[Detailed PharmD Accreditation History](#)
[Detailed BS Accreditation History](#)

Branch Campuses

Grand Rapids, MI

Florida Agricultural & Mechanical University College of Pharmacy and Pharmaceutical Sciences

Accredited
1415 S. Martin Luther King, Jr. Blvd.
New Pharmacy Building, Rm 333
Tallahassee, FL 32307
Michael Thompson, PharmD
Dean
Tel: 850-599-3301
FAX: 850-599-3347
E-Mail: michael.thompson@fam.edu
Web Site: www.fam.edu
[Detailed PharmD Accreditation History](#)
[Detailed BS Accreditation History](#)

Branch Campuses

Crestview, FL

Hampton University School of Pharmacy

Accredited
Hampton, VA 23668
Wayne T. Harris, PhD
Dean
Tel: 757-727-5071
FAX: 757-727-5840
E-Mail: wayne.harris@hamptonu.edu
Web Site: pharm.hamptonu.edu
[Detailed PharmD Accreditation History](#)

Harding University College of Pharmacy

Accredited
915 E. Market Avenue
Box 12230
Searcy, AR 72149
Julie A. Hixson-Wallace, PharmD, BCPS
Dean and Professor
Tel: 501-279-5205
FAX: 501-279-5525
E-Mail: jahixson@harding.edu
Web Site: www.harding.edu/Pharmacy/
[Detailed PharmD Accreditation History](#)

Howard University College of Pharmacy

Accredited
2300 4th Street NW
Washington, DC 20059

Daphne Bernard, PharmD
Interim Dean
Tel: 202-806-5431
FAX: 202-234-1375
E-Mail: dbernard@howard.edu
Web Site: www.howard.edu
[Detailed PharmD Accreditation History](#)
[Detailed BS Accreditation History](#)

**Husson University School of Pharmacy
Accredited**

One College Circle
Bangor, ME 04401-2999
Rodney A. Larson, PhD, RPh
Founding Dean
Tel: 207-941-7163
E-Mail: larsonr@husson.edu
Web Site: www.husson.edu
[Detailed PharmD Accreditation History](#)

**Idaho State University College of Pharmacy
Accredited**

Stop 8288
921 South 8th Ave
Pocatello, ID 83209
Paul Cady, PhD
Dean
Tel: 208-282-2175
FAX: 208-282-4482
E-Mail: cady@pharmacy.isu.edu
Web Site: pharmacy.isu.edu/live/
[Detailed PharmD Accreditation History](#)
[Detailed BS Accreditation History](#)

Branch Campuses
Boise, ID

**Lake Erie College of Osteopathic Medicine School of Pharmacy
Accredited**

1858 West Grandview Blvd.
Erie, PA 16509
Hershey S Bell, MD, MS (Med Ed)
Dean and Vice President of Academic Affairs
Tel: 814-866-8409
FAX: 814-866-8450
E-Mail: hbelle@lecom.edu
Web Site: lecom.edu/school-pharmacy.php
[Detailed PharmD Accreditation History](#)

Branch Campuses
Bradenton, FL

**Lebanese American University School of Pharmacy
Accredited**

P.O. Box 36
Byblos, Lebanon XX
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Dean and Professor, Pharmacy Practice
Tel: 961-9-547-254
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Web Site: lau.edu.lb/academics/schools/pharmacy/
[Detailed PharmD Accreditation History](#)

**Lipscomb University College of Pharmacy and Health Sciences
Accredited**

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[Detailed PharmD Accreditation History](#)

Loma Linda University School of Pharmacy

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[Detailed PharmD Accreditation History](#)

Long Island University Arnold and Marie Schwartz College of Pharmacy and Health Sciences

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[Detailed PharmD Accreditation History](#)
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MCPHS University School of Pharmacy - Worcester

Accredited

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Branch Campuses

Manchester, NH

MCPHS University School of Pharmacy - Boston

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[Detailed PharmD Accreditation History](#)
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Mercer University College of Pharmacy

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[Detailed PharmD Accreditation History](#)

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**Midwestern University College of Pharmacy-Glendale
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[Detailed PharmD Accreditation History](#)

**Midwestern University Chicago College of Pharmacy
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[Detailed PharmD Accreditation History](#)
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**North Dakota State University College of Health Professions School of Pharmacy
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[Detailed PharmD Accreditation History](#)
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**Northeast Ohio Medical University College of Pharmacy
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[Detailed PharmD Accreditation History](#)

**Northeastern University Bouvé College of Health Sciences School of Pharmacy
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[Detailed PharmD Accreditation History](#)
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**Notre Dame of Maryland University School of Pharmacy
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**Nova Southeastern University College of Pharmacy
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[Detailed PharmD Accreditation History](#)
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Branch Campuses
Palm Beach Gardens, FL
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[Detailed PharmD Accreditation History](#)
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[Detailed PharmD Accreditation History](#)
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**Oregon State University College of Pharmacy
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[Detailed PharmD Accreditation History](#)
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Branch Campuses
Portland, OR

**Pacific University School of Pharmacy
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[Detailed PharmD Accreditation History](#)

**Palm Beach Atlantic University Lloyd L. Gregory School of Pharmacy
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**Philadelphia College of Osteopathic Medicine School of Pharmacy
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**Presbyterian College School of Pharmacy
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**Purdue University College of Pharmacy
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[Detailed PharmD Accreditation History](#)
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**Regis University School of Pharmacy
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Roseman University of Health Sciences College of Pharmacy

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Branch Campuses

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Branch Campuses
Ashburn, VA

**South Carolina College of Pharmacy
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**South Dakota State University College of Pharmacy
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[Detailed PharmD Accreditation History](#)
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Branch Campuses
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Branch Campuses
Columbia, SC

**Southern Illinois University Edwardsville School of Pharmacy
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**Southwestern Oklahoma State University College of Pharmacy
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[Detailed PharmD Accreditation History](#)
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**St. John Fisher College Wegmans School of Pharmacy
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[Detailed PharmD Accreditation History](#)
[Detailed BS Accreditation History](#)

**St. Louis College of Pharmacy
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[Detailed PharmD Accreditation History](#)
[Detailed BS Accreditation History](#)

**Sullivan University College of Pharmacy
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[Detailed PharmD Accreditation History](#)

**Temple University School of Pharmacy
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[Detailed PharmD Accreditation History](#)
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**Texas A & M University Health Science Center Irma Lerma Rangel College of
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[Detailed PharmD Accreditation History](#)

Branch Campuses

College Station, TX

**Texas Southern University College of Pharmacy and Health Sciences
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[Detailed PharmD Accreditation History](#)
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**Texas Tech University Health Sciences Center School of Pharmacy
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[Detailed PharmD Accreditation History](#)

Branch Campuses

Dallas, TX
Lubbock, TX
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**Thomas Jefferson University Jefferson School of Pharmacy
Accredited**

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[Detailed PharmD Accreditation History](#)

**Touro New York College of Pharmacy
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[Detailed PharmD Accreditation History](#)

**Touro University - California College of Pharmacy
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[Detailed PharmD Accreditation History](#)

**Union University School of Pharmacy
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[Detailed PharmD Accreditation History](#)

**University at Buffalo The State University of New York School of Pharmacy &
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[Detailed PharmD Accreditation History](#)
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**University of Arizona College of Pharmacy
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Branch Campuses
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[Detailed PharmD Accreditation History](#)
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**University of Findlay College of Pharmacy
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Branch Campuses

St. Petersburg, FL
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Branch Campuses

Augusta, GA
Albany, GA

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**University of Hawaii at Hilo Daniel K. Inouye College of Pharmacy
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Branch Campuses

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NOTE: program standard info starts on page 27

Standards 2016 Crosswalk to Standards 2007

Basic content of each of the 30 standards in Standards 2007 can be found in Standards 2016. While there is not a direct match of the text or perhaps the entire scope of each standard in Standards 2007 to be found in a comparable standard in Standards 2016, the table below provides a general crosswalk between the 2007 and the 2016 Standards.

Standards 2016	Standards 2007
Standard 1: Foundational Knowledge	Standard 12: Professional Competencies & Outcome Expectations Standard 13: Curricular Core-Knowledge, Skills, Attitudes, & Values Standard 14: Curricular Core-Pharmacy Practice Experiences
Standard 2: Essential of Practice and Care	
Standard 3: Approach to Practice and Care	
Standard 4: Personal and Professional Development	
Standard 5: Eligibility and Reporting Requirements	Standard 4: Institutional Accreditation
Standard 6: College or School Vision, Mission, & Goals	Standard 1: College or School Mission & Goals
Standard 7: Strategic Plan	Standard 2: Strategic Plan
Standard 8: Organization and Governance	Standard 7: College or School Organization & Governance Standard 8: Qualifications & Responsibilities of the Dean
Standard 9: Organizational Culture	Standard 5: College or School and University Relationship Standard 6: College or School and Other Administrative Relationships Standard 23: Professional Behavior & Harmonious Relationships
Standard 10: Curriculum Design, Deliver and Oversight	Standard 9: The Goal of the Curriculum Standard 10: Curricular Development, Delivery, and Improvement Standard 11: Teaching and Learning Methods
Standard 11: Interprofessional Education (IPE)	Guidelines 1.6. 3.2, 6.1, 6.2, 8.2, 14.5, 27.1, 30, 2; Standards 9, 12
Standard 12: Pre-Advanced Pharmacy Practice Experience (Pre-APPE) Curriculum	Standard 13: Curricular Core-Knowledge, Skills, Attitudes, & Values Standard 14: Curricular Core-Pharmacy Practice Experiences
Standard 13: Advanced Pharmacy Practice Experience (APPE) Curriculum	Standard 14: Curricular Core-Pharmacy Practice Experiences
Standard 14: Student Services	Standard 16: Organization of Student Services
Standard 15: Academic Environment	Standard 20: Student Complaints Policy Standard 21: Program Information Standard 22: Student Representation & Perspectives
Standard 16: Admissions	Standard 17: Admission Criteria, Policies, & Procedures Standard 18: Transfer of Credits/Waiver of Requisites
Standard 17: Progression	Standard 19: Progression of Students
Standard 18: Faculty and Staff – Quantitative Factors	Standard 24: Faculty and Staff – Quantitative Factors

Standards 2016	Standards 2007
Standard 19: Faculty and Staff – Qualitative Factors	Standard 25: Faculty and Staff – Qualitative Factors Standard 26: Faculty and Staff Continuing Profession Development
Standard 20: Preceptors	Standard 24: Faculty and Staff – Quantitative Factors Standard 25: Faculty and Staff – Qualitative Factors Standard 26: Faculty and Staff Continuing Profession Development
Standard 21: Physical Facilities and Educational Resources	Standard 27: Physical Facilities
Standard 22: Practice Facilities	Standard 28: Practice Facilities
Standard 23: Financial Resources	Standard 30: Financial Resources
Standard 24: Assessment Elements/Educational Outcomes	Standard 15: Assessment/Evaluation of Student Learning/Curricular Effective.
Standard 25: Assessment Elements/Structure & Process	Standard 3: Evaluation of Achievement of Mission & Goals

ACCREDITATION COUNCIL FOR PHARMACY EDUCATION



**ACCREDITATION STANDARDS AND KEY ELEMENTS FOR THE
PROFESSIONAL PROGRAM IN PHARMACY LEADING TO
THE DOCTOR OF PHARMACY DEGREE**

(“STANDARDS 2016”)

APPROVED January 25, 2015

RELEASED February 2, 2015

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Required Elements of the Didactic Doctor of Pharmacy Curriculum

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**ACCREDITATION COUNCIL FOR
PHARMACY EDUCATION****STANDARDS 2016*****PREAMBLE*****Accreditation Council for Pharmacy Education (ACPE)**

The Accreditation Council for Pharmacy Education (ACPE) is the national agency for the accreditation of professional degree programs in pharmacy and providers of continuing pharmacy education. ACPE (until 2003 known as the American Council on Pharmaceutical Education) was established in 1932 for the accreditation of professional degree programs in pharmacy, and in 1975 its scope was broadened to include accreditation of providers of continuing pharmacy education (www.acpe-accredit.org). ACPE expanded its activities to include evaluation and certification of professional degree programs internationally in 2011 and entered into a collaboration with the American Society of Health-System Pharmacists (ASHP) to accredit pharmacy technician education and training programs beginning in 2014. The mission of ACPE is to assure and advance quality in pharmacy education. ACPE is an autonomous and independent agency whose Board of Directors is appointed by the American Association of Colleges of Pharmacy (AACCP), the American Pharmacists Association (APhA), the National Association of Boards of Pharmacy (NABP) (three appointments each), and the American Council on Education (ACE) (one appointment). Since the inception of its accreditation agency recognition program in 1952, the U.S. Department of Education (USDE) has continuously recognized ACPE. ACPE also gained recognition by the Council for Higher Education Accreditation (CHEA) in April 2004. State boards of pharmacy require that licensure applicants from the United States have graduated from an accredited pharmacy degree program to be eligible to sit for the North American Pharmacist Licensure Examination™ (NAPLEX®).

Importance of Standards

To achieve and maintain ACPE accreditation, professional Doctor of Pharmacy (PharmD) degree programs (hereafter described as 'programs') must meet the standards contained in this document. ACPE standards are minimum requirements, and it is expected that programs will exceed these required standards through initiatives designed to ensure continuous quality improvement. These standards describe the various elements needed for quality-assured professional education and are based on evidence and experience. They articulate expectations that ACPE (as well as pharmacy practice and the pharmacy academy) has of academic institutions offering the PharmD degree. ACPE standards also reflect the expectations that the U.S. Department of Education and state boards of pharmacy have of the colleges and schools, and of ACPE, regarding the quality of professional degree programs.

These standards have been developed with input from a broad range of constituents interested in and affected by pharmacy education. They focus on the educational outcomes required of PharmD programs and the assessment of those outcomes. They also address the structural and process-related elements within pharmacy education necessary to implement evidence-based outcome measures that document achievement of the standards. In addition, these standards describe areas where programs can experiment and innovate within the didactic and experiential components of their curricula to meet the required Educational Outcomes (Standards 1–4). Establishing a commitment to continuing professional development (CPD) by

students and graduates is also addressed, as are contemporary educational concepts such as student readiness to:

- Enter advanced pharmacy practice experiences (APPE-ready)
- Provide direct patient care in a variety of healthcare settings (Practice-ready)
- Contribute as a member of an interprofessional collaborative patient care team (Team-ready)

Revision of Standards: Background

All accrediting bodies, including ACPE, periodically review and revise their standards. A number of environmental factors prompted ACPE to conduct a careful reassessment of the standards. These factors included:

- The experience gained by ACPE in its accreditation reviews since the adoption of the Doctor of Pharmacy standards in 2007
- Feedback from ACPE stakeholders regarding quality improvement of the standards
- The reports of the Institute of Medicine (IOM) (www.iom.edu) noting needed changes in our healthcare system to improve medication safety and patient outcomes, including the five competencies that all healthcare professionals should attain during their education:
 - Provide patient-centered care
 - Work in interprofessional teams
 - Employ evidence-based practice
 - Apply quality improvement
 - Utilize informatics
- Expansion of the scope of pharmacy practice in state laws and regulations to include collaborative practice with prescribers
- The revision of the AACP's Center for the Advancement of Pharmacy Education (CAPE) Educational Outcomes in 2013, which are intended to be the target toward which the evolving pharmacy curriculum should be aimed
<http://www.aacp.org/resources/education/cape/Pages/default.aspx>
- The Joint Commission of Pharmacy Practitioners' (JCPP) *Vision of Pharmacy Practice*, accepted by the governing boards of 10 pharmacy organizations, including ACPE, and released in 2013
<http://www.amcp.org/Tertiary.aspx?id=8463>
- The document *Pharmacists' Patient Care Process*, developed by a work group from 11 national pharmacy organizations to promote a consistent approach to the process of care. This document was endorsed by the Joint Commission of Pharmacy Practitioners in 2014.
http://www.pharmacist.com/sites/default/files/JCPP_Pharmacists_Patient_Care_Process.pdf
- Health Professionals for a New Century: Transforming education to strengthen health systems in an interdependent world
[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)61854-5/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61854-5/fulltext)

- Core Competencies for Interprofessional Collaborative Practice
<http://www.aacn.nche.edu/education-resources/ipecreport.pdf>
- Revised NAPLEX Competency Statements
<http://www.nabp.net/programs/examination/naplex/naplex-blueprint>

Revision of Standards: Process Employed

In January 2012, ACPE announced to its stakeholders (including pharmacy colleges and schools, professional pharmacy organizations, student pharmacist organizations, and other accrediting bodies) its intent to revise the Doctor of Pharmacy degree standards. Written comments were solicited from stakeholders, and many were received. In addition, a Web-based survey that allowed anonymous completion was distributed to all the college or school of pharmacy deans. ACPE also held a multi-stakeholder invitational conference in fall, 2012¹ to discuss issues facing pharmacy practice and education. The results of the conference influenced the direction and content of these revised standards. The first draft of the revised standards was approved by the ACPE Board of Directors in January 2014 and distributed to ACPE stakeholders in February 2014. Subsequently, a series of open hearings was conducted at national pharmacy meetings. Another Web-based survey that allowed anonymous completion by stakeholders was conducted during 2014, and an extensive review of the draft standards was completed by an advisory group from various sections of the academic and practice communities. The ACPE Board of Directors approved the revised standards on **January 21–25, 2015** with an effective date of **July 1, 2016**. The new standards will be referred to as “Standards 2016.” Colleges and schools being evaluated by ACPE beginning in the fall of 2016 must comply with the new standards.

Revision of Standards: What’s Different?

- *Format* – The standards revision process yielded two distinct documents: **Standards** and **Guidance**. The *Standards* document includes the 25 standards, required (key) elements, assessment elements, and required documentation for each individual standard. The *Guidance* document was developed to support colleges’ and schools’ efforts to enhance the quality of their PharmD programs and includes suggested strategies, additional examples of compliance evidence, and other important information to facilitate meeting standards. ACPE expects programs to be in compliance with all elements outlined in the *Standards* document and to use the information within the *Guidance* document to improve the quality of their programs. In other words, the *Standards* document contains required elements that all accredited Doctor of Pharmacy programs must meet, while the *Guidance* document contains clarifying statements and suggested strategies for improvement.
- *Philosophy and Emphasis* – Based on stakeholder feedback, the Standards have been refined to ensure that graduating students are “practice-ready” and “team-ready,” that is, prepared to directly contribute to patient care working in collaboration with other healthcare providers. The revision has also placed greater emphasis on critical educational outcomes identified by CAPE and the assessment of the level of student

¹ Zellmer WA, Vlasses PH, Beardsley RS. Summary of the ACPE Consensus Conference on Advancing Quality in Pharmacy Education. Am J Pharm Educ. 2013; 77, 3, Article 44.

achievement of these outcomes. The Standards focus on the (1) development of students' professional knowledge, skills, abilities, behaviors, and attitudes, including scientific foundation, knowledge application, and practice competencies, (2) the manner in which programs assess students' acquisition of knowledge and application of knowledge to practice, (3) mastery of skills and achievement of competencies, and (4) the importance of both curricular and co-curricular experiences in advancing the professional development of students. Throughout the revision process, ACPE has focused on addressing the environmental factors noted above in *Revision of Standards: Background*.

- *Importance of Assessment* – Based on feedback from the academy and other stakeholders, the new Standards emphasize assessment as a means of improving the quality of pharmacy education. Having valid and reliable assessment mechanisms in place will provide additional insights to programs regarding their strengths and deficiencies. Throughout the Standards, terms such as “adequate,” “sufficient,” and “appropriate” appear in several areas. Programs are expected to utilize assessment outcome data to determine if the available resources are adequate, sufficient, etc. to allow for compliance with the Standards.
- *Organization of Standards* – Although, at a minimum, the Standards address the same critical areas as in previous versions, they have been restructured, simplified, and clarified. The Standards are organized into three major sections (Educational Outcomes; Structure and Process to Promote Achievement of Educational Outcomes; and Assessment). The Structure and Process section is further organized into four subsections: (1) Planning and Organization, (2) Educational Program for the Doctor of Pharmacy Degree, (3) Students, and (4) Resources. In the third section, Standards 24 and 25 list the assessment elements for Educational Outcomes and Structure and Process, respectively. Standards and Key Elements are phrased as declarative statements describing the various attributes of an accredited Doctor of Pharmacy program. Programs not meeting the expectations and requirements outlined within these statements will be out of compliance with the Standards. Standards annotated with an asterisk (*) are appropriate for new program initiatives and alternate pathways to degree completion, such as an accelerated curriculum, geographically dispersed campuses, online or distance-learning-based programs, and other educational innovations. Three appendices are included within the Standards. Appendix 1 is a revision of the former Appendix B in Standards 2007 and describes the required elements of the didactic component of the PharmD curriculum. Appendix 2 (formerly Appendix C in Standards 2007) describes the expectations of the experiential learning component of the curriculum. Appendix 3 outlines the documentation needed for the Standards and Key Elements.
- *Organization of Guidance* – Materials are provided in this document to help colleges and schools of pharmacy: (1) understand the breadth and scope of issues underlying the achievement of each standard and (2) achieve academic program enhancement. Suggested strategies for quality improvement are based on evidence gleaned from the literature and/or the evaluation of successful programs.
- *Innovation* – Colleges or schools may choose avenues other than those suggested in the guidance document to achieve compliance with the Standards. In all cases, however, ACPE requires evidence that standards are being met.

- *Style* – The Chicago Manual of Style, 15th Edition, Chicago: The University of Chicago Press, 2003, was used in the preparation of the standards and guidelines.

Summary

ACPE looks forward to working with colleges and schools of pharmacy during the transition to the revised professional degree program Standards. Through its strategic plan, ACPE will also be investigating opportunities for better and more standardized ways to evaluate the achievement of the Standards, including the identification of valid outcome measures to be monitored across all accredited programs. In addition, ACPE will be improving its policies and procedures to allow for greater standardization, consistency, efficiency, and effectiveness in its accreditation activities and evaluations. Feedback from ACPE stakeholders is always invited and valued.

**ACPE Board of Directors and Staff
January 25, 2015**

STANDARDS AND KEY ELEMENTS

SECTION I: EDUCATIONAL OUTCOMES

The educational outcomes² described herein have been deemed essential to the contemporary practice of pharmacy in a healthcare environment that demands interprofessional collaboration and professional accountability for holistic patient well-being.

Standard 1: Foundational Knowledge

The professional program leading to the Doctor of Pharmacy degree (hereinafter “the program”) develops in the graduate the knowledge, skills, abilities, behaviors, and attitudes necessary to apply the foundational sciences to the provision of patient-centered care.

Key Element:

1.1. Foundational knowledge – The graduate is able to develop, integrate, and apply knowledge from the foundational sciences (i.e., biomedical, pharmaceutical, social/behavioral/administrative, and clinical sciences) to evaluate the scientific literature, explain drug action, solve therapeutic problems, and advance population health and patient-centered care.

Standard 2: Essentials for Practice and Care

The program imparts to the graduate the knowledge, skills, abilities, behaviors, and attitudes necessary to provide patient-centered care, manage medication use systems, promote health and wellness, and describe the influence of population-based care on patient-centered care.

Key Elements:

2.1. Patient-centered care – The graduate is able to provide patient-centered care as the medication expert (collect and interpret evidence, prioritize, formulate assessments and recommendations, implement, monitor and adjust plans, and document activities).

2.2. Medication use systems management – The graduate is able to manage patient healthcare needs using human, financial, technological, and physical resources to optimize the safety and efficacy of medication use systems.

2.3. Health and wellness – The graduate is able to design prevention, intervention, and educational strategies for individuals and communities to manage chronic disease and improve health and wellness.

2.4. Population-based care – The graduate is able to describe how population-based care influences patient-centered care and the development of practice guidelines and evidence-based best practices.

² Adapted from the American Association of Colleges of Pharmacy’s Center for the Advancement of Pharmacy Education (CAPE) Educational Outcomes, 2013.

Standard 3: Approach to Practice and Care

The program imparts to the graduate the knowledge, skills, abilities, behaviors, and attitudes necessary to solve problems; educate, advocate, and collaborate, working with a broad range of people; recognize social determinants of health; and effectively communicate verbally and nonverbally.

Key Elements:

- 3.1. Problem solving** – The graduate is able to identify problems; explore and prioritize potential strategies; and design, implement, and evaluate a viable solution.
- 3.2. Education** – The graduate is able to educate all audiences by determining the most effective and enduring ways to impart information and assess learning.
- 3.3. Patient advocacy** – The graduate is able to represent the patient’s best interests.
- 3.4. Interprofessional collaboration** – The graduate is able to actively participate and engage as a healthcare team member by demonstrating mutual respect, understanding, and values to meet patient care needs.
- 3.5. Cultural sensitivity** – The graduate is able to recognize social determinants of health to diminish disparities and inequities in access to quality care.
- 3.6. Communication** – The graduate is able to effectively communicate verbally and nonverbally when interacting with individuals, groups, and organizations.

Standard 4: Personal and Professional Development

The program imparts to the graduate the knowledge, skills, abilities, behaviors, and attitudes necessary to demonstrate self-awareness, leadership, innovation and entrepreneurship, and professionalism.

Key Elements:

- 4.1. Self-awareness** – The graduate is able to examine and reflect on personal knowledge, skills, abilities, beliefs, biases, motivation, and emotions that could enhance or limit personal and professional growth.
- 4.2. Leadership** – The graduate is able to demonstrate responsibility for creating and achieving shared goals, regardless of position.
- 4.3. Innovation and entrepreneurship** – The graduate is able to engage in innovative activities by using creative thinking to envision better ways of accomplishing professional goals.
- 4.4. Professionalism** – The graduate is able to exhibit behaviors and values that are consistent with the trust given to the profession by patients, other healthcare providers, and society.

**SECTION II: STRUCTURE AND PROCESS TO PROMOTE
ACHIEVEMENT OF EDUCATIONAL OUTCOMES**

The Educational Outcomes articulated in Section I can only be fully achieved in an academic culture purposely designed to nurture learners and to support the administrators, faculty, preceptors, and staff who mentor them. The standards in Section II describe essential structures and processes that provide the organizational stability and potential for advancement critical to continuous quality improvement in pharmacy education.

Subsection IIA: Planning and Organization

Standard 5: Eligibility and Reporting Requirements

The program meets all stated degree-granting eligibility and reporting requirements.

Key Elements:

5.1. Autonomy – The academic unit offering the Doctor of Pharmacy program is an autonomous unit organized as a college or school of pharmacy (within a university or as an independent entity). This includes autonomy to manage the professional program within stated policies and procedures, as well as applicable state and federal regulations.

5.2. Legal empowerment – The college or school is legally empowered to offer and award the Doctor of Pharmacy degree.

5.3. Dean's leadership – The college or school is led by a dean, who serves as the chief administrative and academic officer of the college or school and is responsible for ensuring that all accreditation requirements of ACPE are met.

5.4. Regional/institutional accreditation – The institution housing the college or school, or the independent college or school, has (or, in the case of new programs, is seeking) full accreditation by a regional/institutional accreditation agency recognized by the U.S. Department of Education.

5.5. Regional/institutional accreditation actions – The college or school reports to ACPE within 30 days any issue identified in regional/institutional accreditation actions that may have a negative impact on the quality of the professional degree program and compliance with ACPE standards.

5.6. Substantive change – The dean promptly reports substantive changes in organizational structure and/or processes (including financial factors) to ACPE for the purpose of evaluation of their impact on programmatic quality.

Standard 6: College or School Vision, Mission, and Goals

The college or school publishes statements of its vision, mission, and goals.

Key Elements:

6.1. College or school vision and mission – These statements are compatible with the vision and mission of the university in which the college or school operates.

6.2. Commitment to educational outcomes – The mission statement is consistent with a commitment to the achievement of the Educational Outcomes (Standards 1–4).

6.3. Education, scholarship, service, and practice – The statements address the college or school's commitment to professional education, research and scholarship, professional and community service, pharmacy practice, and continuing professional development.

6.4. Consistency of initiatives – All program initiatives are consistent with the college or school's vision, mission, and goals.

6.5. Subunit goals and objectives alignment – If the college or school organizes its faculty into subunits, the subunit goals are aligned with those of the college or school.

Standard 7: Strategic Plan

The college or school develops, utilizes, assesses, and revises on an ongoing basis a strategic plan that includes tactics to advance its vision, mission, and goals.

Key Elements:

7.1. Inclusive process – The strategic plan is developed through an inclusive process, including faculty, staff, students, preceptors, practitioners, and other relevant constituents, and is disseminated in summary form to key stakeholders.

7.2. Appropriate resources – Elements within the strategic plan are appropriately resourced and have the support of the university administration as needed for implementation.

7.3. Substantive change planning – Substantive programmatic changes contemplated by the college or school are linked to its ongoing strategic planning process.

Standard 8: Organization and Governance

The college or school is organized and staffed to advance its vision and facilitate the accomplishment of its mission and goals.

Key Elements:

8.1. Leadership collaboration – University leadership and the college or school dean collaborate to advance the program's vision and mission and to meet ACPE accreditation standards. The dean has direct access to the university administrator(s) with ultimate responsibility for the program.

8.2. Qualified dean – The dean is qualified to provide leadership in pharmacy professional education and practice, research and scholarship, and professional and community service.

8.3. Qualified administrative team – The dean and other college or school administrative leaders have credentials and experience that have prepared them for their respective roles and collectively have the needed backgrounds to effectively manage the educational program.

8.4. Dean's other substantial administrative responsibilities – If the dean is assigned other substantial administrative responsibilities, the university ensures adequate resources to support the effective administration of the affairs of the college or school.

8.5. Authority, collegiality, and resources – The college or school administration has defined lines of authority and responsibility, fosters organizational unit collegiality and effectiveness, and allocates resources appropriately.

8.6. College or school participation in university governance – College or school administrators and faculty are effectively represented in the governance of the university, in accordance with its policies and procedures.

8.7. Faculty participation in college or school governance – The college or school uses updated, published documents, such as bylaws, policies, and procedures, to ensure faculty participation in the governance of the college or school.

8.8. Systems failures – The college or school has comprehensive policies and procedures that address potential systems failures, including technical, administrative, and curricular failures.

8.9. Alternate pathway equitability* – The college or school ensures that any alternative pathways to the Doctor of Pharmacy degree are equitably resourced and integrated into the college or school's regular administrative structures, policies, and procedures, including planning, oversight, and evaluation.

Standard 9: Organizational Culture

The college or school provides an environment and culture that promotes self-directed lifelong learning, professional behavior, leadership, collegial relationships, and collaboration within and across academic units, disciplines, and professions.

Key Elements:

9.1. Leadership and professionalism – The college or school demonstrates a commitment to developing professionalism and to fostering leadership in administrators, faculty, preceptors, staff, and students. Faculty and preceptors serve as mentors and positive role models for students.

9.2. Behaviors – The college or school has policies that define expected behaviors for administrators, faculty, preceptors, staff, and students, along with consequences for deviation from those behaviors.

9.3. Culture of collaboration – The college or school develops and fosters a culture of collaboration within subunits of the college or school, as well as within and outside the university, to advance its vision, mission, and goals, and to support the profession.

Subsection IIB: Educational Program for the Doctor of Pharmacy Degree

Standard 10: Curriculum Design, Delivery, and Oversight

The curriculum is designed, delivered, and monitored by faculty to ensure breadth and depth of requisite knowledge and skills, the maturation of professional attitudes and behaviors, and the

opportunity to explore professional areas of interest. The curriculum also emphasizes active learning pedagogy, content integration, knowledge acquisition, skill development, and the application of knowledge and skills to therapeutic decision-making.

Key Elements:

10.1. Program duration – The professional curriculum is a minimum of four academic years of full-time study or the equivalent.

10.2. Curricular oversight – Curricular oversight involves collaboration between faculty and administration. The body/bodies charged with curricular oversight: (1) are representative of the faculty at large, (2) include student representation, (3) effectively communicate and coordinate efforts with body/bodies responsible for curricular assessment, and (4) are adequately resourced to ensure and continually advance curricular quality.

10.3. Knowledge application – Curricular expectations build on a pre-professional foundation of scientific and liberal studies. The professional curriculum is organized to allow for the logical building of a sound scientific and clinical knowledge base that culminates in the demonstrated ability of learners to apply knowledge to practice.

10.4. Skill development – The curriculum is rigorous, contemporary, and intentionally sequenced to promote integration and reinforcement of content and the demonstration of competency in skills required to achieve the Educational Outcomes articulated in Section I.

10.5. Professional attitudes and behaviors development – The curriculum inculcates professional attitudes and behaviors leading to personal and professional maturity consistent with the Oath of the Pharmacist.

10.6. Faculty and preceptor credentials/expertise – All courses in the curriculum are taught by individuals with academic credentials and expertise that are explicitly linked to their teaching responsibilities.

10.7. Content breadth and depth – Programs document, through mapping or other comparable methods, the breadth and depth of exposure to curricular content areas deemed essential to pharmacy education at the doctoral level (Appendices 1 and 2).

10.8. Pharmacists' Patient Care Process – The curriculum prepares students to provide patient-centered collaborative care as described in the *Pharmacists' Patient Care Process* model endorsed by the Joint Commission of Pharmacy Practitioners.

10.9. Electives – Time is reserved within the core curriculum for elective didactic and experiential education courses that permit exploration of and/or advanced study in areas of professional interest.

10.10. Feedback – The curriculum allows for timely, formative performance feedback to students in both didactic and experiential education courses. Students are also provided the opportunity to give formative and/or summative feedback to faculty, including preceptors, on their perceptions of teaching/learning effectiveness.

10.11. Curriculum review and quality assurance – Curriculum design, delivery, and sequencing are regularly reviewed and, when appropriate, revised by program faculty to ensure optimal achievement of educational outcomes with reasonable student workload expectations.

10.12. Teaching and learning methods – The didactic curriculum is delivered via teaching/learning methods that: (1) facilitate achievement of learning outcomes, (2) actively engage learners, (3) promote student responsibility for self-directed learning, (4) foster collaborative learning, and (5) are appropriate for the student population (i.e., campus-based vs. distance-based).

10.13. Diverse learners – The didactic curriculum incorporates teaching techniques and strategies that address the diverse learning needs of students.

10.14. Course syllabi – Syllabi for didactic and experiential education courses, developed and updated through a faculty-approved process, contain information that supports curricular quality assurance assessment.

10.15. Experiential quality assurance – A quality assurance procedure for all pharmacy practice experiences is established and implemented to: (1) facilitate achievement of stated course expectations, (2) standardize key components of experiences across all sites offering the same experiential course, and (3) promote consistent assessment of student performance.

10.16. Remuneration/employment – Students do not receive payment for participating in curricular pharmacy practice experiences, nor are they placed in the specific practice area within a pharmacy practice site where they are currently employed.³

10.17. Academic integrity* – To ensure the credibility of the degree awarded, the validity of individual student assessments, and the integrity of student work, the college or school ensures that assignments and examinations take place under circumstances that minimize opportunities for academic misconduct. The college or school ensures the correct identity of all students (including distance students) completing proctored assessments.

Standard 11: Interprofessional Education (IPE)

The curriculum prepares all students to provide entry-level, patient-centered care in a variety of practice settings as a contributing member of an interprofessional team. In the aggregate, team exposure includes prescribers as well as other healthcare professionals.

Key Elements:

11.1. Interprofessional team dynamics – All students demonstrate competence in interprofessional team dynamics, including articulating the values and ethics that underpin interprofessional practice, engaging in effective interprofessional communication, including conflict resolution and documentation skills, and honoring interprofessional roles and responsibilities. Interprofessional team dynamics are

³ A professional degree program in an institution that meets the definition of and has an institution-wide commitment to “cooperative education” (Cooperative Education and Internship Association; <http://www.ceiainc.org>) may apply to ACPE for a waiver of this requirement.

introduced, reinforced, and practiced in the didactic and Introductory Pharmacy Practice Experience (IPPE) components of the curriculum, and competency is demonstrated in Advanced Pharmacy Practice Experience (APPE) practice settings.

11.2. Interprofessional team education – To advance collaboration and quality of patient care, the didactic and experiential curricula include opportunities for students to learn about, from, and with other members of the interprofessional healthcare team. Through interprofessional education activities, students gain an understanding of the abilities, competencies, and scope of practice of team members. Some, but not all, of these educational activities may be simulations.

11.3. Interprofessional team practice – All students competently participate as a healthcare team member in providing direct patient care and engaging in shared therapeutic decision-making. They participate in experiential educational activities with prescribers/student prescribers and other student/professional healthcare team members, including face-to-face interactions that are designed to advance interprofessional team effectiveness

Standard 12: Pre-Advanced Pharmacy Practice Experience (Pre-APPE) Curriculum

The Pre-APPE curriculum provides a rigorous foundation in the biomedical, pharmaceutical, social/administrative/behavioral, and clinical sciences, incorporates Introductory Pharmacy Practice Experience (IPPE), and inculcates habits of self-directed lifelong learning to prepare students for Advanced Pharmacy Practice Experience (APPE).

Key Elements:

12.1. Didactic curriculum – The didactic portion of the Pre-APPE curriculum includes rigorous instruction in all sciences that define the profession (see Appendix 1). Appropriate breadth and depth of instruction in these sciences is documented regardless of curricular model employed (e.g., blocked, integrated, traditional ‘stand-alone’ course structure, etc.).

12.2. Development and maturation – The Pre-APPE curriculum allows for the development and maturation of the knowledge, skills, abilities, attitudes, and behaviors that underpin the Educational Outcomes articulated in Standards 1–4 and within Appendices 1 and 2.

12.3. Affective domain elements – Curricular and, if needed, co-curricular activities and experiences are purposely developed and implemented to ensure an array of opportunities for students to document competency in the affective domain-related expectations of Standards 3 and 4. Co-curricular activities complement and advance the learning that occurs within the formal didactic and experiential curriculum.

12.4. Care across the lifespan – The Pre-APPE curriculum provides foundational knowledge and skills that allow for care across the patient’s lifespan.

12.5. IPPE expectations – IPPEs expose students to common contemporary U.S. practice models, including interprofessional practice involving shared patient care decision-making, professional ethics and expected behaviors, and direct patient care activities. IPPEs are structured and sequenced to intentionally develop in students a

clear understanding of what constitutes exemplary pharmacy practice in the U.S. prior to beginning APPE.

12.6. IPPE duration – IPPE totals no less than 300 clock hours of experience and is purposely integrated into the didactic curriculum. A minimum of 150 hours of IPPE are balanced between community and institutional health-system settings.

12.7. Simulation for IPPE – Simulated practice experiences (a maximum of 60 clock hours of the total 300 hours) may be used to mimic actual or realistic pharmacist-delivered patient care situations. However, simulation hours do not substitute for the 150 clock hours of required IPPE time in community and institutional health-system settings. Didactic instruction associated with the implementation of simulated practice experiences is not counted toward any portion of the 300 clock hour IPPE requirement.

Standard 13: Advanced Pharmacy Practice Experience (APPE) Curriculum

A continuum of required and elective APPEs is of the scope, intensity, and duration required to support the achievement of the Educational Outcomes articulated in Standards 1–4 and within Appendix 2 to prepare practice-ready graduates. APPEs integrate, apply, reinforce, and advance the knowledge, skills, attitudes, abilities, and behaviors developed in the Pre-APPE curriculum and in co-curricular activities.

Key Elements:

13.1. Patient care emphasis – Collectively, APPEs emphasize continuity of care and incorporate acute, chronic, and wellness-promoting patient-care services in outpatient (community/ambulatory care) and inpatient (hospital/health system) settings.

13.2. Diverse populations – In the aggregate, APPEs expose students to diverse patient populations as related to age, gender, race/ethnicity, socioeconomic factors (e.g., rural/urban, poverty/affluence), and disease states)

13.3. Interprofessional experiences – In the aggregate, students gain in-depth experience in delivering direct patient care as part of an interprofessional team.

13.4. APPE duration – The curriculum includes no less than 36 weeks (1440 hours) of APPE. All students are exposed to a minimum of 160 hours in each required APPE area. The majority of APPE is focused on direct patient care.

13.5. Timing – APPEs follow successful completion of all IPPE and required didactic curricular content. Required capstone courses or activities that provide opportunity for additional professional growth and insight are allowed during or after completion of APPEs. These activities do not compromise the quality of the APPEs, nor count toward the required 1440 hours of APPE.

13.6. Required APPE – Required APPEs occur in four practice settings: (1) community pharmacy; (2) ambulatory patient care; (3) hospital/health system pharmacy; and (4) inpatient general medicine patient care.

13.7. Elective APPE – Elective APPEs are structured to give students the opportunity to: (1) mature professionally, (2) secure the breadth and depth of experiences needed to

achieve the Educational Outcomes articulated in Standards 1–4, and (3) explore various sectors of practice.

13.8. Geographic restrictions – Required APPEs are completed in the United States or its territories or possessions. All quality assurance expectations for U.S.-based experiential education courses apply to elective APPEs offered outside of the U.S.

Subsection IIC: Students

Standard 14: Student Services

The college or school has an appropriately staffed and resourced organizational element dedicated to providing a comprehensive range of services that promote student success and well-being.

Key Elements:

14.1. FERPA – The college or school has an ordered, accurate, and secure system of student records in compliance with the Family Educational Rights and Privacy Act (FERPA). Student services personnel and faculty are knowledgeable regarding FERPA law and its practices.

14.2. Financial aid – The college or school provides students with financial aid information and guidance by appropriately trained personnel.

14.3. Healthcare – The college or school offers students access to adequate health and counseling services. Appropriate immunization standards are established, along with the means to ensure that such standards are satisfied.

14.4. Advising – The college or school provides academic advising, curricular and career-pathway counseling, and information on post-graduate education and training opportunities adequate to meet the needs of its students.

14.5. Nondiscrimination – The college or school establishes and implements student service policies that ensure nondiscrimination as defined by state and federal laws and regulations.

14.6. Disability accommodation – The college or school provides accommodations to students with documented disabilities that are determined by the university Disability Office (or equivalent) to be reasonable, and provides support to faculty in accommodating disabled students.

14.7. Student services access* – The college or school offering multiple professional degree programs (e.g., PharmD/MPH) or pathways (campus and distance pathways) ensures that all students have equitable access to a comparable system of individualized student services (e.g., tutorial support, faculty advising, counseling, etc.).

Standard 15: Academic Environment

The college or school develops, implements, and assesses its policies and procedures that promote student success and well-being.

Key elements:

15.1. Student information – The college or school produces and makes available to enrolled and prospective students updated information of importance, such as governance documents, policies and procedures, handbooks, and catalogs.

15.2. Complaints policy – The college or school develops, implements, and makes available to students a complaints policy that includes procedures for how students may file complaints within the college or school and also directly to ACPE regarding their college or school's adherence to ACPE standards. The college or school maintains a chronological record of such student complaints, including how each complaint was resolved.

15.3. Student misconduct – The college or school develops and implements policies regarding academic and non-academic misconduct of students that clearly outline the rights and responsibilities of, and ensures due process for, all parties involved.

15.4. Student representation – The college or school considers student perspectives and includes student representation, where appropriate, on committees, in policy-development bodies, and in assessment and evaluation activities.

15.5. Distance learning policies* – For colleges and schools offering distance learning opportunities, admissions information clearly explains the conditions and requirements related to distance learning, including full disclosure of any requirements that cannot be completed at a distance.

Standard 16: Admissions

The college or school develops, implements, and assesses its admission criteria, policies, and procedures to ensure the selection of a qualified and diverse student body into the professional degree program.

Key elements:

16.1. Enrollment management – Student enrollment is managed by college or school administration. Enrollments are in alignment with available physical, educational, financial, faculty, staff, practice site, preceptor, and administrative resources.

16.2. Admission procedures – A duly constituted committee of the college or school has the responsibility and authority for the selection of students to be offered admission. Admission criteria, policies, and procedures are not compromised regardless of the size or quality of the applicant pool.

16.3. Program description and quality indicators – The college or school produces and makes available to the public, including prospective students: (1) a complete and accurate description of the professional degree program; (2) the program's current accreditation status; and (3) ACPE-required program performance information including on-time graduation rates and most recent NAPLEX first-attempt pass rates.

16.4. Admission criteria – The college or school sets performance expectations for admission tests, evaluations, and interviews used in selecting students who have the potential for success in the professional degree program and the profession. Applicant

performance on admission criteria is documented; and the related records are maintained by the college or school as per program/university requirements.

16.5. Admission materials – The college or school produces and makes available to prospective students the criteria, policies, and procedures for admission to the professional degree program. Admission materials clearly state academic expectations, required communication skills, types of personal history disclosures that may be required, and professional and technical standards for graduation.

16.6. Written and oral communication assessment – Written and oral communication skills are assessed in a standardized manner as part of the admission process.

16.7. Candidate interviews – Standardized interviews (in-person, telephonic, and/or computer-facilitated) of applicants are conducted as a part of the admission process to assess affective domain characteristics (i.e., the Personal and Professional Development domain articulated in Standard 4).

16.8. Transfer and waiver policies – A college or school offering multiple professional degree programs, or accepting transfer students from other schools or colleges of pharmacy, establishes and implements policies and procedures for students who request to transfer credits between programs. Such policies and procedures are based on defensible assessments of course equivalency. A college or school offering multiple pathways to a single degree has policies and procedures for students who wish to change from one pathway to another.

Standard 17: Progression

The college or school develops, implements, and assesses its policies and procedures related to student progression through the PharmD program.

Key elements:

17.1. Progression policies – The college or school creates, makes available to students and prospective students, and abides by criteria, policies, and procedures related to:

- Academic progression
- Remediation
- Missed course work or credit
- Academic probation
- Academic dismissal
- Dismissal for reasons of misconduct
- Readmission
- Leaves of absence
- Rights to due process
- Appeal mechanisms (including grade appeals)

17.2. Early intervention – The college or school's system of monitoring student performance provides for early detection of academic and behavioral issues. The college or school develops and implements appropriate interventions that have the potential for successful resolution of the identified issues.

Subsection IID: Resources**Standard 18: Faculty and Staff—Quantitative Factors**

The college or school has a cohort of faculty and staff with the qualifications and experience needed to effectively deliver and evaluate the professional degree program.

Key Elements:

18.1. Sufficient faculty – The college or school has a sufficient number of faculty members to effectively address the following programmatic needs:

- Teaching (didactic, simulation, and experiential)
- Professional development
- Research and other scholarly activities
- Assessment activities
- College/school and/or university service
- Intraprofessional and interprofessional collaboration
- Student advising and career counseling
- Faculty mentoring
- Professional service
- Community service
- Pharmacy practice
- Responsibilities in other academic programs (if applicable)
- Support of distance students and campus(es) (if applicable)*

18.2. Sufficient staff – The college or school has a sufficient number of staff to effectively address the following programmatic needs:

- Student and academic affairs-related services, including recruitment and admission
- Experiential education
- Assessment activities
- Research administration
- Laboratory maintenance
- Information technology infrastructure
- Pedagogical and educational technology support
- Teaching assistance
- General faculty and administration clerical support
- Support of distance students and campus(es) (if applicable)*

Standard 19: Faculty and Staff—Qualitative Factors

Faculty and staff have academic and professional credentials and expertise commensurate with their responsibilities to the professional program and their academic rank.

Key Elements:

19.1. Educational effectiveness – Faculty members have the capability and demonstrate a continuous commitment to be effective educators and are able to effectively use contemporary educational techniques to promote student learning in all offered pathways.

19.2. Scholarly productivity – The college or school creates an environment that both requires and promotes scholarship and also develops mechanisms to assess both the quantity and quality of faculty scholarly productivity.

19.3. Service commitment – In the aggregate, faculty engage in professional, institutional, and community service that advances the program and the profession of pharmacy.

19.4. Practice understanding – Faculty members, regardless of their discipline, have a conceptual understanding of and commitment to advancing current and proposed future pharmacy practice.

19.5. Faculty/staff development – The college or school provides opportunities for career and professional development of its faculty and staff, individually and collectively, to enhance their role-related skills, scholarly productivity, and leadership.

19.6. Policy application – The college or school ensures that policies and procedures for faculty and staff recruitment, performance review, promotion, tenure (if applicable), and retention are applied in a consistent manner.

Standards 20: Preceptors

The college or school has a sufficient number of preceptors (practice faculty or external practitioners) to effectively deliver and evaluate students in the experiential component of the curriculum. Preceptors have professional credentials and expertise commensurate with their responsibilities to the professional program.

Key Elements:

20.1. Preceptor criteria – The college or school makes available and applies quality criteria for preceptor recruitment, orientation, performance, and evaluation. The majority of preceptors for any given student are U.S. licensed pharmacists.

20.2. Student-to-preceptor ratio – Student to precepting pharmacist ratios allow for the individualized mentoring and targeted professional development of learners.

20.3. Preceptor education and development – Preceptors are oriented to the program's mission, the specific learning expectations for the experience outlined in the syllabus, and effective performance evaluation techniques before accepting students. The college or school fosters the professional development of its preceptors commensurate with their educational responsibilities to the program.

20.4. Preceptor engagement – The college or school solicits the active involvement of preceptors in the continuous quality improvement of the educational program, especially the experiential component.

20.5. Experiential education administration – The experiential education component of the curriculum is led by a pharmacy professional with knowledge and experience in experiential learning. The experiential education program is supported by an appropriate number of qualified faculty and staff.

Standard 21: Physical Facilities and Educational Resources

The college or school has adequate and appropriately equipped physical and educational facilities to achieve its mission and goals.

Key Elements:

21.1. Physical facilities – The college or school's physical facilities (or the access to other facilities) meet legal and safety standards, utilize current educational technology, and are clean and well maintained.

21.2. Physical facilities' attributes – The college or school's physical facilities also include adequate:

- Faculty office space with sufficient privacy to permit accomplishment of responsibilities
- Space that facilitates interaction of administrators, faculty, students, and interprofessional collaborators
- Classrooms that comfortably accommodate the student body and that are equipped to allow for the use of required technology
- Laboratories suitable for skills practice, demonstration, and competency evaluation
- Access to educational simulation capabilities
- Faculty research laboratories with well-maintained equipment including research support services within the college or school and the university
- Animal facilities that meet care regulations (if applicable)
- Individual and group student study space and student meeting facilities

21.3. Educational resource access – The college or school makes available technological access to current scientific literature and other academic and educational resources by students, faculty, and preceptors.

21.4 Librarian expertise access – The college or school has access to librarian resources with the expertise needed to work with students, faculty, and preceptors on effective literature and database search and retrieval strategies.

Standard 22: Practice Facilities

The college or school has the appropriate number and mix of facilities in which required and elective practice experiences are conducted to accommodate all students. Practice sites are appropriately licensed and selected based on quality criteria to ensure the effective and timely delivery of the experiential component of the curriculum.

Key Elements:

22.1. Quality criteria – The college or school employs quality criteria for practice facility recruitment and selection, as well as setting forth expectations and evaluation based on student opportunity to achieve the required Educational Outcomes as articulated in Standards 1–4.

22.2. Affiliation agreements – The college or school secures and maintains signed affiliation agreements with the practice facilities it utilizes for the experiential component of the curriculum. At a minimum, each affiliation agreement ensures that all experiences are conducted in accordance with state and federal laws.

22.3. Evaluation – Practice sites are regularly evaluated. Quality enhancement initiatives and processes are established, as needed, to improve student learning outcomes.

Standard 23: Financial Resources

The college or school has current and anticipated financial resources to support the stability of the educational program and accomplish its mission, goals, and strategic plan.

Key Elements:

23.1. Enrollment support – The college or school ensures that student enrollment is commensurate with resources.

23.2. Budgetary input – The college or school provides input into the development and operation of a budget that is planned, executed, and managed in accordance with sound and accepted business practices.

23.3. Revenue allocation – Tuition and fees for pharmacy students are not increased to support other educational programs if it compromises the quality of the professional program.

23.4. Equitable allocation – The college or school ensures that funds are sufficient to maintain equitable facilities (commensurate with services and activities) across all program pathways.

SECTION III: ASSESSMENT OF STANDARDS AND KEY ELEMENTS

In the spirit of continuous quality improvement and transparency, colleges and schools evaluate and report to constituents the extent to which they meet their programmatic goals. Insights gained from the valid and reliable assessment of outcomes related to mission, strategic planning, educational programs, and other key institutional initiatives are channeled into constructive change to enhance programmatic quality.

Standard 24: Assessment Elements for Section I: Educational Outcomes

The college or school develops, resources, and implements a plan to assess attainment of educational outcomes to ensure that graduates are prepared to enter practice.

Key Elements:

24.1. Formative and summative assessment – The assessment plan incorporates systematic, valid, and reliable knowledge-based and performance-based formative and summative assessments.

24.2. Standardized and comparative assessments – The assessment plan includes standardized assessments as required by ACPE (see Appendix 3) that allow for national comparisons and college- or school-determined peer comparisons.

24.3. Student achievement and readiness – The assessment plan measures student achievement at defined levels of the professional competencies that support attainment of the Educational Outcomes in aggregate and at the individual student level. In addition to college/school desired assessments, the plan includes an assessment of student readiness to:

- Enter advanced pharmacy practice experiences
- Provide direct patient care in a variety of healthcare settings
- Contribute as a member of an interprofessional collaborative patient care team

24.4. Continuous improvement – The college or school uses the analysis of assessment measures to improve student learning and the level of achievement of the Educational Outcomes.

Standard 25: Assessment Elements for Section II: Structure and Process

The college or school develops, resources, and implements a plan to assess attainment of the Key Elements within Standards 5–23.

Specific Key Elements:

25.1. Assessment of organizational effectiveness – The college or school's assessment plan is designed to provide insight into the effectiveness of the organizational structure in engaging and uniting constituents and positioning the college or school for success through purposeful planning.

25.2. Program evaluation by stakeholders – The assessment plan includes the use of data from AACP standardized surveys of graduating students, faculty, preceptors, and alumni.

25.3. Curriculum assessment and improvement – The college or school systematically assesses its curricular structure, content, organization, and outcomes. The college or school documents the use of assessment data for continuous improvement of the curriculum and its delivery.

25.4. Faculty productivity assessment – The college or school systematically assesses the productivity of its faculty in scholarship, teaching effectiveness, and professional and community service.

25.5. Pathway comparability* – The assessment plan includes a variety of assessments that will allow comparison and establishment of educational parity of alternative program pathways to degree completion, including geographically dispersed campuses and online or distance learning-based programs.

25.6. Interprofessional preparedness – The college or school assesses the preparedness of all students to function effectively and professionally on an interprofessional healthcare team.

25.7. Clinical reasoning skills – Evidence-based clinical reasoning skills, the ability to apply these skills across the patient's lifespan, and the retention of knowledge that underpins these skills, are regularly assessed throughout the curriculum.

25.8. APPE preparedness – The Pre-APPE curriculum leads to a defined level of competence in professional knowledge, knowledge application, patient and population-based care, medication therapy management skills, and the attitudes important to success in the advanced experiential program. Competence in these areas is assessed prior to the first APPE.

25.9. Admission criteria – The college or school regularly assesses the criteria, policies, and procedures to ensure the selection of a qualified and diverse student body, members of which have the potential for academic success and the ability to practice in team-centered and culturally diverse environments.

Appendix 1 Required Elements of the Didactic Doctor of Pharmacy Curriculum⁴

The following didactic content areas and associated learning expectations are viewed as central to a contemporary, high-quality pharmacy education and are incorporated at an appropriate breadth and depth in the required didactic Doctor of Pharmacy curriculum. Where noted, content areas may be addressed in the pre-professional curriculum (i.e., as requirements for admission). Required content areas may be delivered within individual or integrated courses, and may involve multiple disciplines.

This appendix was purposely written at the level of broad learning outcomes. It was constructed to provide statements of concepts and understandings essential for pharmacists to master, rather than a list of required topics to cover in the didactic curriculum. The goal is to ensure that critical areas of learning are included in the curricula of all programs without dictating how the lessons are structured, organized, or delivered.

The clear expectation embedded within Appendix 1 is that students will develop the comprehensive knowledge base required to be ‘practice ready’ and that they will be able to retain, recall, build upon, and apply that knowledge to deliver quality patient care in a variety of entry-level practice settings.

NOTE: The topics under each Science category are organized in alphabetical order.

Biomedical Sciences (may be addressed in the pre-professional curriculum)

Biochemistry

- Structure, properties, biological functions, applicable kinetics, and metabolic fate of macromolecules essential to life (proteins, lipids, carbohydrates, and nucleic acids). Application of these concepts to identify endogenous targets for drug therapy and rational drug design strategies.

Biostatistics

- Appropriate use of commonly employed statistical tests, management of data sets, and the evaluation of the validity of conclusions generated based on the application of those tests to the data sets.

Human Anatomy

- Structure of major human body systems at the cellular, tissue, organ, and system level.

Human Physiology

- Homeostatic function and normal response reactions across the lifespan of non-diseased human cells, organs, and systems.

Immunology

- Human immune system components, innate and adaptive immune responses to infection, injury and disease, and augmentation of the human immune system to prevent disease.

⁴ Revised Appendix B from Standards 2007.

Medical Microbiology

- Structure, function, and properties of microorganisms (bacteria, viruses, parasites, and fungi) responsible for human disease, and rational approaches to their containment or eradication.

Pathology/Pathophysiology

- Basic principles, mechanisms, functional changes and metabolic sequelae of human disease impacting cells, organs, and systems.

Pharmaceutical Sciences

Clinical Chemistry

- Application of clinical laboratory data to disease state management, including screening, diagnosis, progression, and treatment evaluation.

Extemporaneous Compounding

- Preparation of sterile and non-sterile prescriptions which are pharmaceutically accurate regarding drug product and dose, free from contamination, and appropriately formulated for safe and effective patient use. Analysis of the scientific principles and quality standards upon which these compounding requirements are based.

Medicinal Chemistry

- Chemical basis of drug action and behavior in vivo and in vitro, with an emphasis on pharmacophore recognition and the application of physicochemical properties, structure-activity relationships, intermolecular drug-receptor interactions and metabolism to therapeutic decision-making.

Pharmaceutical Calculations

- Mastery of mathematical skills required to accurately prepare prescriptions (including extemporaneously compounded dosage forms) that are therapeutically sound and safe for patient use. Calculation of patient-specific nutritional and drug dosing/delivery requirements.

Pharmaceutics/Biopharmaceutics

- Physicochemical properties of drugs, excipients, and dosage forms important to the rational design and manufacture of sterile and non-sterile products. Application of physical chemistry and dosage form science to drug stability, delivery, release, disposition, pharmacokinetics, therapeutic effectiveness, and the development of quality standards for drug products.

Pharmacogenomics/genetics

- Genetic basis for disease and individual differences in metabolizing enzymes, transporters, and other biochemicals impacting drug disposition and action that underpin the practice of personalized medicine.

Pharmacokinetics

- Mathematical determination of the rate of drug movement from one therapeutic or physiologic compartment to another. Application of physicochemical and kinetic principles and parameters to therapeutically important issues, such as drug delivery, disposition, therapeutic effectiveness, and beneficial or adverse interactions in general and specific populations.

Pharmacology

- Pharmacodynamics, mechanisms of therapeutic and adverse drug actions and interactions, lifespan-dependent variations in physiology or biochemistry that impact drug action and effectiveness, and application of these principles to therapeutic decision-making.

Toxicology

- Pharmacodynamics, mechanisms, prevention, and treatment of the toxic effects of drugs and poisons, including poisons associated with bioterrorism.

Social/Administrative/Behavioral Sciences

Cultural Awareness

- Exploration of the potential impact of cultural values, beliefs, and practices on patient care outcomes.

Ethics

- Exploration of approaches for resolving ethical dilemmas in patient care, with an emphasis on moral responsibility and the ability to critically evaluate viable options against the needs of patients and other key stakeholders.

Healthcare Systems

- Examination of U.S. health systems and contemporary reimbursement models in which patient-centered and/or population-based care is provided and paid for, and how social, political, economic, organizational, and cultural factors influence providers' ability to ensure patient safety and deliver coordinated interprofessional care services.

History of Pharmacy

- Exploration of the evolution of pharmacy as a distinct profession, the transition from a focus on the drug to a focus on the patient and the drug (including pharmacist-provided patient care), and major milestones and contributors in the evolution of pharmacy.

Pharmacoeconomics

- Application of economic principles and theories to the provision of cost-effective pharmacy products and services that optimize patient-care outcomes, particularly in situations where healthcare resources are limited.

Pharmacoepidemiology

- Cause-and-effect patterns of health and disease in large populations that advance safe and effective drug use and positive care outcomes within those populations.

Pharmacy Law and Regulatory Affairs

- Federal and appropriate state-specific statutes, regulations, policies, executive orders, and court decisions that regulate the practice of pharmacy, including the mitigation of prescription drug abuse and diversion.

Practice Management

- Application of sound management principles (including operations, information, resource, fiscal, and personnel) and quality metrics to advance patient care and service delivery within and between various practice settings.

Professional Communication

- Analysis and practice of verbal, non-verbal, and written communication strategies that promote effective interpersonal dialog and understanding to advance specific patient care, education, advocacy, and/or interprofessional collaboration goals. Exploration of technology-based communication tools and their impact on healthcare delivery, healthcare information, and patient empowerment.

Professional Development/Social and Behavioral Aspects of Practice

- Development of professional self-awareness, capabilities, responsibilities, and leadership. Analysis of contemporary practice roles and innovative opportunities, and inculcation of professional attitudes, behaviors, and dispositions.

Research Design

- Evaluation of research methods and protocol design required to conduct valid and reliable studies to test hypotheses or answer research questions, and to appropriately evaluate the validity and reliability of the conclusions of published research studies.

Clinical Sciences

Clinical Pharmacokinetics

- Application of basic pharmacokinetic principles and mathematical models to calculate safe and effective doses of drugs for individual patients, and adjust therapy as appropriate through the monitoring of drug concentration in biological fluids.

Health Informatics

- Effective and secure design and use of electronic and other technology-based systems, including electronic health records, to capture, store, retrieve, and analyze data for use in patient care, and confidentially/legally share health information in accordance with federal policies.

Health Information Retrieval and Evaluation

- Critical analysis and application of relevant health sciences literature and other information resources to answer specific patient-care and/or drug-related questions and provide evidence-based therapeutic recommendations to healthcare providers or, when appropriate, the public.

Medication Dispensing, Distribution and Administration

- Preparation, dispensing and administration of prescriptions, identification and prevention of medication errors and interactions, maintaining and using patient profile systems and

prescription processing technology and/or equipment, and ensuring patient safety. Educating about appropriate medication use and administration.

Natural Products and Alternative and Complementary Therapies

- Evidence-based evaluation of the therapeutic value, safety, and regulation of pharmacologically active natural products and dietary supplements. Cultural practices commonly selected by practitioners and/or patients for use in the promotion of health and wellness, and their potential impact on pharmacotherapy.

Patient Assessment

- Evaluation of patient function and dysfunction through the performance of tests and assessments leading to objective (e.g., physical assessment, health screening, and lab data interpretation) and subjective (patient interview) data important to the provision of care.

Patient Safety

- Analysis of the systems- and human-associated causes of medication errors, exploration of strategies designed to reduce/eliminate them, and evaluation of available and evolving error-reporting mechanisms.

Pharmacotherapy

- Evidence-based clinical decision making, therapeutic treatment planning, and medication therapy management strategy development for patients with specific diseases and conditions that complicate care and/or put patients at high risk for adverse events. Emphasis on patient safety, clinical efficacy, pharmacogenomic and pharmacoeconomic considerations, and treatment of patients across the lifespan.

Public Health

- Exploration of population health management strategies, national and community-based public health programs, and implementation of activities that advance public health and wellness, as well as provide an avenue through which students earn certificates in immunization delivery and other public health-focused skills.

Self-Care Pharmacotherapy

- Therapeutic needs assessment, including the need for triage to other health professionals, drug product recommendation/selection, and counseling of patients on non-prescription drug products, non-pharmacologic treatments and health/wellness strategies.

Appendix 2 Expectations within the APPE Curriculum

Builds on IPPE. APPE follows IPPE, which is designed to progressively develop the professional insights and skills necessary to advance into responsibilities in APPE. Colleges and schools use a variety of IPPE delivery mechanisms to ensure students are ready to meet the expectations of APPE. IPPE involves interaction with practitioners and patients to advance patient welfare in authentic practice settings, and provides exposure to both medication distribution systems and high-quality, interprofessional, team-based patient care.

APPE curriculum. APPE ensures that students have multiple opportunities to perform patient-centered care and other activities in a variety of settings. Experiences are in-depth, structured, and comprehensive in the aggregate, and carefully coordinated with other components of the PharmD curriculum. Collectively, APPE hones the practice skills, professional judgment, behaviors, attitudes and values, confidence, and sense of personal and professional responsibility required for each student to practice independently and collaboratively in an interprofessional, team-based care environment.

Learning outcomes. General and experience-specific learning outcomes are established for all APPEs. Learning outcomes identify the competencies to be achieved, expected patient populations (if applicable), level of student responsibility, and the setting needed for the outcomes to be met. Learning outcomes for each experience are mapped to the professional practice competencies outlined in the Standards, as well as to any additional competencies developed by the school or college.

Assessment. Colleges and schools assess student achievement of APPE competencies within their assessment plans using reliable, validated assessments. Formative feedback related to specific performance criteria is provided to students throughout the experience. At a minimum, performance competence is documented midway through the experience and at its completion.

Learning activities. The APPE curriculum, in the aggregate, includes but is not limited to: (1) direct patient care, (2) interprofessional interaction and practice, (3) medication dispensing, distribution, administration, and systems management, and (4) professional development. Examples of possible activities within these broad areas are listed in the Guidance document.

Interprofessional interaction. The need for interprofessional interaction is paramount to successful treatment of patients. Colleges and schools provide pharmacy students the opportunity to gain interprofessional skills using a variety of mechanisms including face-to-face interactions in clinical settings or in real-time telephonic or video-linked interactions. Regardless of the methods used, students demonstrate those interprofessional skills articulated in Standard 11.

Direct patient care focus. The majority of student time in APPE is focused on the provision of direct patient care to both inpatients and outpatients. APPE is of sufficient length to permit continuity of care of individual patients and documentation of achievement of competencies associated with the APPE curriculum.

Practice settings. Students demonstrate competence within four main practice types: community, ambulatory care, general medicine, and health system pharmacy. Colleges and

schools draft competency statements for each type of setting along with appropriate assessment plans.

Ambulatory care. Ambulatory care pharmacy practice is the provision of integrated, accessible health care services by pharmacists who are accountable for addressing medication needs, developing sustained partnerships with patients, and practicing in the context of family and community.⁵ The ambulatory care setting involves interprofessional communication and collaboration to provide acute and chronic patient care that can be accomplished outside the inpatient setting.

Blended environments. The literature documents that the demarcations between various types of pharmacy practice are blurring. A specific APPE may involve skill-development activities in more than one of the four required practice settings (i.e., the 'blending' of two or more of the four required practice types within one APPE). In addition, 'longitudinal' experiences may exist where students participate in more than one of the four required APPEs within the same institution (i.e., taking a general medicine APPE, an ambulatory care APPE, and a health system pharmacy APPE in the same hospital). The key is that a college or school documents how its APPE program is balanced between the four required practice areas and how all program outcomes, student performance competencies, and ACPE standards are met.

Elective APPE. Elective rotations allow students to explore areas of professional interest and/or expand their understanding of professional opportunities. Elective APPE may include a maximum of two experiences without a patient care focus.

⁵ www.bpsweb.org/specialties/AmbulatoryCarePharmacy.cfm

**Appendix 3
Required Documentation for
Standards and Key Elements 2016**

To provide evidence of achievement of the standards and key elements, colleges and schools provide, at a minimum, the following outcomes data and documentation. Many of these documents are embedded within the *Assessment and Accreditation Management System* (AAMS) system (co-developed and managed by the American Association of Colleges of Pharmacy and ACPE), while others are created by individual colleges and schools to be shared with ACPE at appropriate times during the quality improvement process (e.g., within self-study submissions or during site visits). As noted below, an individual document may be used for multiple standards. Colleges and schools are encouraged to develop additional documentation processes to meet their mission-specific quality assurance needs.

Standard 1 – Foundational Knowledge

- Student academic performance throughout the program (e.g., progression rates, academic probation rates, attrition rates)
- Annual performance of students nearing completion of the didactic curriculum on the Pharmacy Curriculum Outcomes Assessment (PCOA) - an assessment of knowledge of the essential content areas identified in Appendix 1
- Performance of graduates (passing rate) on NAPLEX
- Performance of graduates in the various NAPLEX competency areas
- Performance of graduates on Multistate Pharmacy Jurisprudence Examination (MPJE) and/or other state required law examination

Standard 2 – Essentials for Practice and Care

- Outcome data from assessments summarizing overall student achievement of relevant didactic, IPPE, and APPE learning objectives

Standard 3 – Approach to Practice and Care

- Examples of student participation in Interprofessional Education activities (didactic, simulation, experiential)
- Outcome data from assessments summarizing overall student achievement of relevant didactic, IPPE, and APPE learning objectives
- Outcome data from assessments summarizing overall student participation in Interprofessional Education activities
- Examples of curricular and co-curricular experiences made available to students to document developing competence in affective domain-related expectations of Standard 3
- Outcome data from assessments of student achievement of problem-solving and critical thinking capabilities
- Outcome data from assessments of students' ability to communicate professionally, advocate for patients, and educate others
- Outcome data from assessments of students' demonstration of cultural awareness and sensitivity.

Standard 4 – Personal and Professional Development

- Outcome data from assessments summarizing students' overall achievement of relevant didactic, IPPE, and APPE learning objectives
- Examples of curricular and co-curricular experiences made available to students to document developing competence in affective domain-related expectations of Standard 4

- Outcome data from assessments summarizing students' overall achievement of professionalism, leadership, self-awareness, and creative thinking expectations
- Description of tools utilized to capture students' reflections on personal/professional growth and development
- Description of processes by which students are guided to develop a commitment to continuous professional development and to self-directed lifelong learning

Standard 5 – Eligibility and Reporting Requirements

- Legal authority to offer/award the Doctor of Pharmacy degree
- Documents verifying institutional accreditation
- Accreditation reports identifying deficiencies (if applicable)
- University organizational chart
- Description of level of autonomy of the college or school

Standard 6 – College or School Vision, Mission, and Goals

- Vision, mission, and goal statements (college, school, parent institution, department/division)
- Outcome data from assessments summarizing the extent to which the college or school is achieving its vision, mission, and goals

Standard 7 – Strategic Plan

- Strategic planning documents, including a description of the process through which the strategic plan was developed.
- Outcome data from assessments summarizing the implementation of the strategic plan

Standard 8 - Organization and Governance

- Curriculum vitae of the dean and others on the administrative leadership team
- Organization chart of the college or school
- Responsibilities of dean and other administrative leadership team members
- Faculty governance documents (by-laws, policies, procedures, etc.)
- List of committees and designated charges
- Evidence of faculty participation in university governance
- Policies and procedures related to system failures, data security and backup, and contingency planning
- Outcome data from assessments (e.g., AACP faculty, preceptor, graduating student and alumni surveys) summarizing the effectiveness of the organizational structure and governance

Standard 9 – Organizational Culture

- Policies describing expectations of faculty, administrators, students, and staff behaviors
- Examples of intra/interprofessional and intra/interdisciplinary collaboration
- Affiliation agreements for purposes of research, teaching, or service (if applicable)
- Outcome data from AACP faculty and graduating student surveys related to collaboration, morale, professionalism, etc.

Standard 10 - Curriculum Design, Delivery, and Oversight

- Description of curricular and degree requirements, including elective didactic and experiential expectations
- All required and elective didactic and experiential course syllabi
- Mapping of required curricular content and experiential education expectations to individual courses
- Curriculum vitae of faculty teaching within the curriculum
- A tabular display of courses, faculty members assigned to each course and their role, and credentials supporting the teaching assignments

- List of Curriculum Committee (or equivalent) members with position/affiliation within college/school
- List of charges, assignments, and accomplishments of Curriculum Committee over the last 1–3 years
- Examples of tools (e.g., portfolios) used by students to document self-assessment of, and reflection on, learning needs, plans and achievements, and professional growth and development
- Sample documents used by faculty, preceptors, and students to evaluate learning experiences and provide formative and/or summative feedback
- Policies related to academic integrity
- Policies related to experiential learning that ensures compliance with Key Element 10.15
- Examples of instructional methods used by faculty and the extent of their employment to:
 - Actively engage learners
 - Integrate and reinforce content across the curriculum
 - Provide opportunity for mastery of skills
 - Instruct within the experiential learning program
 - Stimulate higher-order thinking, problem-solving, and clinical-reasoning skills
 - Foster self-directed lifelong learning skills and attitudes
 - Address/accommodate diverse learning styles
 - Incorporate meaningful interprofessional learning opportunities

Standard 11 - Interprofessional Education (IPE)

- Vision, mission, and goal statements related to IPE
- Statements addressing IPE and practice contained within student handbooks and/or catalogs
- Relevant syllabi for required and elective didactic and experiential education courses that incorporate elements of IPE to document that concepts are reinforced throughout the curriculum and that IPE-related skills are practiced at appropriate times during pre-APPE
- Student IPPE and APPE evaluation data documenting extent of exposure to interprofessional, team-based patient care
- Outcome data from assessments summarizing students' overall achievement of expected interprofessional educational outcomes in the pre-APPE and APPE curriculum

Standard 12 - Pre-APPE Curriculum

- Description of curricular and degree requirements, including elective didactic and experiential expectations
- A tabular display of courses, faculty members assigned to each course and their role, and credentials supporting the teaching assignments
- Curriculum maps documenting breadth and depth of coverage of Appendix 1 content and learning expectations in the professional (and, if appropriate, preprofessional) curriculum
- Examples of curricular and co-curricular experiences made available to students to document developing competence in affective domain-related expectations of Standards 3 and 4
- Outcome data from assessments of student preparedness to progress to APPE (e.g., comprehensive assessments of knowledge, skills, and competencies)
- Description of the IPPE learning program and its goals, objectives, and time requirements
- List of simulation activities and hours counted within the IPPE 300 hour requirement
- IPPE course syllabi including general and rotation-specific learning objectives and extent of IPE exposure

- IPPE student and preceptor manuals
- IPPE student and preceptor assessment tools
- IPPE preceptor recruitment and training manuals and/or programs
- List of active preceptors with credentials and practice site
- Outcome data from assessments summarizing overall student achievement of Pre-APPE educational outcomes

Standard 13 – APPE Curriculum

- Overview of APPE curriculum (duration, types of required and elective rotations, etc.)
- APPE course syllabi including general and experience-specific learning objectives
- APPE student and preceptor manuals
- APPE student and preceptor assessment tools
- Preceptor recruitment and training manuals and/or programs
- List of active preceptors with credentials and practice site
- Student APPE evaluation data documenting extent of exposure to diverse patient populations and interprofessional, team-based patient care
- Outcome data from assessments summarizing students' overall achievement of APPE educational outcomes

Standard 14 - Student Services

- Organizational chart depicting Student Services unit and responsible administrators
- Synopsis of curriculum vitae of Students Services administrative officer(s) and staff
- Student Handbook and/or Catalog (college, school or university), and copies of additional information distributed to students regarding student service elements (financial aid, health insurance, etc.)
- Copies of policies that ensure nondiscrimination and access to allowed disability accommodations
- Results from AACCP graduating student survey
- Student feedback on the college/school's self-study

Standard 15 - Academic Environment

- Student Handbook and/or Catalog (college, school, or university), and copies of additional information distributed to students regarding the academic environment
- URL or link to program information on college or school's website
- Copy of student complaint policy related to college or school adherence to ACPE standards
- Number and nature of student complaints related to college or school adherence to ACPE standards (inspection of the file by evaluation teams during site visits)
- List of committees involving students with names and professional years of current student members
- College or school's code of conduct (or equivalent) addressing professional behavior

Standard 16 – Admissions

- Organizational chart depicting Admissions unit and responsible administrator(s)
- Enrollment data for the past five years by year; and by branch campus or pathway (if applicable)
- Enrollment projections for the next five years
- Pharmacy College Aptitude Test (PCAT) scores (mean, maximum, and minimum), if required, for the past three admitted classes
- GPA scores (mean, maximum, and minimum) for preprofessional coursework for the past three admitted classes
- GPA scores (mean, maximum, and minimum) for preprofessional science courses for the past three admitted classes

- Comparisons of PCAT scores and preprofessional GPAs with peer schools for last admitted three admitted classes
- List of admission committee members with name and affiliation
- Policies and procedures regarding the admissions process including selection of admitted students, transfer of credit, and course waiver policies
- Professional and technical standards for school, college, and/or university (if applicable)
- List of preprofessional requirements for admission into the professional program
- Copies of instruments used during the admissions process including interview evaluation forms and assessment of written and oral communication
- Section of Student Handbook and/or Catalog (college, school, or university) regarding admissions
- Link to websites (or documentation of other mechanisms) that provide to the public information on required indicators of quality

Standard 17 – Progression

- Policies and procedures regarding student progression, early intervention, academic probation, remediation, missed course work or credit, leaves of absence, dismissal, readmission, due process, and appeals
- Section of Student Handbook and/or Catalog (college, school, or university) regarding student progression
- Student progression and academic dismissal data for the last three admitted classes
- Correlation analysis of admission variables and academic performance

Standard 18 – Faculty and Staff – Quantitative Factors

- Organizational chart depicting all full-time faculty by department/division
- List of full-time staff in each department/division and areas of responsibility
- ACPE documents (e.g., resource report) related to number of full-time and part-time faculty
- List of faculty turnover for the past five years by department/division with reasons for departure
- Description of coursework mapped to full-time and part-time faculty teaching in each course
- Results from AACP faculty survey regarding adequacy of quantitative strength of faculty and staff

Standard 19 – Faculty and Staff – Qualitative Factors

- Curriculum vitae of faculty and professional staff
- List of active research areas of faculty and an aggregate summary of faculty publications/presentations over the past three years.
- Procedures employed to promote a conceptual understanding of contemporary practice, particularly among non-pharmacist faculty
- Policies and procedures related to faculty recruitment, performance review, promotion, tenure (if applicable), and retention
- Faculty Handbook
- Data from AACP faculty survey regarding qualitative faculty factors

Standard 20 - Preceptors

- List of active preceptors with credentials and practice site
- Number, percentage of required APPE precepted by non-pharmacists categorized by type of experience.
- Description of practice sites (location, type of practice, student/preceptor ratios)
- Policies and procedures related to preceptor recruitment, orientation, development, performance review, promotion, and retention

- Examples of instruments used by preceptors to assess student performance
- Curriculum vitae of administrator(s) responsible for overseeing the experiential education component of the curriculum
- Description of the structure, organization and administrative support of the Experiential Education office (or equivalent)
- Results from AACP preceptor surveys

Standard 21 – Physical Facilities and Educational Resources

- Floor plans for college or school's facilities and descriptions of the use(s) of available space
- Description of shared space and how such space promotes interprofessional interaction
- Analysis of the quantity and quality of space available to the program and plans to address identified inadequacies.
- Documentation of Association for Assessment and Accreditation of Laboratory Animal Care (AAALAC) or other nationally recognized accreditation of animal care facilities, if applicable
- Results from AACP faculty, alumni, and graduating student surveys related to facilities
- Description of educational resources available to faculty, preceptors, and students (library, internet access, etc.)

Standard 22 – Practice Facilities

- Description of practice sites (location, type of practice, student:preceptor ratios) and involvement in IPPE, APPE, or both
- Policies and procedures related to site selection, recruitment, and assessment
- Examples of quality improvements made to improve student learning outcomes as a result of site/facility assessment
- Examples of affiliation agreements between college/school and practice sites (all agreements will be reviewed during site visits)
- ACPE IPPE and APPE Capacity Charts

Standard 23 – Financial Resources

- Detailed budget plan as defined by AACP (previous, current, and subsequent years)
- Description of college or school's budgetary processes
- In-state and out-of-state tuition compared to peer schools
- Results from AACP faculty survey regarding adequacy of financial resources

Standard 24 – Assessment Elements for Section I

- College or school's curriculum assessment plan(s)
- Description of formative and summative assessments of student learning and professional development used by college or school
- Description of standardized and comparative assessments of student learning and professional development used by college or school
- Description of how the college or school uses information generated within the curriculum assessment plan(s) to advance quality within its Doctor of Pharmacy program

Standard 25 – Assessment Elements for Section II

- College or school's program assessment plan(s)
- Description of how the college or school uses information generated by assessments related to its organizational effectiveness, mission and goals, didactic curriculum, experiential learning program, co-curriculum activities, and interprofessional education to advance overall programmatic quality

Frequently Asked Questions

Download a copy of the Policies and Procedures for ACPE Accreditation of Professional Degree Programs [here](#)

What is the customary review cycle for continued accreditation? (Policies and Procedures, pp 9-10)

What items are reviewed annually by the Board? (Policies and Procedures, pp 17-21)

What can a program expect if NAPLEX® expectations are not met? (Policies and Procedures, pp 17-18)

What can a program expect if enrollment changes? (Policies and Procedures, pp 18-19)

What items are included in the on-time graduation rate monitoring? (Policies and Procedures, p. 19)

When will a program be asked to identify the cause of any negative changes or trends in on-time graduation rates? (Policies and Procedures, p. 19)

When will a program be asked to identify the cause of the change in Financial Resources? (Policies and Procedures, p. 19)

What are programs required to report annually to ACPE? (Policies and Procedures, pp. 20)

When could a program expect further action from the Board regarding repeated annual monitoring concerns? (Policies and Procedures, pp. 21)

What is considered a substantive change? (Policies and Procedures, pp. 21-22)

Accreditation Statistics

What is the customary review cycle for continued accreditation? (Policies and Procedures, pp 9-10)

The customary on-site review cycle is eight years. ACPE reserves the right to review programs for purposes of accreditation in a cycle of less than eight years.

What items are reviewed annually by the Board? (Policies and Procedures, pp 17-21)

- Changes and Trends in NAPLEX® Outcomes
- Changes and Trends in Enrollment
- On-Time Graduation Rate
- Financial Resources
- Job placement/gainful employment

What can a program expect if NAPLEX® expectations are not met? (Policies and Procedures, pp 17-18)

- A letter will be sent to a program whose graduates obtain a percentage pass rate on the NAPLEX® lower than that represented by at least two standard deviations below the average obtained by all candidates taking that examination. This shall apply only to first-time examination candidates from ACPE-accredited programs using both calendar year and academic year data.
- A letter will be sent to a program whose graduates obtain a Mean Scaled Score on the NAPLEX® lower than that represented by at least two standard deviations below the average obtained by all candidates taking that examination. This shall apply only to first-time examination candidates from ACPE-accredited programs using both calendar year and academic year data.
- A letter will be sent to a program based on any other analysis indicating a negative trend in NAPLEX® outcomes. (e.g., branch campus analysis)

What can a program expect if enrollment changes? (Policies and Procedures, pp 18-19)

- A letter will be sent to a program having a newly identified change in the first professional year enrollment larger than 20 percent over a five year period or less. Situations in which a program is deemed to be in a period of transition between professional programs will be taken into account in a review of a program's ability to remain in compliance with the standards, particularly those addressing curricular effectiveness
- A letter will be sent to a program based on any other analysis indicating a substantial trend affecting a program's ability to remain in compliance with the standards, particularly those standards addressing curricular effectiveness.
- An increase in headcount enrollment of 50 percent or more within one institutional fiscal year will be reported to the Secretary within 30 days of ACPE's receipt of notification of such an increase, in accord with expectations established by the USDE.

What items are included in the on-time graduation rate monitoring? (Policies and Procedures, p. 19)

The Board will review the data provided by the American Association of Colleges of Pharmacy (AACCP) which includes:

- Matriculating class size for the first professional year of graduating class (e.g., for 2009-2010 graduates, entry class size in 2006-2007 for an academic four-year curriculum)
- Number of graduates of the class completing the curriculum in the specified timeframe (i.e., 3 or 4 years).
- Number of academic dismissals
- Number of withdrawals

When will a program be asked to identify the cause of any negative changes or trends in on-time graduation rates? (Policies and Procedures, p. 19)

- The number of academic dismissals is greater than or equal to six percent of the matriculating class size.
- The number of students withdrawing from the program is greater than or equal to six percent of the matriculating class size.
- The number of students with a delayed graduation is greater than or equal to fifteen percent of the matriculating class size.
- The total attrition related to on-time graduation is greater than or equal to twenty four percent of the matriculating class size. For this purpose, attrition is the total number of students who did not graduate on time for any reason, including delayed graduation, academic dismissal, or withdrawal from the program.

When will a program be asked to identify the cause of the change in Financial Resources? (Policies and Procedures, p. 19)

- A 10% decrease in its annual budget.
- A program experiencing a net loss for two consecutive years.

What are programs required to report annually to ACPE? (Policies and Procedures, pp. 20)

- Job placement/gainful employment

What does ACPE require of programs concerning job placement/gainful employment? (Policies and Procedures, pp. 20)

In July of each year, ACPE will request from the college or school summary statistics of job placement/gainful employment for the cohort graduating the previous year.

This summary shall be reported as percent of graduates whose primary pursuit is: 1) employment within the profession of pharmacy; 2) employment outside the profession of pharmacy; 3) post-graduate education or residency training; or 4) other/lost to follow-up. A full accounting across these four categories (i.e., 100%) of the graduating class is expected. How and when the data are captured to prepare this summary report is at the discretion of the college or school; a brief description of the methodology used to capture the data should be included with the report.

When could a program expect further action from the Board regarding repeated annual monitoring concerns? (Policies and Procedures, pp. 21)

If a program has met any of the criteria for annual monitoring follow up in three or more years within any five-year period, and has not previously appeared before the Board to discuss previous annual monitoring concerns, the Board will invite representatives of the program to meet with the Board.

What is considered a substantive change? (Policies and Procedures, pp. 21-22)

ACPE's definition of substantive change includes, but is not limited to:

- Any change in the established mission or goals of the institution or college/school;
- Curricular change that represent a significant departure in either content or method of delivery, from those that were offered during the program's previous accreditation cycle including:
 - Development of a non-traditional doctor of pharmacy program
 - Development of a joint delivery of program agreement
 - Use of distance learning technologies or other unique methodologies to deliver a substantial portion of the curriculum (e.g., 25% or higher);
 - A substantial change in enrollment in the professional program (defined as 20% or more in one year or cumulatively over two consecutive years);
 - A substantial change in the number of clock or credit hours required for successful completion of the program;
 - A significant change in the length of the program;
 - The establishment of an additional geographic location at which substantial portions of the program are offered;
 - A substantial change in faculty composition or size;
 - Change in the legal status, governance, or ownership of the program;
 - Changes in financial resources that could affect the quality of the program;
 - Changes in leadership;
 - Changes in organizational structure;

- Change in status with other accrediting agency; and
- Any other changes that the Dean feels require notification of ACPE

Accreditation Statistics

135 Colleges and Schools with accreditation status

- 125 Colleges and Schools with full accreditation
- 7 Colleges and Schools with Candidate status
- 3 Colleges and Schools with Precandidate status

353 Continuing Education Providers with Accreditation Status

4 Continuing Education Providers have inactive status

3 Continuing Education Providers have probation status



**Accreditation Council for Pharmacy Education
Definition of Continuing Education for the Profession of Pharmacy**

What is the definition of continuing education?

Continuing education for the profession of pharmacy is a structured¹ educational activity designed or intended to support the continuing development of pharmacists and/or pharmacy technicians to maintain and enhance their competence. Continuing pharmacy education (CPE) should promote problem-solving and critical thinking and be applicable to the practice of pharmacy.

What does 'applicable to the practice of pharmacy' mean?

In general, for guidance in organizing and developing CPE activity content, providers should ensure that, as for all health care professionals, pharmacists and pharmacy technicians should develop and maintain proficiency in six core areas*:

- delivering patient-centered care,
- working as part of interprofessional teams,
- practicing evidence-based medicine,
- focusing on quality improvement,
- using information technology, and
- developing and maintaining safe and effective medication use processes**.

*Adapted from Institute of Medicine's Health Professions Education: A Bridge to Quality, April 2003.

**Added competency by ACPE CPE Pharmacy Technician Group

The following guidance should be utilized by ACPE-accredited providers as guides in developing CE activity content appropriate for pharmacists and/or pharmacy technicians:

Pharmacist competencies. Specific pharmacist outcomes have been developed by the American Association Colleges of Pharmacy's Center for the Advancement of Pharmacy Education (CAPE) Educational Outcomes (2013):

Domain 1 – Foundational Knowledge

1.1. Learner (Learner) - Develop, integrate, and apply knowledge from the foundational sciences (i.e., pharmaceutical, social/behavioral/administrative, and clinical sciences) to evaluate the scientific literature, explain drug action, solve therapeutic problems, and advance population health and patient centered care.

Domain 2 – Essentials for Practice and Care

2.1. Patient-centered care (Caregiver) - Provide patient-centered care as the medication expert (collect and interpret evidence, prioritize, formulate assessments and recommendations, implement, monitor and adjust plans, and document activities).

2.2. Medication use systems management (Manager) - Manage patient healthcare needs using human, financial, technological, and physical resources to optimize the safety and efficacy of medication use systems.

¹ Continuing education whereby the components comply with the ACPE *Standards for Continuing Pharmacy Education*
ACPE Definition of Continuing Education for the Profession of Pharmacy
Approved January 2015

2.3. Health and wellness (Promoter) - Design prevention, intervention, and educational strategies for individuals and communities to manage chronic disease and improve health and wellness.

2.4. Population-based care (Provider) - Describe how population-based care influences patient centered care and influences the development of practice guidelines and evidence-based best practices.

Domain 3 - Approach to Practice and Care

3.1. Problem Solving (Problem Solver) – Identify problems; explore and prioritize potential strategies; and design, implement, and evaluate a viable solution.

3.2. Educator (Educator) – Educate all audiences by determining the most effective and enduring ways to impart information and assess understanding.

3.3. Patient Advocacy (Advocate) - Assure that patients' best interests are represented.

3.4. Interprofessional collaboration (Collaborator) – Actively participate and engage as a healthcare team member by demonstrating mutual respect, understanding, and values to meet patient care needs.

3.5. Cultural sensitivity (Includer) - Recognize social determinants of health to diminish disparities and inequities in access to quality care.

3.6. Communication (Communicator) – Effectively communicate verbally and nonverbally when interacting with an individual, group, or organization.

Domain 4 – Personal and Professional Development

4.1. Self-awareness (Self-aware) – Examine and reflect on personal knowledge, skills, abilities, beliefs, biases, motivation, and emotions that could enhance or limit personal and professional growth.

4.2. Leadership (Leader) - Demonstrate responsibility for creating and achieving shared goals, regardless of position.

4.3. Innovation and Entrepreneurship (Innovator) - Engage in innovative activities by using creative thinking to envision better ways of accomplishing professional goals.

4.4. Professionalism (Professional) - Exhibit behaviors and values that are consistent with the trust given to the profession by patients, other healthcare providers, and society.

Pharmacy Technician Competencies. Specific pharmacy technician knowledge statements (numbers 1.0 – 9.0) have been developed by the Pharmacy Technician Certification Board (PTCB) (2013):

1.0 Pharmacology for Pharmacy Technicians

1.1 Generic and brand names of pharmaceuticals

1.2 Therapeutic equivalence

1.3 Drug interactions (e.g., drug-disease, drug-drug, drug-dietary supplement, drug-OTC, drug-laboratory, drug-nutrient)

1.4* Strengths/dose, dosage forms, physical appearance, routes of administration, and duration of drug therapy

1.5 Common and severe side or adverse effects, allergies, and therapeutic contraindications associated with medications

1.6 Dosage and indication of legend, OTC medications, herbal and dietary

2.0 Pharmacy Law and Regulations

2.1 Storage, handling, and disposal of hazardous substances and wastes (e.g., MSDS)

2.2 Hazardous substances exposure, prevention and treatment (e.g., eyewash, spill kit, MSDS)

2.3 Controlled substance transfer regulations (DEA)

- 2.4 Controlled substance documentation requirements for receiving, ordering, returning, loss/theft, destruction (DEA)
- 2.5 Formula to verify the validity of a prescriber's DEA number (DEA)
- 2.6 Record keeping, documentation, and record retention (e.g., length of time prescriptions are maintained on file)
- 2.7 Restricted drug programs and related prescription-processing requirements (e.g., thalidomide, isotretinoin, clozapine)
- 2.8 Professional standards related to data integrity, security, and confidentiality (e.g., HIPAA, backing up and archiving)
- 2.9 Requirement for consultation (e.g., OBRA'90)
- 2.10 FDA's recall classification
- 2.11 Infection control standards (e.g., laminar air flow, clean room, hand washing, cleaning counting trays, countertop, and equipment) (OSHA, USP 795 and 797)
- 2.12 Record keeping for repackaged and recalled products and supplies (TJC, BOP)
- 2.13 Professional standards regarding the roles and responsibilities of pharmacists, pharmacy technicians, and other pharmacy employees (TJC, BOP)
- 2.14 Reconciliation between state and federal laws and regulations
- 2.15 Facility, equipment, and supply requirements (e.g., space requirements, prescription file storage, cleanliness, reference materials) (TJC, USP, BOP)

3.0 Sterile and Non-Sterile Compounding

- 3.1 Infection control (e.g., hand washing, PPE)
- 3.2 Handling and disposal requirements (e.g., receptacles, waste streams)
- 3.3* Documentation (e.g., batch preparation, compounding record)
- 3.4* Determine product stability (e.g., beyond use dating, signs of incompatibility)
- 3.5 Selection and use of equipment and supplies
- 3.6* Sterile compounding processes
- 3.7* Non-sterile compounding processes

4.0 Medication Safety

- 4.1 Error prevention strategies for data entry (e.g., prescription or medication order to correct patient)
- 4.2 Patient package insert and medication guide requirements (e.g., special directions and precautions)
- 4.3 Identify issues that require pharmacist intervention (e.g., DUR, ADE, OTC recommendation, therapeutic substitution, misuse, missed dose)
- 4.4 Look-alike/sound-alike medications
- 4.5 High-alert/risk medications
- 4.6 Common safety strategies (e.g., tall man lettering, separating inventory, leading and trailing zeros, limit use of error prone abbreviations)

5.0 Pharmacy Quality Assurance

- 5.1 Quality assurance practices for medication and inventory control systems (e.g., matching National Drug Code (NDC) number, bar code, data entry)
- 5.2 Infection control procedures and documentation (e.g., personal protective equipment [PPE], needle recapping)
- 5.3 Risk management guidelines and regulations (e.g., error prevention strategies)
- 5.4 Communication channels necessary to ensure appropriate follow-up and problem resolution (e.g., product recalls, shortages)
- 5.5 Productivity, efficiency, and customer satisfaction measures

6.0 Medication Order Entry and Fill Process

- 6.1* Order entry process

- 6.2* Intake, interpretation, and data entry
- 6.3* Calculate doses required
- 6.4 Fill process (e.g., select appropriate product, apply special handling requirements, measure, and prepare product for final check)
- 6.5 Labeling requirements (e.g., auxiliary and warning labels, expiration date, patient specific information)
- 6.6* Packaging requirements (e.g., type of bags, syringes, glass, pvc, child resistant, light resistant)
- 6.7 Dispensing process (e.g., validation, documentation and distribution)

7.0 Pharmacy Inventory Management

- 7.1 Function and application of NDC, lot numbers and expiration dates
- 7.2 Formulary or approved/preferred product list
- 7.3* Ordering and receiving processes (e.g., maintain par levels, rotate stock)
- 7.4 Storage requirements (e.g., refrigeration, freezer, warmer)
- 7.5 Removal (e.g., recalls, returns, outdates, reverse distribution)

8.0 Pharmacy Billing and Reimbursement

- 8.1 Reimbursement policies and plans (e.g., HMOs, PPO, CMS, private plans)
- 8.2* Third party resolution (e.g., prior authorization, rejected claims, plan limitations)
- 8.3 Third-party reimbursement systems (e.g., PBM, medication assistance programs, coupons, and self-pay)
- 8.4 Healthcare reimbursement systems (e.g., home health, long-term care, home infusion)
- 8.5 Coordination of benefits

9.0 Pharmacy Information System Usage and Application

- 9.1 Pharmacy-related computer applications for documenting the dispensing of prescriptions or medication orders (e.g., maintaining the electronic medical record, patient adherence, risk factors, alcohol drug use, drug allergies, side effects)
- 9.2 Databases, pharmacy computer applications, and documentation management (e.g., user access, drug database, interface, inventory report, usage reports, override reports, diversion reports)

10.0 Verbal Communication Skills for Pharmacy Technicians

- 10.1 Effective and professional verbal communication skills with multidisciplinary healthcare members and patients/customers (e.g., effective listening, feedback, using proper verbal syntax, and questioning)
- 10.2 Effective telephone communication techniques/etiquette which comply with organizational protocols in both receiving and initiating calls
- 10.3 Identify nonverbal gestures (e.g., body language) which can positively or negatively affect verbal communication

**denotes content including calculations.*

How will CPE activities for pharmacists and pharmacy technicians be designated?

Announcement materials (e.g., brochures, advertisements, e-mail blasts, or other announcements) should clearly and explicitly identify the target audience that will benefit from the content of the CPE activity. If a CPE activity includes pharmacists and pharmacy technicians in the same CPE activity specific and separate learning objectives should be described for each, pharmacists and pharmacy technicians. Please note that CPE activities pertaining to, for example, law, may have one set of objectives for pharmacists and pharmacy technicians.

In addition, a Universal Activity Number is an identification number that is assigned to each CPE activity developed and provided, or jointly provided, by an ACPE-accredited provider. This number is developed by appending to the ACPE provider identification number (e.g. 197), the joint provider designation number (0000 for no joint provider, 9999 for joint providers), the year of CE activity development (e.g., 15), the sequential number of the CPE activity from among the new CPE activities developed during that year (e.g., 001), and the topic and format designators (see below).

Joint Provider Designators:

- 0000 - no jointly provided organization
- 9999 - joint provider

Format Designators:

- L - Live activities
- H - Home study and other mediated activities
- B - Activities that contain both live and home study or mediated components (Practice-based activities)

Topic Designators – activities are related to:

If a CPE activity's target audience is exclusively for *pharmacists* the designation "P" will be used as follows:

- 01-P Disease State Management/Drug therapy
- 02-P AIDS therapy
- 03-P Law (related to pharmacy practice)
- 04-P General Pharmacy
- 05-P Patient Safety

If a CPE activity's target audience is exclusively for *pharmacy technicians* the designation "T" will be used as follows:

- 01-T Disease State Management/Drug therapy
- 02-T AIDS therapy
- 03-T Law (related to pharmacy practice)
- 04-T General Pharmacy
- 05-T Patient Safety

Note: If the CPE activity is intended for both pharmacists and pharmacy technicians, that activity will have the same Universal Activity Number with respect to the provider identification number, joint provider designation, year of release, sequence number and format; however, the topic designator in the number will be specific to each audience, either a "P" or "T." For example:

- 197-000-15-001-L05-**P** (activity number to be used for pharmacists)
- 197-000-15-001-L05-**T** (activity number to be used for pharmacy technicians)

Have questions?

If you have any questions as to what constitutes continuing education for the profession of pharmacy, please contact the ACPE staff at ceinfo@acpe-accredit.org or phone 312-664-3575.

Please note: ACPE-accredited providers should be aware that the roles of pharmacy technicians are evolving and vary according to state and workplace setting. Thus it is important to conduct an appropriate educational needs assessment and practice gap analysis to guide continuing education programming.

Joint Accreditation for Interprofessional Continuing Education™ Creates New Logo and Provider Mark

Logos Convey the Collaboration, Leadership, and Forward Thinking of Healthcare Education by the Team, for the Team

Chicago, IL and Silver Spring, MD | March 28, 2016

Joint Accreditation for Interprofessional Continuing Education™ is proud to announce a new logo. A mark is also now available to identify [interprofessional continuing education \(IPCE\) providers](#) that have been awarded Joint Accreditation.

[Joint Accreditation for Interprofessional Continuing Education](#) is a collaboration of the Accreditation Council for Continuing Medical Education (ACCME®), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC). The first and only collaboration of its kind, Joint Accreditation establishes the standards for education providers to deliver continuing education planned by the healthcare team for the healthcare team.

Created with input from jointly accredited providers and the continuing education accreditors, both marks are designed to convey the collaboration, leadership, and forward thinking of Joint Accreditation. The logo and mark will serve to promote the value of IPCE to the community of healthcare professionals and other stakeholders.

The logo and the provider mark are similar to communicate a consistent brand. The difference is that the logo for the accreditors, shown on the left below, says Joint Accreditation under the image, while the provider mark, shown on the right, says Jointly Accredited Provider.



JOINT ACCREDITATION™
INTERPROFESSIONAL CONTINUING EDUCATION



JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

“This milestone represents the ongoing growth and success of Joint Accreditation and the commitment of jointly accredited providers to delivering effective, relevant healthcare education by the team, for the team. We thank our jointly accredited providers for their dedication to high-quality IPCE and the work they do every day to make a difference.” — **Graham McMahon, MD, MMSc, President and CEO, Accreditation Council for Continuing Medical Education (ACCME®)**

“The new logo symbolizes that our three accrediting bodies continue to respect our differences while building on our shared values in a concerted effort to facilitate team-based continuing education and collaborative practice through the work of jointly accredited providers. *We* — not *me* — is the essence of our collaboration and the impetus for our new logo.” — **Peter H. Vlasses, PharmD, DSc (Hon), BCPS, FCCP, Executive Director, Accreditation Council for Pharmacy Education (ACPE)**

"Joint Accreditation is the first and only accreditation designed to promote interprofessional collaborative practice in healthcare delivery. Healthcare providers worldwide can trust organizations with this mark to deliver the highest quality, evidence-based continuing education for physicians, pharmacists, and nurses." — **Kathy Chappell, PhD, RN, FAAN, FNAP, Vice President, Accreditation Program and Institute for Credentialing Research, American Nurses Credentialing Center (ANCC)**

Joint Accreditation for Interprofessional Continuing Education™

Launched in 2009, Joint Accreditation for Interprofessional Continuing Education is a collaboration of the Accreditation Council for Continuing Medical Education (ACCME®), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC).

Joint Accreditation promotes interprofessional continuing education (IPCE) specifically designed to improve interprofessional collaborative practice in healthcare delivery. A leading model for interprofessional collaborative practice, Joint Accreditation establishes the standards for education providers to deliver continuing education planned by the healthcare team for the healthcare team.

This innovation promotes interprofessional education that leads to improved healthcare delivery and better patient outcomes. Joint Accreditation enables providers to achieve distinction from three leading healthcare continuing education accreditors; increase operational efficiency, saving time, money, and resources; provide continuing education for physicians, pharmacists, or nurses separately or together; and improve collaboration and reduce hierarchies among healthcare professions.

Jointly accredited continuing education providers must meet rigorous standards for educational quality and independence—including the [Standards for Commercial Support: Standards to Ensure Independence in CME ActivitiesSM](#). With Joint Accreditation for Interprofessional Continuing Education, the ACCME, the ACPE, and the ANCC seek to assure the public that healthcare teams receive education that is designed to be independent, free from commercial bias, based on valid content, and effective in improving the quality and safety of care delivered by the team.

Joint Accreditation Media Inquiries

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Joint Accreditation Eligibility Inquiries

info@jointaccreditation.org

Joint Accreditation Speaking Engagements

Joint Accreditation executive leaders are available for speaking engagements to discuss the opportunities for continuing education to advance interprofessional education and collaborative practice through the Joint Accreditation program. For more information, please contact:

info@jointaccreditation.org.

Accreditation Council for Continuing Medical Education

The Accreditation Council for Continuing Medical Education (ACCME®) is a nonprofit organization based in Chicago that is responsible for accrediting institutions that offer continuing medical education (CME) through a voluntary, self-regulatory system. The ACCME also has a system for recognizing state medical societies as accreditors for local organizations offering CME.

The ACCME's mission is to identify, develop, and promote standards for quality CME that improves healthcare for patients and their communities. There are approximately 1,900 accredited CME providers within the ACCME System that offer more than 147,000 activities each year, comprising more than one million hours of instruction and including more than 25 million interactions with physicians and other healthcare professionals.

The ACCME's member organizations—which represent the profession of medicine and include physician licensing and credentialing bodies—are the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, the Association for Hospital Medical Education, the Council of Medical Specialty Societies, and the Federation of State Medical Boards of the US, Inc.

For more information, visit www.accme.org.

Accreditation Council for Pharmacy Education

ACPE is the national agency for the accreditation of professional degree programs in pharmacy and providers of continuing pharmacy education. In collaboration with the American Society of Health-System Pharmacists, ACPE accredits pharmacy technician education and training programs. ACPE also offers evaluation and certification of professional degree programs internationally. The mission of ACPE is to assure and advance excellence in education for the profession of pharmacy. ACPE is an autonomous and independent agency whose Board of Directors is derived through the American

Association of Colleges of Pharmacy (ACCP), the American Pharmacists Association (APhA), the National Association of Boards of Pharmacy (NABP), and the American Council on Education (ACE). To learn more about ACPE, visit www.acpe-accredit.org or follow us on Facebook, LinkedIn, and Twitter.

American Nurses Credentialing Center (ANCC)

The mission of the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA), is to promote excellence in nursing and health care globally through credentialing programs. ANCC's internationally renowned credentialing programs certify and recognize individual nurses in specialty practice areas. ANCC recognizes healthcare organizations that promote nursing excellence and quality patient outcomes while providing safe, positive work environments. ANCC also accredits healthcare organizations that provide and approve continuing nursing education. Joint Accreditation for Interprofessional Continuing Education™ is the only unified process for organizations to be simultaneously accredited to provide medicine, pharmacy, and nursing continuing education. www.nursecredentialing.org

Board and Other Pharmacist Appointments

Appointed to	Appointee	Date appointed	Term expires	Appointed by	Notes
Council on Optometric Non-topical Formulary	Bill Boyce	Dec 2001	Dec 2015	Board of Pharmacy	Two year terms (no limit) ORS 683.240
Council on Naturopathic Physicians Formulary	Justin Bednar Natalie Gustafson John Block	Jun 2013 Aug 2011 Jun 2006	Jun 2017 Jun 2017 Dec 2016	Board of Pharmacy Board of Pharmacy Naturopathic Formulary Council	Two year terms (no limit) ORS 685.145
Rural Health Coordinating Council	Mike Patrick	Jun 2004	Jun 2016	Board of Pharmacy	Two year terms (no limit) ORS 442.490
Nursing Home Administrators Board	Nicolle King Deering	Feb 2010	Jun 2015	Governor	Three year term , two term limit ORS 678.800
Oregon Patient Safety Commission Board of Directors	Maureen Ober	Oct 2014	Sept. 2018	Governor (Subject to Senate confirmation)	Four year term, two term limit ORS 442.830
Pain Management Commission	Michele Koder	2014	July 2018	Director of Human Services	Four year terms (no limit) ORS 409.520
Immunization Policy Advisory Team	Linda Howrey	2006	None	DHS Immunization Program Manager	Indefinite appointment

Rural Health Coordinating Council Applicant Summary

Amy Baker (#C3)

- License No: RPH-0014019
- Issue Date: 04/24/14
- Discipline: No
- Believes that pharmacies can better assist rural patients and that clinical pharmacists can serve a vital need to remote Family Planning clinics.
- Director of a Rogue Community Health in Southern Oregon. Their pharmacy serves three school-based health centers and five clinics, two of which are rural.
- She has held a variety of positions in multiple professional committees.
- She has also contributed to two publications and has given presentations for several conferences and forums.

Hope Murphy (#C4)

- License No. RPH-0011332
- Issue Date: 07/29/08
- Discipline: No
- Believes she would be a productive member of the council in having specific training to evaluate data and being able to share the needs of her patients. Brings an interest in developing collaborative information with her personal knowledge of the population she serves.
- Pharmacist at Klamath Open Door Family Practice Clinic in Klamath Falls.
- She has given multiple presentations and has contributed to publications.

Dianna Pimlott (#C5)

- License No. RPH-0009206
- Issue Date: 07/01/1997
- Discipline: No
- Director of Pharmacy Services at PeaceHealth in Florence.
- Has held several committee appointment positions and has received many awards as well as professional recognition.
- Appointed a member of the Oregon Board of Pharmacy for two terms.

Evon Anukam (#C6)

- License No. RPH-0010023
- Issue Date: 07/27/01
- Discipline: No
- Serving on the council interests her because she is an advocate for policies that will eliminate health disparities in rural settings.
- Clinical Pharmacist at Providence Milwaukie Hospital in Milwaukie.
- Founder and team leader of Team Africa Mission International (www.teamafricamission.org). Leads annual medical mission trips of 25-30 health care professionals on a two week mission trip to third world African countries.
- She has been given mission leadership and community service awards.

Leanne Yantis (#C7)

- License No. RPH-0011104
- Issue Date: 08/20/07
- Discipline: No
- Believes she would add value to the council based on her education and experience as a practicing pharmacist in a rural community for the last nine years. She expressed a desire to work collaboratively with others to help rural communities. Pharmacist Leanne Yantis also desires to take what she would learn on the council and utilize it in her work on Curry Community Health's Board of Directors and as a community pharmacist. She would also like to share her work on the council with colleagues to help demonstrate the importance of collaboration with other health professional to address the unmet health needs of rural communities.
- Co-owner and pharmacist at Corner Drug Store in Gold Beach. She is also a pharmacist consultant for Rush Surgery Center and a per diem clinical pharmacist for Curry General Hospital.
- Member of the Curry Community Health Board of Directors.
- Recommendation letter.

John Begert (#C8)

- License No. RPH-0013721
- Issue Date: 08/20/13
- Discipline: No
- Has a large passion for development and betterment of healthcare in rural areas.
- Assistant Professor at Pacific University School of Pharmacy.
- Composed a variety of publications and projects and has given many presentations and posters for multiple topics.
- John had a post-graduate two year residency, as well as an academic fellowship at Virginia Garcia Memorial Health Clinic.

Council on Optometric Non-Topical Formulary Applicant Summary

Christopher de Guzman (#C9)

- License No: RPH-0012738
- Issue Date: 08/15/11
- Discipline: No
- States that he would bring a unique skill set to the council that would represent the local pharmacy community well.
- Has dealt with formulary management on a daily basis and is experienced in managed care. Believes that his managed care perspective can help providers to understand the process after a medication on the formulary is prescribed for a patient.
- Employed as Pharmacist-in-Charge at Providence Health Plan. Previously worked for Lloyd Center Compounding Pharmacy (3 years), Target Pharmacy (2 years) and Moda (1 month).

**BOARDS & COMMISSIONS
ETHICS LAW SUMMARY**

DISCLAIMER: THIS IS ONLY A GENERALIZED SUMMARY AND IS NOT INTENDED TO BE LEGAL ADVICE. PLEASE REVIEW OREGON REVISED STATUTES (ORS) CHAPTER 244 AND CONSULT AN ATTORNEY OR THE OREGON GOVERNMENT ETHICS COMMISSION (www.oregon.gov/ogec; 503-378-5105) FOR ADVICE ABOUT YOUR SPECIFIC SITUATION.

PROHIBITED USE OF OFFICE

You may not use or attempt to use the position you hold as a public official to obtain a financial benefit, if the opportunity for the financial benefit would not otherwise be available but for you holding the position or office. The financial benefit prohibited can be either an opportunity for gain or to avoid an expense.

Not only is a public official prohibited from using the position as a public official to receive certain financial benefits, but the public official is prohibited from using or attempting to use the position as a public official to obtain financial benefits for a relative or a member of the public official's household. Also prohibited is the use or attempted use of the public official position to obtain financial benefits for a business with which the public official, a relative, or a member of the public official's household is associated.

You may have access to or manage information that is confidential and not available to members of the general public. Oregon Government Ethics law specifically prohibits public officials from attempting to use confidential information gained because of the position held or by carrying out assigned duties to further the public official's personal gain.

The following examples are offered to illustrate what may constitute prohibited use or attempted use:

- A board member votes on a contract obligating his agency to pay for janitorial services provided by a business owned by a relative of the board member.
- A commissioner approves her own request for reimbursement of personal expenses she incurred when conducting official business.

CONFLICTS OF INTEREST

In brief, a public official is met with a conflict of interest when participating in official action which could or would result in a financial benefit or detriment to the public official, a relative of the public official or a business with which either is associated.

Oregon Government Ethics law identifies two types of conflicts of interest. The difference between an actual conflict of interest and a potential conflict of interest is determined by the words "would" and "could." A public official is met with an **actual** conflict of interest when the public official participates in action that **would** affect the financial interest of the official, the official's relative or a business with which the official or a relative of the official is associated. A public official is met with a **potential** conflict of interest when the public official participates in action that **could** affect the financial interest of the official, a relative of that official or a business with which the official or the relative of that official is associated.

You must publicly disclose the nature of a conflict of interest on each occasion that you are met with that conflict. Elected or appointed members of boards and commissions must use the following methods of handling conflicts:

- **Potential Conflict of Interest:** Following the public announcement, you may participate in official action on the issue that gave rise to the conflict of interest.
- **Actual Conflict of Interest:** Following the public announcement, you must refrain from further participation in official action (i.e. debate, discussion or voting) on the issue that gave rise to the conflict of interest.

GIFTS

Receiving Gifts: As a public official, you may not solicit or receive any gift or gifts with an aggregate value in excess of \$50 per calendar year from a single source that could reasonably be known to have a legislative or administrative interest in any matter subject to the decisions or votes you make in your official capacity.

- Your relatives and members of your household are also bound by this law and cannot solicit or receive gifts worth more than \$50 per calendar year from a source that could reasonably be known to have a legislative or administrative interest in the decisions or votes you make in your official capacity.
- “Legislative or administrative interest” means an economic interest, distinct from that of the general public, in any matter subject to the decision or vote of the public official acting in the public official’s capacity as a public official.

Gift Exceptions: ORS 244.020(6)(b) details a list of exceptions to the definition of gifts, the application of which can be highly dependent on the specific fact circumstances of your situation. For more information about these exceptions, please review statute and consult the Oregon Government Ethics Commission. Some of these exceptions include:

- **Gifts From Relatives:** Gift limits do not apply to gifts you receive from people you live with or certain relatives (including your spouse, domestic partner, children, siblings and parents).
- **Political Contributions:** Gift limits do not apply to political contributions.
- **Food & Beverage Exceptions:** Generally, the gift limits apply to food and drink, but there are some exceptions:
 - You may accept food and beverage, as well as the cost of admission, when representing your public body at a reception, meal or meeting held by an organization.
 - You may accept incidental food and beverage that is free to everyone at a reception (does not include plated, sit-down meals).
- **Food, Lodging & Travel Exceptions:** Generally, the gift limits apply to gifts of food, lodging and travel, but there are some exceptions (sanctioning or approval by your public body may be required in advance):
 - You may accept the cost of food, lodging & travel when attending a convention, fact-finding mission or trip, conference or other meeting if you are scheduled to deliver a speech, make a presentation, participate on a panel or otherwise represent your public body, if the expenses are paid for by:
 - Federal, state or local government;
 - Tribal government;
 - Membership organization to which a public body in Oregon pays dues; or
 - 501(c)(3) nonprofit organization.
 - You may accept the cost of food, lodging & travel when representing your public body:
 - On an officially sanctioned trade-promotion or fact-finding mission; or
 - In officially designated negotiations, or economic development activities.
 - You may receive expenses provided by another public official for travel inside this state to or from an event that bears a relationship to the receiving public official’s office and at which you participate in an official capacity.
- **Entertainment Exceptions:** Generally, the gift limits apply to gifts of entertainment, but there are some exceptions:
 - Entertainment that is incidental to the main purpose of another event (e.g. the guitarist in the corner).
 - Entertainment provided to you when you are acting in your official capacity for a ceremonial purpose (e.g. first pitch at a baseball game, ribbon-cutting ceremony).

REPORTING CONFLICTS OF INTEREST

It is an ethical duty of a public official to identify and respond appropriately to any *actual* or *potential* conflict of interest. A *potential* conflict of interest arises when a public official may take any action or make any decision or recommendation in the capacity of a public official that *could* be to the private pecuniary *benefit or detriment* of the public official, a business with which the public official is associated, a relative of the public official, or a business with which a relative of the public official is associated. An *actual* conflict exists when the decision, recommendation or action *would* result in a private pecuniary benefit.

“Relative” means the spouse of the public official, any children of the public official or of the spouse, and brothers, sisters or parents of the public official or of the public official’s spouse. A “business with which the public official is associated” means (a) any private business or organization of which the person or the person’s relative is a director, officer, owner, employee or agent or any private business/corporation of which the public official or relative owns or has owned a form of equity interest worth \$1,000 or more at any point in the preceding calendar year; (b) any publicly held corporation in which the person or the person’s relative owns or has owned \$100,000 or more in equity interest at any point in the preceding calendar year; and (c) any public corporation of which the person or the person’s relative is a director or officer.

STEPS EVERY PUBLIC OFFICIAL WHO IS AN APPOINTED MEMBER OF A BOARD OR COMMISSION SHOULD TAKE BEFORE PARTICIPATING IN ANY ACTION, RECOMMENDATION OR DECISION

- (1) Determine whether a *potential* or *actual* conflict of interest exists. If the action *could not* result in a financial benefit or avoidance of a financial detriment to you or a relative or business with which you are or a relative is associated, proceed with the action.
- (2) If the action involves a *potential* or *actual* conflict of interest, determine if an exception applies. (See below).
- (3) For a *potential* conflict you must publicly announce and describe the nature of the conflict. You may then participate in the action. Public announcement must be made on each separate occasion the matter giving rise to the conflict is discussed or debated.
- (4) For an *actual* conflict, you must publicly announce and describe the nature of the conflict. You may NOT participate in the action. However, you may vote on the action if your vote is required to take action, but you may not participate in the discussion or debate. Again, public announcement must be made on each separate occasion.
- (5) Additionally, as part of the code of ethics, a public official shall not use or attempt to use official position to obtain financial gain or avoidance of financial detriment that would not otherwise be available but for the official’s holding of the position/office.

EXCEPTIONS: You need not declare a conflict if the financial benefit or detriment arises from:

- (a) an interest or membership in a business, industry, or occupation that is a prerequisite to the holding by the person of the office or position, or
- (b) membership in or membership on the board of directors of a nonprofit corporation that is tax-exempt under section 501(c) of the Internal Revenue Code, or
- (c) any action which would affect to the same degree a “class” consisting of all inhabitants of the state, or a smaller class or group. Only the Govt. Standards and Practices Commission can determine what constitutes a “class,” so it is best to ask.

CONTROLLED SUBSTANCES

- ALPHABETICAL ORDER -

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
1-(1-Phenylcyclohexyl)pyrrolidine	7458	I	N	PCPy, PHP, rolicyclidine
1-(2-Phenylethyl)-4-phenyl-4-acetoxypiperidine	9663	I	Y	PEPAP, synthetic heroin
1-[1-(2-Thienyl)cyclohexyl]piperidine	7470	I	N	TCP, tenocyclidine
1-[1-(2-Thienyl)cyclohexyl]pyrrolidine	7473	I	N	TCPy
13Beta-ethyl-17beta-hydroxygon-4-en-3-one	4000	III	N	
17Alpha-methyl-3alpha,17beta-dihydroxy-5alpha-androstane	4000	III	N	
17Alpha-methyl-3beta,17beta-dihydroxy-5alpha-androstane	4000	III	N	
17Alpha-methyl-3beta,17beta-dihydroxyandrost-4-ene	4000	III	N	
17Alpha-methyl-4-hydroxynandrolone (17alpha-methyl-4-hydroxy-17beta-hydroxyestr-4-en-3-one)	4000	III	N	
17Alpha-methyl-delta1-dihydrotestosterone (17beta-hydroxy-17alpha-methyl-5alpha-androst-1-en-3-one)	4000	III	N	17-Alpha-methyl-1-testosterone
19-Nor-4,9(10)-androstadienedione	4000	III	N	
19-Nor-4-androstenediol (3beta,17beta-dihydroxyestr-4-ene; 3alpha,17beta-dihydroxyestr-4-ene)	4000	III	N	
19-Nor-4-androstenedione (estr-4-en-3,17-dione)	4000	III	N	
19-Nor-5-androstenediol (3beta,17beta-dihydroxyestr-5-ene; 3alpha,17beta-dihydroxyestr-5-ene)	4000	III	N	
19-Nor-5-androstenedione (estr-5-en-3,17-dione)	4000	III	N	
1-Androstenediol (3beta,17beta-dihydroxy-5alpha-androst-1-ene; 3alpha,17beta-dihydroxy-5alpha-androst-1-ene)	4000	III	N	
1-Androstenedione (5alpha-androst-1-en-3,17-dione)	4000	III	N	
1-Methyl-4-phenyl-4-propionoxypiperidine	9661	I	Y	MPPP, synthetic heroin
1-Phenylcyclohexylamine	7460	II	N	PCP precursor
1-Piperidinocyclohexanecarbonitrile	8603	II	N	PCC, PCP precursor
2-(2,5-Dimethoxy-4-(n)-propylphenyl) ethanamine (2C-P)	7524	I	N	2C-P
2-(2,5-Dimethoxy-4-ethylphenyl) ethanamine (2C-E)	7509	I	N	2C-E (Positional Isomer: 2,5-Dimethoxy-3,4-dimethylphenethylamine (2C-G))
2-(2,5-Dimethoxy-4-methylphenyl) ethanamine (2C-D)	7508	I	N	2C-D
2-(2,5-Dimethoxy-4-nitro-phenyl) ethanamine (2C-N)	7521	I	N	2C-N
2-(2,5-Dimethoxyphenyl) ethanamine (2C-H)	7517	I	N	2C-H
2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl) ethanamine (25B-NBOMe)	7536	I	N	25B-NBOMe, 2C-B-NBOMe, 25B, Cimbi-36
2-(4-Chloro-2,5-dimethoxyphenyl) ethanamine (2C-C)	7519	I	N	2C-C

Abbreviations: "NARC"= Narcotic, "CSA SCH"= CSA Schedule

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl) ethanamine (25C-NBOMe)	7537	I	N	25C-NBOMe, 2C-C-NBOMe, 25C, Cimbi-82
2-(4-Ethylthio-2,5-dimethoxyphenyl) ethanamine (2C-T-2)	7385	I	N	2C-T-2
2-(4-Iodo-2,5-dimethoxyphenyl) ethanamine (2C-I)	7518	I	N	2C-I
2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl) ethanamine (25I-NBOMe)	7538	I	N	25I-NBOMe, 2C-I-NBOMe, 25I, Cimbi-5
2-(4-Isopropylthio)-2,5-dimethoxyphenyl) ethanamine (2C-T-4)	7532	I	N	2C-T-4 (Positional Isomer: 2,5-Dimethoxy-4-ethylthioamphetamine (Aleph-2))
2,5-Dimethoxy-4-(n)-propylthiophenethylamine (2C-T-7)	7348	I	N	2C-T-7 (Positional Isomer: 2,5-Dimethoxy-4-ethylthioamphetamine (Aleph-2))
2,5-Dimethoxy-4-ethylamphetamine	7399	I	N	DOET
2,5-Dimethoxyamphetamine	7396	I	N	DMA, 2,5-DMA
3,4,5-Trimethoxyamphetamine	7390	I	N	TMA (Positional Isomers: 2,4,5-Trimethoxyamphetamine (TMA-5), 2,4,6-Trimethoxyamphetamine (TMA-6))
3,4-Methylenedioxyamphetamine	7400	I	N	MDA, Love Drug
3,4-Methylenedioxyamphetamine	7405	I	N	MDMA, Ecstasy, XTC
3,4-Methylenedioxy-N-ethylamphetamine	7404	I	N	N-ethyl MDA, MDE, MDEA
3Alpha,17beta-dihydroxy-5alpha-androstane	4000	III	N	
3Beta,17beta-dihydroxy-5alpha-androstane	4000	III	N	
3-Fluoro-N-methylcathinone (3-FMC)	1233	I	N	1-(3-fluorophenyl)-2-(methylamino)propan-1-one) (Positional isomer: 2-FMC)
3-Methylfentanyl	9813	I	Y	China White, fentanyl
3-Methylthiofentanyl	9833	I	Y	Chine White, fentanyl
4-Androstenediol (3beta,17beta-dihydroxy-androst-4-ene)	4000	III	N	4-AD
4-Androstenedione (androst-4-en-3,17-dione)	4000	III	N	
4-Anilino-N-phenethyl-4-piperidine (ANPP)	8333	II	N	ANPP
4-Bromo-2,5-dimethoxyamphetamine	7391	I	N	DOB, 4-bromo-DMA
4-Bromo-2,5-dimethoxyphenethylamine	7392	I	N	2C-B, Nexus, has been sold as Ecstasy, i.e. MDMA
4-Dihydrotestosterone (17beta-hydroxyandrost-3-one)	4000	III	N	Anabolex, Andractim, Pesomax, Stanolone
4-Fluoro-N-methylcathinone (4-FMC)	1238	I	N	flephedrone; 1-(4-fluorophenyl)-2-(methylamino)propan-1-one) (Positional isomer: 2-FMC)
4-Hydroxy-19-nortestosterone (4,17beta-dihydroxyestr-4-en-3-one)	4000	III	N	
4-Hydroxytestosterone (4,17beta-dihydroxyandrost-4-en-3-one)	4000	III	N	
4-Methoxyamphetamine	7411	I	N	PMA
4-Methyl-2,5-dimethoxyamphetamine	7395	I	N	DOM, STP (Positional Isomer: 2,5-Dimethoxy-3,4-dimethylphenethylamine (2C-G))

Abbreviations: "NARC"= Narcotic, "CSA SCH"= CSA Schedule

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
4-Methyl-alpha-pyrrolidinopropiophenone (4-MePPP)	7498	I	N	MePPP, 4-methyl- α -pyrrolidinopropiophenone, 1-(4-methylphenyl)-2-(pyrrolidin-1-yl)-propan-1-one
4-Methylaminorex (cis isomer)	1590	I	N	U4Euh, McN-422
4-Methyl-N-ethylcathinone (4-MEC)	1249	I	N	2-(ethylamino)-1-(4-methylphenyl)propan-1-one)(Positional Isomers:3-methylethcathinone (3-MEC), 4-ethylmethcathinone (4-EMC), 4-methylbuphedrone (4-MeMABP;4-MeBP), 3,4-dimethylmethcathinone(3,4-DMMC),N-ethylbuphedrone (NEB),N-ethyl-N-methylcathinone(EMC))
5-Androstenediol (3beta,17beta-dihydroxy-androst-5-ene)	4000	III	N	
5-Androstenedione (androst-5-en-3,17-dione)	4000	III	N	
5-Flouro-UR-144 and XLR11 [1-(5-Flouro-pentyl)1H-indol-3-yl][2,2,3,3-tetramethylcyclopropyl)methanone	7011	I	N	5-Flouro-UR-144, XLR-11 and XLR11
5F-PB-22 (Quinolin-8-yl 1-(5-fluoropentyl)-1H-indole-3-carboxylate)	7225	I	N	5-Flouro-PB-22; 5F-PB-22
5-Methoxy-3,4-methylenedioxyamphetamine	7401	I	N	MMDA
5-Methoxy-N,N-diisopropyltryptamine	7439	I	N	5-MeO-DIPT (Positional Isomer: 5-Methoxy-N,N-dipropyltryptamine (5-MeO-DPT))
5-Methoxy-N,N-dimethyltryptamine	7431	I	N	5-MeO-DMT (Positional Isomer: 4-Methoxy-N,N-dimethyltryptamine (4-MeO-DMT))
AB-CHMINACA (N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide	7031	I	N	AB-CHMINACA
AB-FUBINACA (N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide)	7012	I	N	AB-FUBINACA
AB-PINACA (N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide)	7023	I	N	AB-PINACA
Acetorphine	9319	I	Y	
Acetyl Fentanyl (N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide)	9821	I	Y	
Acetyl-alpha-methylfentanyl	9815	I	Y	
Acetyldihydrocodeine	9051	I	Y	Acetylcodone
Acetylmethadol	9601	I	Y	Methadyl acetate
ADB-PINACA (N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide)	7035	I	N	ADB-PINACA
Alfaxalone	2731	IV	N	Alfaxan, 5 α -pregnan-3 α -ol-11,20-dione
Alfentanil	9737	II	Y	Alfenta
Allylprodine	9602	I	Y	
Alphacetylmethadol except levo-alphacetylmethadol	9603	I	Y	
Alpha-ethyltryptamine	7249	I	N	ET, Trip
Alphameprodine	9604	I	Y	
Alphamethadol	9605	I	Y	

Abbreviations: "NARC"= Narcotic, "CSA SCH"= CSA Schedule

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Alpha-methylfentanyl	9814	I	Y	China White, fentanyl
Alpha-methylthiofentanyl	9832	I	Y	China White, fentanyl
Alpha-methyltryptamine	7432	I	N	AMT (Positional Isomer: N-Methyltryptamine)
Alphaprodine	9010	II	Y	Nisentil
alpha-pyrrolidinobutiophenone (α-PBP)	7546	I	N	1-phenyl-2-(pyrrolidin-1-yl)butan-1-one
alpha-pyrrolidinopentiophenone (α-PVP)	7545	I	N	α-pyrrolidinovalerophenone, 1-phenyl-2- (pyrrolidin-1-yl)pentan-1-one)(Positional isomers: 4-methyl-α-pyrrolidinobutiophenone (4-MePBP), 1-phenyl-2-(piperidin-1-yl)butan-1-one)
Alprazolam	2882	IV	N	Xanax
AM-2201 (1-(5-Fluoropentyl)-3-(1-naphthoyl) indole)	7201	I	N	AM-2201
AM-694 (1-(5-Fluoropentyl)-3-(2-iodobenzoyl) indole)	7694	I	N	AM-694
Aminorex	1585	I	N	has been sold as methamphetamine
Amobarbital	2125	II	N	Amytal, Tuinal
Amobarbital & noncontrolled active ingred.	2126	III	N	
Amobarbital suppository dosage form	2126	III	N	
Amphetamine	1100	II	N	Dexedrine, Adderall, Obetrol
Anabolic steroids	4000	III	N	"Body Building" drugs
Androstenedione (5alpha-androstan-3,17-dione)	4000	III	N	
Anileridine	9020	II	Y	Leritine
APINACA and AKB48 N-(1-Adamantyl)-1-pentyl-1H-indazole-3-carboxamide	7048	I	N	APINACA and AKB48
Aprobarbital	2100	III	N	Alurate
Barbital	2145	IV	N	Veronal, Plexonal, barbitone
Barbituric acid derivative	2100	III	N	Barbiturates not specifically listed
Benzethidine	9606	I	Y	
Benzphetamine	1228	III	N	Didrex, Inapetyl
Benzylmorphine	9052	I	Y	
Betacetylmethadol	9607	I	Y	
Beta-hydroxy-3-methylfentanyl	9831	I	Y	China White, fentanyl
Beta-hydroxyfentanyl	9830	I	Y	China White, fentanyl
Betameprodine	9608	I	Y	
Betamethadol	9609	I	Y	
Betaprodine	9611	I	Y	
Bezitamide	9800	II	Y	Burgodin
Bolasterone (7alpha,17alpha-dimethyl-17beta-hydroxyandrost-4-en-3-one)	4000	III	N	
Boldenone (17beta-hydroxyandrost-1,4-diene-3-one)	4000	III	N	Equipoise, Parenabol, Vebonol, dehydrotestosterone
Boldione	4000	III	N	

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SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Bromazepam	2748	IV	N	Lexotan, Lexatin, Lexotanol
Bufotenine	7433	I	N	Mappine, N,N-dimethylserotonin
Buprenorphine	9064	III	Y	Buprenex, Temgesic, Subutex, Suboxone
Butabarbital (secbutabarbital)	2100	III	N	Butisol, Butibel
Butalbital	2100	III	N	Fiorinal, Butalbital with aspirin
Butobarbital (butethal)	2100	III	N	Soneryl (UK)
Butorphanol	9720	IV	N	Stadol, Stadol NS, Torbugesic, Torbutrol
Butylone	7541	I	N	bk-MBDB; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one (Positional Isomers: ethylone (bk-MDEA; MDEC), dimethylone (bk-MDDMA; MDDMC))
Calusterone (7beta,17alpha-dimethyl-17beta-hydroxyandrost-4-en-3-one)	4000	III	N	Methosarb
Camazepam	2749	IV	N	Albego, Limpidon, Paxor
Carfentanil	9743	II	Y	Wildnil
Carisoprodol	8192	IV	N	Soma
Cathine	1230	IV	N	Constituent of "Khat" plant, (+)-norpseudoephedrine
Cathinone	1235	I	N	Constituent of "Khat" plant
Chloral betaine	2460	IV	N	Beta Chlor
Chloral hydrate	2465	IV	N	Noctec
Chlordiazepoxide	2744	IV	N	Librium, Libritabs, Limbitrol, SK-Lygen
Chlorhexadol	2510	III	N	Mechloral, Mecoral, Medodorm, Chloralodol
Chlorphentermine	1645	III	N	Pre-Sate, Lucofen, Apsedon, Desopimon
Clobazam	2751	IV	N	Urbadan, Urbanyl
Clonazepam	2737	IV	N	Klonopin, Clonopin
Clonitazene	9612	I	Y	
Clorazepate	2768	IV	N	Tranxene
Clortermine	1647	III	N	Voranil
Clostebol (4-chloro-17beta-hydroxyandrost-4-en-3-one)	4000	III	N	Alfa-Trofodermin, Clostene, 4-chlorotestosterone
Clotiazepam	2752	IV	N	Trecalmo, Rize, Clozan, Veratran
Cloxazolam	2753	IV	N	Akton, Lubalix, Olcadil, Sepazon
Coca Leaves	9040	II	Y	
Cocaine	9041	II	Y	Methyl benzoylcegonine, Crack
Codeine	9050	II	Y	Morphine methyl ester, methyl morphine
Codeine & isoquinoline alkaloid 90 mg/du	9803	III	Y	Codeine with papaverine or noscapine
Codeine combination product 90 mg/du	9804	III	Y	Empirin, Fiorinal, Tylenol, ASA or APAP w/codeine
Codeine methylbromide	9070	I	Y	
Codeine preparations - 200 mg/(100 ml or 100 gm)		V	Y	Cosanyl, Robitussin A-C, Cheracol, Cerose, Pediacof

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Codeine-N-oxide	9053	I	Y	
CP-47,497 (5-(1,1-Dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol)	7297	I	N	CP-47,497
CP-47,497 C8 Homologue (5-(1,1-Dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol)	7298	I	N	CP-47,497 C8 Homologue
Cyprenorphine	9054	I	Y	
Dehydrochloromethyltestosterone (4-chloro-17beta-hydroxy-17alpha-methylandro-1,4-dien-3-one)	4000	III	N	Oral-Turinabol
Delorazepam	2754	IV	N	
Delta1-dihydrotestosterone (17beta-hydroxy-5alpha-androst-1-en-3-one)	4000	III	N	1-Testosterone
Desomorphine	9055	I	Y	
Desoxymethyltestosterone	4000	III	N	
Dexfenfluramine	1670	IV	N	Redux
Dextromoramide	9613	I	Y	Palfium, Jetrium, Narcolo
Dextropropoxyphene dosage forms	9278	IV	Y	Darvon, propoxyphene, Darvocet, Propacet
Dextropropoxyphene, bulk (non-dosage forms)	9273	II	Y	Propoxyphene
Diampromide	9615	I	Y	
Diazepam	2765	IV	N	Valium, Diastat
Dichloralphenazone	2467	IV	N	Midrin, dichloralantipyrene
Diethylpropion	1610	IV	N	Tenuate, Tepanil
Diethylthiambutene	9616	I	Y	
Diethyltryptamine	7434	I	N	DET, N,N-Diethyltryptamine (Positional Isomer: N-Methyl-N-isopropyltryptamine (MiPT))
Difenoxin	9168	I	Y	Lyspafen
Difenoxin 1 mg/25 ug AtSO4/du	9167	IV	Y	Motofen
Difenoxin preparations - 0.5 mg/25 ug AtSO4/du		V	Y	Motofen
Dihydrocodeine	9120	II	Y	Didrate, Parzone
Dihydrocodeine combination product 90 mg/du	9807	III	Y	Synalgos-DC, Compal
Dihydrocodeine preparations 100mg/(100 ml or 100 gm)		V	Y	Cophene-S, various others
Dihydroetorphine	9334	II	Y	DHE
Dihydromorphine	9145	I	Y	
Dimenoxadol	9617	I	Y	
Dimepheptanol	9618	I	Y	
Dimethylthiambutene	9619	I	Y	
Dimethyltryptamine	7435	I	N	DMT
Dioxaphetyl butyrate	9621	I	Y	
Diphenoxylate	9170	II	Y	

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Diphenoxylate preparations 2.5 mg/25 ug AtSO4		V	Y	Lomotil, Logen
Dipipanone	9622	I	Y	Dipipan, phenylpiperone HCl, Diconal, Wellconal
Dronabinol (synthetic) in sesame oil in soft gelatin capsule as approved by FDA	7369	III	N	Marinol, synthetic THC in sesame oil/soft gelatin as approved by FDA
Drostanolone (17beta-hydroxy-2alpha-methyl-5alpha-androstan-3-one)	4000	III	N	Drolban, Masterid, Permastril
Drotebanol	9335	I	Y	Metebanyl, oxymethebanol
Ecgonine	9180	II	Y	Cocaine precursor, in Coca leaves
Eluxadoline	9725	IV	N	VIBERZI
Embutramide	2020	III	N	Tributane
Estazolam	2756	IV	N	ProSom, Domnamid, Eurodin, Nuctalon
Ethchlorvynol	2540	IV	N	Placidyl
Ethinamate	2545	IV	N	Valmid, Valamin
Ethyl loflazepate	2758	IV	N	
Ethylestrenol (17alpha-ethyl-17beta-hydroxyestr-4-ene)	4000	III	N	Maxibolin, Orabolin, Durabolin-O, Duraboral
Ethylmethylthiambutene	9623	I	Y	
Ethylmorphine	9190	II	Y	Dionin
Ethylmorphine combination product 15 mg/du	9808	III	Y	
Ethylmorphine preparations 100 mg/(100 ml or 100 gm)		V	Y	
Etonitazene	9624	I	Y	
Etorphine (except HCl)	9056	I	Y	
Etorphine HCl	9059	II	Y	M 99
Etoxeridine	9625	I	Y	
Ezogabine	2779	V	N	Potiga
Fencamfamin	1760	IV	N	Reactivan
Fenethylline	1503	I	N	Captagon, amfetyline, ethyltheophylline amphetamine
Fenfluramine	1670	IV	N	Pondimin, Ponderal
Fenproporex	1575	IV	N	Gacilin, Solvolip
Fentanyl	9801	II	Y	Duragesic, Oralet, Actiq, Sublimaze, Innovar
Fludiazepam	2759	IV	N	
Flunitrazepam	2763	IV	N	Rohypnol, Narcozep, Darkene, Roipnol
Fluoxymesterone (9-fluoro-17alpha-methyl-11beta,17beta-dihydroxyandrost-4-en-3-one)	4000	III	N	Anadroid-F, Halotestin, Ora-Testryl
Flurazepam	2767	IV	N	Dalmane
Formebolone (2-formyl-17alpha-methyl-11alpha,17beta-dihydroxyandrost-1,4-dien-3-one)	4000	III	N	Esiclone, Hubernol
Fospropofol	2138	IV	N	Lusedra
Furazabol (17alpha-methyl-17beta-hydroxyandrostano[2,3-c]-furan)	4000	III	N	Frazalon, Miotolon, Qu Zhi Shu

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Furethidine	9626	I	Y	
Gamma Hydroxybutyric Acid	2010	I	N	GHB, gamma hydroxybutyrate, sodium oxybate
Gamma Hydroxybutyric Acid preparations	2012	III	N	Xyrem
Glutethimide	2550	II	N	Doriden, Dorimide
Halazepam	2762	IV	N	Paxipam
Haloxazolam	2771	IV	N	
Heroin	9200	I	Y	Diacetylmorphine, diamorphine
Hydrocodone	9193	II	Y	dihydrocodeinone
Hydromorhinol	9301	I	Y	
Hydromorphone	9150	II	Y	Dilaudid, dihydromorphinone
Hydroxypethidine	9627	I	Y	
Ibogaine	7260	I	N	Constituent of "Tabernanthe iboga" plant
Isomethadone	9226	II	Y	Isoamidone
JWH-018 (also known as AM678) (1-Pentyl-3-(1-naphthoyl)indole)	7118	I	N	JWH-018 and AM-678
JWH-019 (1-Hexyl-3-(1-naphthoyl)indole)	7019	I	N	JWH-019
JWH-073 (1-Butyl-3-(1-naphthoyl)indole)	7173	I	N	JWH-073
JWH-081 (1-Pentyl-3-(1-(4-methoxynaphthoyl) indole)	7081	I	N	JWH-081
JWH-122 (1-Pentyl-3-(4-methyl-1-naphthoyl) indole)	7122	I	N	JWH-122
JWH-200 (1-[2-(4-Morpholinyl)ethyl]-3-(1-naphthoyl)indole)	7200	I	N	JWH-200
JWH-203 (1-Pentyl-3-(2-chlorophenylacetyl) indole)	7203	I	N	JWH-203
JWH-250 (1-Pentyl-3-(2-methoxyphenylacetyl) indole)	6250	I	N	JWH-250
JWH-398 (1-Pentyl-3-(4-chloro-1-naphthoyl) indole)	7398	I	N	JWH-398
Ketamine	7285	III	N	Ketaset, Ketalar, Special K, K
Ketazolam	2772	IV	N	Anxon, Loftran, Solatran, Contamex
Ketobemidone	9628	I	Y	Cliradon
Lacosamide	2746	V	N	Vimpat
Levo-alphaacetylmethadol	9648	II	Y	LAAM, long acting methadone, levomethadyl acetate
Levomethorphan	9210	II	Y	
Levomoramide	9629	I	Y	
Levophenacymorphan	9631	I	Y	
Levorphanol	9220	II	Y	Levo-Dromoran
Lisdexamfetamine	1205	II	N	Vyvanse
Loprazolam	2773	IV	N	
Lorazepam	2885	IV	N	Ativan
Lorcaserin	1625	IV	N	Belviq
Lormetazepam	2774	IV	N	Noctamid

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Lysergic acid	7300	III	N	LSD precursor
Lysergic acid amide	7310	III	N	LSD precursor
Lysergic acid diethylamide	7315	I	N	LSD, lysergide
MAB-CHMINACA (N-(1-amino-3,3dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide)	7032	I	N	MAB-CHMINACA and ADB-CHMINACA
Marihuana	7360	I	N	Cannabis, marijuana
Mazindol	1605	IV	N	Sanorex, Mazanor
MDPV (3,4-Methylenedioxypropylvalerone)	7535	I	N	MDPV
Mebutamate	2800	IV	N	Capla
Mecloqualone	2572	I	N	Nubarene
Medazepam	2836	IV	N	Nobrium
Mefenorex	1580	IV	N	Anorexic, Amexate, Doracil, Pondinil
Meperidine	9230	II	Y	Demerol, Mepergan, pethidine
Meperidine intermediate-A	9232	II	Y	Meperidine precursor
Meperidine intermediate-B	9233	II	Y	Meperidine precursor, normeperidine
Meperidine intermediate-C	9234	II	Y	Meperidine precursor
Mephedrone (4-Methyl-N-methylcathinone)	1248	I	N	(Positional Isomers: 3-Methyl-methcathinone, Buphedrone, Ethcathinone, N,N-Dimethyl-cathinone)
Meprobamate	2820	IV	N	Miltown, Equanil, Micrainin, Equagesic, Meprospan
Mescaline	7381	I	N	Constituent of "Peyote" cacti
Mestanolone (17alpha-methyl-17beta-hydroxy-5alpha-androstan-3-one)	4000	III	N	Assimil, Ermalone, Methybol, Tantarone
Mesterolone (1alpha-methyl-17beta-hydroxy-5alpha-androstan-3-one)	4000	III	N	Androviron, Proviron, Testiwop
Metazocine	9240	II	Y	
Methadone	9250	II	Y	Dolophine, Methadose, Amidone
Methadone intermediate	9254	II	Y	Methadone precursor
Methamphetamine	1105	II	N	Desoxyn, D-desoxyephedrine, ICE, Crank, Speed
Methandienone (17alpha-methyl-17beta-hydroxyandrost-1,4-diene-3-one)	4000	III	N	Dianabol, Metabolina, Nerobol, Perbolin
Methandriol (17alpha-methyl-3beta,17beta-dihydroxyandrost-5-ene)	4000	III	N	Sinesex, Stenediol, Troformone
Methaqualone	2565	I	N	Quaalude, Parest, Somnafac, Opitimid, Mandrax
Methasterone (2alpha,17alpha-dimethyl-5alpha-androstan-17beta-ol-3-one)	4000	III	N	Methasterone
Methcathinone	1237	I	N	N-Methylcathinone, "cat"
Methenolone (1-methyl-17beta-hydroxy-5alpha-androst-1-en-3-one)	4000	III	N	Primobolan, Primobolan Depot, Primobolan S
Methohexital	2264	IV	N	Brevital
Methyldesorphine	9302	I	Y	

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Methyldienolone (17alpha-methyl-17beta-hydroxyestr-4,9(10)-dien-3-one)	4000	III	N	
Methyldihydromorphine	9304	I	Y	
Methylone (3,4-Methylenedioxy-N-methylcathinone)	7540	I	N	Methylone
Methylphenidate	1724	II	N	Concerta, Ritalin, Methylin
Methylphenobarbital (mephobarbital)	2250	IV	N	Mebaral, mephobarbital
Methyltestosterone (17alpha-methyl-17beta-hydroxyandrost-4-en-3-one)	4000	III	N	Android, Oreton, Testred, Virilon
Methyltrienolone (17alpha-methyl-17beta-hydroxyestr-4,9,11-trien-3-one)	4000	III	N	Metribolone
Methypylon	2575	III	N	Noludar
Metopon	9260	II	Y	
Mibolerone (7alpha,17alpha-dimethyl-17beta-hydroxyestr-4-en-3-one)	4000	III	N	Cheque, Matenon
Midazolam	2884	IV	N	Versed
Modafinil	1680	IV	N	Provigil
Moramide-intermediate	9802	II	Y	
Morpheridine	9632	I	Y	
Morphine	9300	II	Y	MS Contin, Roxanol, Oramorph, RMS, MSIR
Morphine combination product/50 mg/(100 ml or 100 gm)	9810	III	Y	
Morphine methylbromide	9305	I	Y	
Morphine methylsulfonate	9306	I	Y	
Morphine-N-oxide	9307	I	Y	
Myrophine	9308	I	Y	
N,N-Dimethylamphetamine	1480	I	N	
Nabilone	7379	II	N	Cesamet
Nalorphine	9400	III	Y	Nalline
Nandrolone (17beta-hydroxyestr-4-en-3-one)	4000	III	N	Deca-Durabolin, Durabolin, Durabolin-50
Naphyrone	1258	I	N	naphthylpyrovalerone; 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl)pentan-1-one) (Positional Isomer: α -naphyrone)
N-Benzylpiperazine	7493	I	N	BZP, 1-benzylpiperazine
N-Ethyl-1-phenylcyclohexylamine	7455	I	N	PCE
N-Ethyl-3-piperidyl benzilate	7482	I	N	JB 323
N-Ethylamphetamine	1475	I	N	NEA
N-Hydroxy-3,4-methylenedioxyamphetamine	7402	I	N	N-hydroxy MDA
Nicocodeine	9309	I	Y	
Nicomorphine	9312	I	Y	Vilan
Nimetazepam	2837	IV	N	Erimin

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Nitrazepam	2834	IV	N	Mogadon
N-Methyl-3-piperidyl benzilate	7484	I	N	JB 336
Noracymethadol	9633	I	Y	
Norbolethone (13beta,17alpha-diethyl-17beta-hydroxygon-4-en-3-one)	4000	III	N	Genabol
Norclostebol (4-chloro-17beta-hydroxyestr-4-en-3-one)	4000	III	N	Anabol-4-19, Lentabol
Nordiazepam	2838	IV	N	Nordazepam, Demadar, Madar
Norethandrolone (17alpha-ethyl-17beta-hydroxyestr-4-en-3-one)	4000	III	N	Nilevar, Pronabol, Solevar
Norlevorphanol	9634	I	Y	
Normethadone	9635	I	Y	Phenyldimazone
Normethandrolone (17alpha-methyl-17beta-hydroxyestr-4-en-3-one)	4000	III	N	Lutenin, Matronal, Orgasteron
Normorphine	9313	I	Y	
Norpipanone	9636	I	Y	
Opium combination product 25 mg/du	9809	III	Y	Paregoric, other combination products
Opium extracts	9610	II	Y	
Opium fluid extract	9620	II	Y	
Opium poppy	9650	II	Y	Papaver somniferum
Opium preparations - 100 mg/(100 ml or 100 gm)		V	Y	Parepectolin, Kapectolin PG, Kaolin Pectin P.G.
Opium tincture	9630	II	Y	Laudanum
Opium, granulated	9640	II	Y	Granulated opium
Opium, powdered	9639	II	Y	Powdered opium
Opium, raw	9600	II	Y	Raw opium, gum opium
Oripavine	9330	II	Y	
Oxandrolone (17alpha-methyl-17beta-hydroxy-2-oxa-5alpha-androstan-3-one)	4000	III	N	Anavar, Lonavar, Oxandrin, Provitar, Vasorome
Oxazepam	2835	IV	N	Serax, Serenid-D
Oxazolam	2839	IV	N	Serenal, Converal
Oxycodone	9143	II	Y	OxyContin, Percocet, Endocet, Roxicodone, Roxicet,
Oxymesterone (17alpha-methyl-4,17beta-dihydroxyandrost-4-en-3-one)	4000	III	N	Anamidol, Balnimax, Oranabol, Oranabol 10
Oxymetholone (17alpha-methyl-2-hydroxymethylene-17beta-hydroxy-5alpha-androstan-3-one)	4000	III	N	Anadrol-50, Adroyd, Anapolon, Anasteron, Pardroyd
Oxymorphone	9652	II	Y	Numorphan
Para-Fluorofentanyl	9812	I	Y	China White, fentanyl
Parahexyl	7374	I	N	Synhexyl,
Paraldehyde	2585	IV	N	Paral
PB-22 (Quinolin-8-yl 1-pentyl-1H-indole-3-carboxylate)	7222	I	N	QUPIC; PB-22

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Pemoline	1530	IV	N	Cylert
Pentazocine	9709	IV	N	Talwin, Talwin NX, Talacen, Talwin Compound
Pentedrone (α-methylaminovalerophenone)	1246	I	N	2-(methylamino)-1-phenylpentan-1-one)(Positional Isomers:3-methylethcathinone (3-MEC), 4-ethylmethcathinone (4-EMC), 4-methylbuphedrone (4-MeMABP;4-MeBP), 3,4-dimethylmethcathinone (3,4-DMMC),N-ethylbuphedrone (NEB),N-ethyl-N-methylcathinone(EMC))
Pentobarbital	2270	II	N	Nembutal
Pentobarbital & noncontrolled active ingred.	2271	III	N	FP-3
Pentobarbital suppository dosage form	2271	III	N	WANS
Pentylone	7542	I	N	bk-MBDP; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one) (Positional Isomer: dibutylone (bk-DMBDB))
Perampanel	2261	III	N	Fycompa, [2-(2-oxo-1-phenyl-5-pyridin-2-yl-1,2-dihydropyridin-3-yl) benzonitrile]
Petrichloral	2591	IV	N	Pentaerythritol chloral, Periclor
Peyote	7415	I	N	Cactus which contains mescaline
Phenadoxone	9637	I	Y	
Phenampromide	9638	I	Y	
Phenazocine	9715	II	Y	Narphen, Prinadol
Phencyclidine	7471	II	N	PCP, Sernylan
Phendimetrazine	1615	III	N	Plegine, Prelu-2, Bontril, Melfiat, Statobex
Phenmetrazine	1631	II	N	Preludin
Phenobarbital	2285	IV	N	Luminal, Bellergal-S
Phenomorphane	9647	I	Y	
Phenoperidine	9641	I	Y	Operidine, Lealgin
Phentermine	1640	IV	N	Ionamin, Fastin, Adipex-P, Obe-Nix, Zantryl
Phenylacetone	8501	II	N	P2P, phenyl-2-propanone, benzyl methyl ketone
Pholcodine	9314	I	Y	Copholco, Adaphol, Codisol, Lantuss, Pholcolin
Piminodine	9730	II	Y	
Pinazepam	2883	IV	N	Domar
Pipradrol	1750	IV	N	Detaril, Stimolag Fortis
Piritramide	9642	I	Y	Piridolan
Poppy Straw	9650	II	Y	Opium poppy capsules, poppy heads
Poppy Straw Concentrate	9670	II	Y	Concentrate of Poppy Straw, CPS
Prazepam	2764	IV	N	Centrax
Pregabalin	2782	V	N	Lyrica
Proheptazine	9643	I	Y	
Properidine	9644	I	Y	

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Propiram	9649	I	Y	Algeril
Prostanazol (17beta-hydroxy-5alpha-androstano[3,2-c]pyrazole)	4000	III	N	Prostanazol
Psilocybin	7437	I	N	Constituent of "Magic mushrooms"
Psilocyn	7438	I	N	Psilocin, constituent of "Magic mushrooms"
Pyrovalerone	1485	V	N	Centrotron, Thymergix
Quazepam	2881	IV	N	Doral
Racemethorphan	9732	II	Y	
Racemoramide	9645	I	Y	
Racemorphan	9733	II	Y	Dromoran
Remifentanil	9739	II	Y	Ultiva
Secobarbital	2315	II	N	Seconal, Tuinal
Secobarbital & noncontrolled active ingred	2316	III	N	
Secobarbital suppository dosage form	2316	III	N	
Sibutramine	1675	IV	N	Meridia
SPA	1635	IV	N	1-dimethylamino-1,2-diphenylethane, Lefetamine
SR-18 (Also known as RCS-8) (1-Cyclohexylethyl-3-(2-methoxyphenylacetyl) indole)	7008	I	N	SR-18 and RCS-8
SR-19 (Also known as RCS-4) (1-Pentyl-3-[(4-methoxy)-benzoyl] indole)	7104	I	N	SR-19 and RCS-4
Stanozolol (17alpha-methyl-17beta-hydroxy-5alpha-androst-2-eno[3,2-c]-pyrazole)	4000	III	N	Winstrol, Winstrol-V
Stenbolone (17beta-hydroxy-2-methyl--5alpha-androst-1-en-3-one)	4000	III	N	
Stimulant compounds previously excepted	1405	III	N	Mediatric
Sufentanil	9740	II	Y	Sufenta
Sulfondiethylmethane	2600	III	N	
Sulfonethylmethane	2605	III	N	
Sulfonmethane	2610	III	N	
Suvorexant	2223	IV	N	MK-4305, [[(7R)-4-(5-chloro-1,3-benzoxazol-2-yl)-7-methyl-1,4-diazepan-1-yl]][5-methyl-2-(2H-1,2,3-triazol-2-yl)phenyl]methanone
Talbutal	2100	III	N	Lotusate
Tapentadol	9780	II	Y	
Temazepam	2925	IV	N	Restoril
Testolactone (13-hydroxy-3-oxo-13,17-secoandrost-1,4-dien-17-oic acid lactone)	4000	III	N	Teolit, Teslac
Testosterone (17beta-hydroxyandrost-4-en-3-one)	4000	III	N	Android-T, Androlan, Depotest, Delatestryl
Tetrahydrocannabinols	7370	I	N	THC, Delta-8 THC, Delta-9 THC, dronabinol and others

Abbreviations: "NARC"= Narcotic, "CSA SCH"= CSA Schedule

SUBSTANCE	DEA NUMBER	CSA SCH	NARC	OTHER NAMES
Tetrahydrogestrinone (13beta,17alpha-diethyl-17beta-hydroxygon-4,9,11-trien-3-one)	4000	III	N	THG
Tetrazepam	2886	IV	N	Myolastan, Musaril
Thebacon	9315	I	Y	Acetylhydrocodone, Acedicon, Thebacetyl
Thebaine	9333	II	Y	Precursor of many narcotics
Thiamylal	2100	III	N	Surital
Thiofentanyl	9835	I	Y	Chine white, fentanyl
Thiopental	2100	III	N	Pentothal
THJ-2201 [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl)methanone	7024	I	N	THJ-2201
Tiletamine & Zolazepam Combination Product	7295	III	N	Telazol
Tilidine	9750	I	Y	Tilidate, Valoron, Kitadol, Lak, Tilsa
Tramadol (2-[(dimethylamino)methyl]-1-(3-methoxyphenyl)cyclohexanol)	9752	IV	Y	Tramadol
Trenbolone (17beta-hydroxyestr-4,9,11-trien-3-one)	4000	III	N	Finaplix-S, Finajet, Parabolan
Triazolam	2887	IV	N	Halcion
Trimeperidine	9646	I	Y	Promedolum
UR-144 (1-Pentyl-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone	7144	I	N	UR-144
Vinbarbital	2100	III	N	Delvinal, vinbarbitone
Zaleplon	2781	IV	N	Sonata
Zolpidem	2783	IV	N	Ambien, Ivadal, Stilnoct, Stilnox
Zopiclone	2784	IV	N	Lunesta

Abbreviations: "NARC"= Narcotic, "CSA SCH"= CSA Schedule

Please click on the link below for an overview of the National Association of Boards of Pharmacy's Test of English as a Foreign Language (TOEFL). Note that there has not been any recent program updates, no action necessary.

<http://www.nabp.net/programs/examination/fpgec/toefl-ibt>

Oregon Board of Pharmacy - Staff Authority Grid

Revision date: 5/19/16

JUNE 2016 / C14

	Subject	Description	Notice of Proposed Disciplinary Action	Consent Order	Board Review	Approval Date	Number of Cases
1	CS annual inventory missing (or change in PIC)	Issue a letter of Non-Compliance	\$1,000 civil penalty per violation	After 15 days, if they are not able to submit then issue \$1,000 Civil Penalty stay \$700 no further violation of PIC requirements		6/11/2008	
	Intern Extensions	Give staff authority to extend pharmacy intern licenses one year to individuals that need additional time to complete their schooling and rotations. Individuals that are granted an extension will be reported on the Board Consent Agenda.				6/8/2011	
2 a.	Medication errors	Where it is the first error; and no patient was harmed: PHARMACIST: Issue Letter of Concern reminding pharmacist that effective from June 1, 2011, at least one hour of continuing education credit must be earned in the area of patient safety or medication error reduction. Letter to recommend that licensee complete more than the minimum requirement in medication error reduction CE. TECHNICIANS & INTERNS: Letter to recommend that licensee complete continuing education in medication error reduction to prevent future errors.			Consent Agenda "Letter of Concern Cases". Letters will not issued until after meeting.	6/8/2011	
2 b.	Medication errors	PHARMACIST: Where significant harm has occurred as noted by seeking medical assistance (visit to an Emergency Department or Urgent Care Clinic) or as determined by staff consensus.			Board Review	4/10/2012	
2 c.	Medication errors	PHARMACIST: Second error in 5 years			Board Review	4/10/2012	
3	Modified, negotiated, or default Orders	Authority to Compliance Director to issue modified, negotiated, and default Consent Orders. May also issue Stipulated Orders accepting license surrender.					
4	Non-sufficient Funds	Board direct staff to revoke licenses issued under the misrepresentation of proper payment of fees via non-sufficient funds				6/11/2008	
5	PIC gap	1 to 5 days = LOC	\$1,000 civil penalty per violation	\$1,000 Civil Penalty per week starting with Day 6	two months - send to the Board for	6/11/2008	
6	PIC report missing		\$1,000 civil penalty per violation	\$1,000 stay \$700 no further violations of PIC requirements		6/11/2008	
7	Preceptor	Registration not current: Issue LOC to preceptor				6/11/2008	
8	Product ID Label (PIL)	If approximately 5 % of a sampling of labels is missing the PIL	\$5,000 civil penalty			6/11/2008	

9	Release of information - federal subpoenas	The Board staff may disclose confidential investigative information to federal agencies in response to subpoenas or in a cooperative investigation.			JUNE 2016 / C14	6/11/2008	
10	Release of information - health care boards/public	The Board staff may disclose confidential information to other relevant healthcare boards and other public entities consistent with ORS 676.177				6/11/2008	
11	RPH renewals: CE AUDITS	<p>Staff to issue LOC if CE completed in June.</p> <p>CE not completed/completed outside of timeframe/not by end of June-</p> <p>1. Take and pass MPJE and complete and submit documentation of CE licensee was short within 120 days (in lieu of discipline); or</p> <p>2. Notice: \$1,500 civil penalty Order: \$1,500 stay \$1,000 and complete and submit documentation of CE licensee was short.</p>				4/9/2014	
12	Short counts	The Board staff may issue a Letter of Concern in complaints involving allegations of 'short counts' where pharmacist admits to violation				6/11/2008	
13 a.	Technician renewals: CE AUDITS	Technicians who did not respond to technician audit;	Issue notice to Revoke	Revoke		6/11/2014	
13 b.		Technicians whose CE was unacceptable and/or did not have current National Certification after a certified mail request.	Issue notice to suspend and \$1,000 civil penalty per violation.	<p>\$150 per violation, up to 4 violations (ie: no CE for 1 year and no certification for 3 years). More than 4 violations = Board review.</p> <p>Single violation: \$1,000 CP stay \$850 = \$150 Both violations: \$1,000 CP stay \$700 = \$300</p> <p>CE = provide 3 hours of CE</p> <p>National Certification: provide documentation of current certification plus an additional \$150 for each additional year not certified when renewing the license.</p>		6/11/2014	
13 c.	Technician extension requests	<p>Authorize Executive and Administrative Directors and Licensing Department Supervisor to approve Pharmacy Technician extension requests as needed with the following parameters:</p> <ul style="list-style-type: none"> • The licensee must have a clear Law Enforcement Data System (LEDS) background check; • No active disciplinary action; and • The extension is not to exceed one year and 364 days from the original date of issuance. <p>Individuals that are granted an extension will be reported on the Board Consent Agenda. Requests that do not fit the above parameters are to be presented for Board review.</p>				4/9/2015	

14	Unregistered Outlets	Authority to encompass unregistered wholesalers, manufacturers and out-of-state pharmacies	Issue \$10,000 civil penalty per violation		JUNE 2016 / C14	12/1/2008
15 a.	Wholesalers - designated reps	#1 of licensing's grid: Designated Representative of more than one facility within multiple states. Notification of need for corporation to appoint additional designated representative has been mailed by licensing. No response to Board's request. Authorize board staff to send second letter "certified return receipt" if response is not received within 15 days of original letter from licensing. Second letter to refer to failure to cooperate basis for disciplinary action.	If corrective action is not received within 30 days, then issue NPDA imposing civil penalty.	Imposition of \$10,000 civil penalty		6/11/2008
15 b.		#2 of Licensing's grid: Designated representative of more than one corporation within the same facility. Applicant must submit detailed description of managerial process and include the hours that he/she will be physically present at facility.	Board staff to review information on case-by-case basis and grant or deny.			
16	Wholesaler Applications	1. Staff may review state wholesale inspection forms and include acceptable inspections on the state approved list 2. Staff may make determination if the license requires a manufacturer or wholesaler license 3. Staff may grant waivers if they determine that the license meets the state's small business requirements 4. Staff may issue a license if the applicant has demonstrated registration with VAWD and submits confirmation of approval to the Board office when VAWD certified				8/12/2008
	Denial of applications and renewals	Felony (theft, drugs, or active probation)				
	Staff will review & make recommendations for any applicants not specifically mentioned	Convictions	Deny	Deny		12/14/09
		Arrest or citation with no conviction (diversion; dismissed, case has not gone to trial yet)			Board Review	12/14/09
		Theft				

				JUNE 2016 / C14	
	Theft II or lower = issue license if greater than 5 years	Theft III = in a single ...transaction is less than \$100 Theft II = in a single ... is \$100 or more and less than \$1,000			12/14/09
	Aggravated, Theft I or higher	Theft I = in a single or aggregate transaction is \$1,000 or more; or by means of riot...; theft precursor; livestock, etc		Board Review	12/14/09
	Less than 5 years			Board Review	12/14/09
	Multiple Offenses			Board Review	12/14/09
Controlled Substances (not felony)					
	Less than 5 years	Deny	Deny		12/14/09
	More than 5 years			Board Review	12/14/09
DUI/MIP					
	One in the last 5 years (BAC >= 0.20)	Deny	Deny (or evaluation)		12/14/09
	Two or more (less than 10 years)	Deny	Deny (or evaluation)		12/14/09
	One DUI/MIP (BAC < 0.20) or 2 over 10 years = issue license				12/14/09
17	Unsworn Falsification	A) Felony conviction (theft, drugs, or active probation)	Deny with \$1,000 civil penalty per violation	Proposed: Deny	12/14/09
		B) Single LEADS incident	Deny with \$1,000 civil penalty per violation	\$1,000 civil penalty stay \$850 no further violations for 3 years, 3 hours of CE	Compliance Dir. with staff input, can determine the terms of the order and issue the license or orders <u>prior</u> to the Board Meeting.
		C) Multiple LEADS incidents	Deny with \$1,000 civil penalty per violation	Proposed: Deny	Issue after Board meeting.
18 a.	Probation Orders Amended	Compliance Director to amend probation orders to match PRN contract changes or removal of Board probation after completion of PRN contract	None	Amended Consent Order	12/14/09
18 b.	Probation Orders: modification of work restrictions	After 2 years from execution of Bd Order: Compliance Director may issue letter granting temporary modifications to probation work restrictions. Request to be presented at next available Board meeting via consent agenda. Clarification: Any requests for permanent modifications to work restrictions, will need to go to the Board as an Administrative Discussion item. Within the first two years of probation: No temporary modifications of work restrictions to be granted.			2/13/13
19	Foreign Manufactures	Direct staff to not license foreign manufacturers but to license first possessor or manufacturer in the US or territory	None	None	10/13/09
20	Device wholesalers	Give staff authority to waive surety bond or VAWD certification for device wholesalers	None	None	10/13/09

21	License for Manufactures and Wholesalers	Give staff authority to match probations from other states within last 5 years.	NPDA	Match probation	JUNE 2016 / C14	10/13/09
22	License for Consulting Pharmacies (Drugless Pharmacy)	Give staff authority to license consulting pharmacies by granting waiver of equipment and drug related rules for retail licensure	None	None		6/16/2010
	Licensees on Board Screening Probation - Non-compliance with probation sanctions	Refer to policy				5/21/2012

2009 ORS edition
 164.043 Theft in the third degree.
 (1)(b) The total value of the property in a single or an aggregate transaction is less than \$100.
 (2) Theft in the third degree is a Class C misdemeanor

2009 ORS edition
 164.045 Theft in the second degree.
 (1)(b) The total value of the property in a single or aggregate transaction is \$100 or more and less than \$1,000.
 (2) Theft in the second degree is a Class A misdemeanor.2009 ORS edition

2009 ORS edition
 164.055 Theft in the first degree.
 (1)(a) The total value of the property in a single or aggregate transaction is \$1,000 or more;
 (b) The theft is committed during a riot, fire, explosion, catastrophe or other emergency in an area affected by the riot, fire, explosion, catastrophe or other emergency;
 (c) The theft is theft by receiving committed by buying, selling, borrowing or lending on the security of the property;
 (d) The subject of the theft is a firearm or explosive;
 (e) The subject of the theft is a livestock animal, a companion animal or a wild animal removed from habitat or born of a wild animal removed from habitat, pursuant to ORS 497.308 (2)(c); or
 (f) The subject of the theft is a precursor substance.

**Appendix A
Best Practices Self-Assessment Guidance**

Annually, board members are to self-evaluate their adherence to a set of best practices and report the percent of total best practices met by the board (percent of yes responses in the table below) in the *Annual Performance Progress Report* as specified in the agency Budget Instructions.

Recommended Assessment Process

1. Select a neutral party to facilitate the self-evaluation (recommended, not required).
2. Individual board members complete the score card shown below.
3. Tabulate the results for all board members (can be done by neutral party in advance).
4. Discuss the results—particularly the results for those areas where there are disparate responses or where the group agrees that they are not adhering to a best practice.
5. Record the group’s joint response to each best practice on a new score card. If consensus is not achieved, the board or commission should record the response as “no.”

Best Practices Assessment Score Card

Best Practices Criteria	Yes	No
1. Executive Director’s performance expectations are current.		
2. Executive Director’s receives annual performance feedback.		
3. The agency’s mission and high-level goals are current and applicable.		
4. The board reviews the <i>Annual Performance Progress Report</i> .		
5. The board is appropriately involved in review of agency’s key communications.		
6. The board is appropriately involved in policy-making activities.		
7. The agency’s policy option packages are aligned with their mission and goals.		
8. The board reviews all proposed budgets.		
9. The board periodically reviews key financial information and audit findings.		
10. The board is appropriately accounting for resources.		
11. The agency adheres to accounting rules and other relevant financial controls.		
12. Board members act in accordance with their roles as public representatives.		
13. The board coordinates with others where responsibilities and interests overlap.		
14. The board members identify and attend appropriate training sessions.		
15. The board reviews its management practices to ensure best practices are utilized.		
16. Others <i>[The board may add additional best practices; however, they are not to be counted when calculating the percentage adherence to best practices.]</i>		
Total Number		
Percentage of Total		

Analyzing Assessment Results and Defining Next Steps

Once the above table has been completed, the board will want to prepare responses to the following questions. Responses should be integrated into the *Annual Performance Progress Report*, which is due from agencies on September 30th of each year.

- How are we doing?
- How do we compare to others and/or to our target? (Once this data is available.)
- What factors are affecting our results?
- What needs to be done to improve future performance?

**OREGON BOARD OF PHARMACY
PER DIEM & EXPENSE REIMBURSEMENT POLICY**

PER DIEM AND EXPENSES

The following Oregon Statutes (ORS) guide the Board's policy for Per Diem compensation and reimbursement for expenses - ORS 292.210 - 292.250, 292.495, 689.115(4), 689.175(1):

292.495 Compensation and expenses of members of state boards and commissions. (1) Subject to the availability of funds therefor in the budget of the state board or commission, and except as otherwise provided by law, *any member of a state board or commission, other than a member who is employed in full-time public service*, who is authorized by law to receive compensation for time spent in performance of official duties, *shall receive a payment of \$30 for each day or portion thereof during which the member is actually engaged in the performance of official duties.*

(2) Except as otherwise provided by law, *all members of state boards and commissions, including those employed in full-time public service, may receive actual and necessary travel or other expenses actually incurred in the performance of their official duties within the limits provided by law or by the Oregon Department of Administrative Services under ORS 292.210 to 292.250.*

(3) As used in subsection (2) of this section, "other expenses" includes expenses incurred by a member of a state board or commission in employing a substitute to perform duties, including personal, normally performed by the member which the member is unable to perform because of the performance of official duties and which by the nature of such duties cannot be delayed without risk to health or safety. No member shall be reimbursed for expenses incurred in employing a substitute in excess of \$25 per day. [1969 c.314 §1; 1973 c.224 §2; 1975 c.441 §1; 1979 c.616 §1]

689.115(4) OBOP Compensation

(4) Members of the board are entitled to compensation and expenses as provided in ORS 292.495. *The board may provide by rule for compensation to board members for the performance of official duties at a rate that is greater than the rate provided in ORS 292.495.* [1979 c.777 §§7,8,9,11; 1987 c.108 §2; 2009 c.535 §29]

689.175 Compensation of board members (1) Each member of the State Board of Pharmacy shall receive compensation for each day on which the member is engaged in performance of the official duties of the board, and reimbursement for all expenses incurred in connection with the discharge of such official duties as provided in ORS 292.495.

COMPENSATION

Board Members authorized by ORS 292.495(1) may choose, if eligible, to receive the \$30 daily allowable per diem when they perform official OBOP duties including: any Board of Pharmacy meeting and for other meetings and activities under which the following circumstances apply:

- ❖ A minimum of 2 hours including prep and travel is required
- ❖ The activity furthers the Board's mission
- ❖ The activity is/has been approved, assigned, or endorsed by the Board

Note -1 : *292.495(1) does not allow a member who is employed in full-time public service to receive compensation.*

Note -2 : The Board has not elected to adopt a rule as 689.115(4) allows to be compensated at a rate that is greater than the \$30 listed in ORS 292.495.

Board members will report meetings and activities to staff and they will process per diem assignments monthly. In the interest of efficiency and cost savings, all members have been asked to set up *direct deposit* for per diem.

EXPENSE REIMBURSEMENT

Expenses incurred in the course of a Board Member's official duties will be reimbursed pursuant to ORS 292.210-292.250 and the Department of Administrative Services Fiscal Policies and Procedures identified in the Oregon Accounting Manual (OAM).

Reimbursements typically include mileage and hotel/meal reimbursement for individuals that have to travel to the Board office for Board meetings and require an overnight stay or anytime a member is required to travel to an out of state meeting to represent the Board.

Reimbursements are calculated based on the OAM allowable or actual and necessary if receipts are submitted.

Board Members are asked to submit reimbursement requests in a timely manner. Staff prepares the paperwork for signature and sends it to member's following each Board meeting or official activity. All members have been asked to set up *direct deposit* for reimbursements to reduce the overall cost to the agency.

Citizen Advocacy Center **2016 Annual Meeting**

*Preliminary Program Announcement,
Agenda, and Meeting Registration Form*

Modernizing the Regulatory Framework for Telehealth

Presented in conjunction with CLEAR

**Saturday, September 17, 2016
and
Sunday, September 18, 2016**

*Portland Marriott Downtown Waterfront
1401 SW Naito Pkwy.
Portland, OR 97201
(503) 226-7600*

Citizen Advocacy Center 2016 Annual Meeting

On Saturday afternoon, September 17th and Sunday, September 18th, immediately following the close of the CLEAR Annual Educational Conference at the Portland Marriott Downtown Waterfront, **CLEAR and the Citizen Advocacy Center (CAC) will co-sponsor a national conference on Telehealth.**

This conference will be CAC's 2016 meeting, and will bring stakeholders together to identify and discuss ways in which the health professional regulatory system can facilitate the use of telehealth technologies and maximize the benefits to the public, consistent with safe, quality, affordable care. Many health care professionals and their respective boards are taking steps to enable the appropriate, safe use of telehealth technologies. The conference will address such topics as:

- How do patients feel about telehealth?
- What are the main regulatory hurdles that need to be overcome?
- How can telehealth outcomes be evaluated?

ABOUT CAC

Since 1987, CAC has been serving the public interest by enhancing the effectiveness and accountability of health professional oversight bodies. We offer training, research and networking opportunities for public members and for the health care regulatory, credentialing, and governing boards on which they serve.

Created as a support program for the thousands of public members serving on health professional boards as representatives of the consumer interest, CAC soon became a resource for the health professional boards themselves.

Day One – Saturday, September 17, 2016

11:00 A.M. – REGISTRATION DESK OPENS – COFFEE AND BAGELS WILL BE AVAILABLE

12:00 P.M. – 12:30 P.M. – WELCOME AND INTRODUCTION REMARKS BY CAC AND CLEAR

12:30 P.M. – 1:30 P.M. – KEYNOTE ADDRESS: “TELEHEALTH POLICY TRENDS AND CONSIDERATIONS”

Late in 2015 the National Conference of State Legislatures (NCSL) issued a blockbuster report entitled, *Telehealth Policy Trends and Considerations*. The report was the product of a year’s deliberation among state legislators, legislative staff, private industry, consumer organizations and others about the promise of telehealth technologies and barriers in the way of their dissemination. The report overview states: “Telehealth can increase health care access including the ability to reach care outside typical provider office hours or in different settings such as homes, long-term care facilities, schools, workplaces or prisons... (T)he possibility to improve health, along with consumer demand for convenience, is also a driving factor... For example, 74% of consumers reported they were likely to use online services.” A project committee co-chair will discuss the findings and recommendations contained in the report, including what the report has to say about licensure, safety and security, and coverage/reimbursement.

1:30 P.M. – 2:30 P.M. – CONSUMER PERSPECTIVES

Speakers will discuss the findings of recent surveys of consumer experiences and attitudes regarding telehealth.

2:30 P.M. – 3:00 P.M. – BREAK

3:00 P.M. – 4:00 P.M. – PROVIDER PERSPECTIVES

Speakers representing providers of telehealth services and technologies will share their opinions about how regulation and reimbursement policies can promote or inhibit the growth of safe and effective telehealth service delivery. They will also talk about the desirability of license mobility.

BREAK UNTIL EVENING SHIMBERG EVENTS (DETAILS ON PAGE 6):

5:30 P.M. – 6:30 P.M. – COCKTAIL RECEPTION

6:30 P.M. – 7:15 P.M. – SHIMBERG LECTURE

7:15 P.M. – 7:30 P.M. – PRESENTATION OF SHIMBERG AWARD

MEETING ADJOURNS FOR THE DAY

Day Two – Sunday, September 18, 2016

8:00 A.M. – REGISTRATION DESK OPENS – COFFEE AND BAGELS WILL BE AVAILABLE

8:30 A.M. – 9:30 A.M. – KEYNOTE ADDRESS: A VIEW FROM THE FEDERAL TRADE COMMISSION

A spokesperson for the FTC will talk about ways in which the agency’s antitrust enforcement activities may relate to telehealth in instances such as the Teledoc case in Texas. We will also learn whether the *FTC Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants* in the wake of the Supreme Court’s *North Carolina Dental* decision has relevance to telehealth regulation.

9:30 A.M. – 10:30 A.M. – VIEWS FROM STATE HEALTH PROFESSION REGULATORS – PART I (NURSING, PHYSICAL THERAPY AND PSYCHOLOGY)

Regulatory representatives of these three professions will bring us up to date on the regulation of telehealth technologies in their fields. Just a few examples: nursing pioneered the interstate compact concept that facilitates practice across jurisdictional lines. Physical therapy, in the U.S. and internationally, is looking at how its regulators can avoid creating barriers to the safe and appropriate use of telehealth delivery methods. In psychology, two mental healthcare reform bills introduced in the U.S. Congress in early 2016 have telehealth provisions.

10:30 A.M. – 11:00 A.M. – COFFEE BREAK

11:00 A.M. – 12:00 P.M. – VIEWS FROM STATE HEALTH PROFESSION REGULATORS – PART II (PHARMACY, OPTOMETRY AND MEDICINE)

Regulatory representatives of these three professions will bring us up to date on the regulation of telehealth technologies in their fields. Just a few examples: Telehealth technology allows Iowa pharmacists in one location to manage pharmacies in other locations and consult with patients via teleconferencing. Several states permit teleprescribing. Teleophthalmology is gaining acceptance worldwide for both diagnosis and treatment. Among U.S. regulators, the Federation of State Medical Boards published advisory guidelines for its member boards that provide “flexibility” for doctors consistent with accepted standards of care.

12:00 P.M. – 12:45 P.M. – FIXING MEDICARE

Thus far, the conference has focused on licensing and regulation. Reimbursement policy can also help or hurt the expansion of telehealth delivery. Speakers representing Medicare and private insurers will comment on their approaches to telehealth reimbursement and on major legislative reform proposals introduced in Congress in 2016.

Medicare now largely limits telehealth payments through its traditional fee-for-service program to cases where people live some distance from providers, thus largely restricting this service to rural areas. Medicare Advantage programs and demonstration programs such as accountable care organizations also can provide medical consultations via computer or phone. In some cases where telehealth is widely used, 60 to 70% of people’s contact with their doctors is handled remotely.

12:45 P.M. – MEETING ADJOURNS

ABOUT THE SHIMBERG AWARD AND LECTURE

Dr. Benjamin Shimberg, widely considered the “father” of accountability in professional and occupational licensing, was the first chair of CAC’s board of directors until his death in September 2003. The board named Ben Chairman Emeritus of CAC and created an annual Ben Shimberg public service award. Each year, the board asks the award recipient to deliver a lecture.

This year’s Shimberg Award winner is Kathleen Haley, Executive Director of the Oregon Medical Board.

Past recipients of the award were:

- 2015 Lisa McGiffert, Director, Consumers Union’s Safe Patient Project
- 2014 ProPublica, accepted by Charles Ornstein and Tracy Weber
- 2013 Kathy Apple, former Executive Director, National Council of State Boards of Nursing (NCSBN)
- 2012 Paul Grace, President and Executive Director, National Board for Certification in Occupational Therapy
- 2011 Catherine Dower, former Associate Director for Research, Center for the Health Professions, UCSF
- 2010 Art Levin, Director, Center for Medical Consumers
- 2009 Sidney Wolfe, former Director, Public Citizen’s Health Research Group
- 2008 Polly Johnson, former Executive Director of the North Carolina Board of Nursing
- 2007 Barbara Safriet, former Public Member on the Federation of State Boards of Physical Therapy
- 2006 John Rother, former Policy and Strategy Director for AARP
- 2005 Julie D’Angelo Fellmeth, Administrative Director, Center for Public Interest Law, University of San Diego School of Law, and former Enforcement Monitor for the Medical Board of California
- 2004 Mark Yessian, Former Regional Inspector General for Evaluation and Inspections, Boston Region, Office of the Inspector General, U.S. Department of Health and Human Services

HOTEL INFORMATION

The annual meeting is being held in Portland Marriott Downtown Waterfront, 1401 SW Naito Pkwy., Portland, OR 97201. We have arranged **preferred rates** at our host hotel, which are good until **August 15, 2016**. Please make your reservations early, before the rooms are all booked:

\$169/night – Cityview King/Queen/Double

\$189/night – Riverview King/Queen/Double

Discounted reservations must be made by calling (503) 226-7600 and identifying yourself as part of the CLEAR Annual Educational Conference Group block, or by going to the online booking tool at <https://aws.passkey.com/e/14403676>.

MEETING REGISTRATION FORM

To register for our 2016 annual meeting, please complete this form and mail, email, or fax it to:

CAC

1400 16th Street NW • Suite 101
Washington, D.C. 20036
Voice (202) 462-1174 • FAX: (202) 354-5372
register@cacenter.org

Name:		
Title:		
Name of Organization or Board:		
Address:		
City:	State:	Zip:
Telephone:		
Email:		

PAYMENT OPTIONS:

- 1) Mail us a check payable to CAC for the appropriate amount,
- 2) Provide us with your email address so that we can send you an invoice, or
- 3) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing address:	

Signature

Date

	Early Bird Rate (through August 14, 2016)	Standard Rate (beginning August 15, 2016)
Registration fee:	<input type="checkbox"/> \$495.00	<input type="checkbox"/> \$545.00
Registration fee for CAC or CLEAR Member Organizations:	<input type="checkbox"/> \$400.00	<input type="checkbox"/> \$475.00

CANCELLATION POLICY: NO REFUNDS ARE POSSIBLE, BUT YOUR FULL PAYMENT MAY BE APPLIED TOWARDS A FUTURE MEETING.

Our Federal Identification Number is 52-1856543.

MEMBERSHIP INFORMATION

CAC offers memberships to state health professional licensing boards and other organizations and individuals interested in our work. We invite your agency to become a **CAC** member, and request that you put this invitation on your board agenda at the earliest possible date.

CAC is a not-for-profit, 501(c)(3) tax-exempt service organization dedicated to supporting public members serving on healthcare regulatory and oversight boards. Over the years, it has become apparent that our programs, publications, meetings, and services are of as much value to the boards themselves as they are to the public members. Therefore, the **CAC** board decided to offer memberships to health regulatory and oversight boards in order to allow the boards to take full advantage of our offerings.

We provide the following services to boards that become members:

- 1) **Free** copies of all **CAC** publications that are available to download from our website for **all** of your board members and **all** of your staff.
- 2) A **10% discount** for **CAC** meetings, including our fall annual meeting, for **all** of your board members and **all** of your staff;
- 3) A \$20.00 discount for **CAC** webinars.
- 4) If requested, a **free** review of your board's website in terms of its consumer-friendliness, with suggestions for improvements;
- 5) **Discounted rates** for **CAC's on-site training** of your board on how to most effectively utilize your public members, and on how to connect with citizen and community groups to obtain their input into your board rule-making and other activities;
- 6) Assistance in **identifying qualified individuals** for service as public members.

The annual membership fees are as follows:

Individual Regulatory Board	\$275.00
"Umbrella" Governmental Agency plus regulatory boards	\$275.00 for the umbrella agency, plus \$225.00 for each participating board
Non-Governmental organization	\$375.00
Association of regulatory agencies or organizations	\$450.00
Consumer Advocates and Other Individuals (NOT associated with any state licensing board, credentialing organization, government organization, or professional organization)	\$100.00

MEMBERSHIP ENROLLMENT FORM

To become a CAC Member Organization for the remainder of 2016 please complete this form and mail or fax it to:

CAC

1400 16th Street NW • Suite 101
Washington, D.C. 20036
Voice (202) 462-1174 • FAX: (202) 354-5372

Name:		
Title:		
Name of Organization or Board:		
Address:		
City:	State:	Zip:
Telephone:		
Email:		

PAYMENT OPTIONS:

- 1) Mail us a check payable to CAC for the appropriate amount,
- 2) Provide us with your email address so that we can send you an invoice, or
- 3) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	

Signature

Date

Our Federal Identification Number is 52-1856543.

Second Draft

1. **The Research Council.** This Council should consist of not more than one Board member and will have a staff person as coordinator and facilitator. It should have a representative selection of experts in the specific field. A Research Council must be authorized by Board motion and will be tasked to do specific research and provide information back to the Board by a specified date. A Research Council will not normally be asked to provide recommendations. If the research is intended to lead to a Board policy or decision, then the meetings of the Council are subject to the Public Meetings law. If the research is purely for background information and is not directed towards a future policy decision, then the meetings probably do not fall under the Public Meetings law.

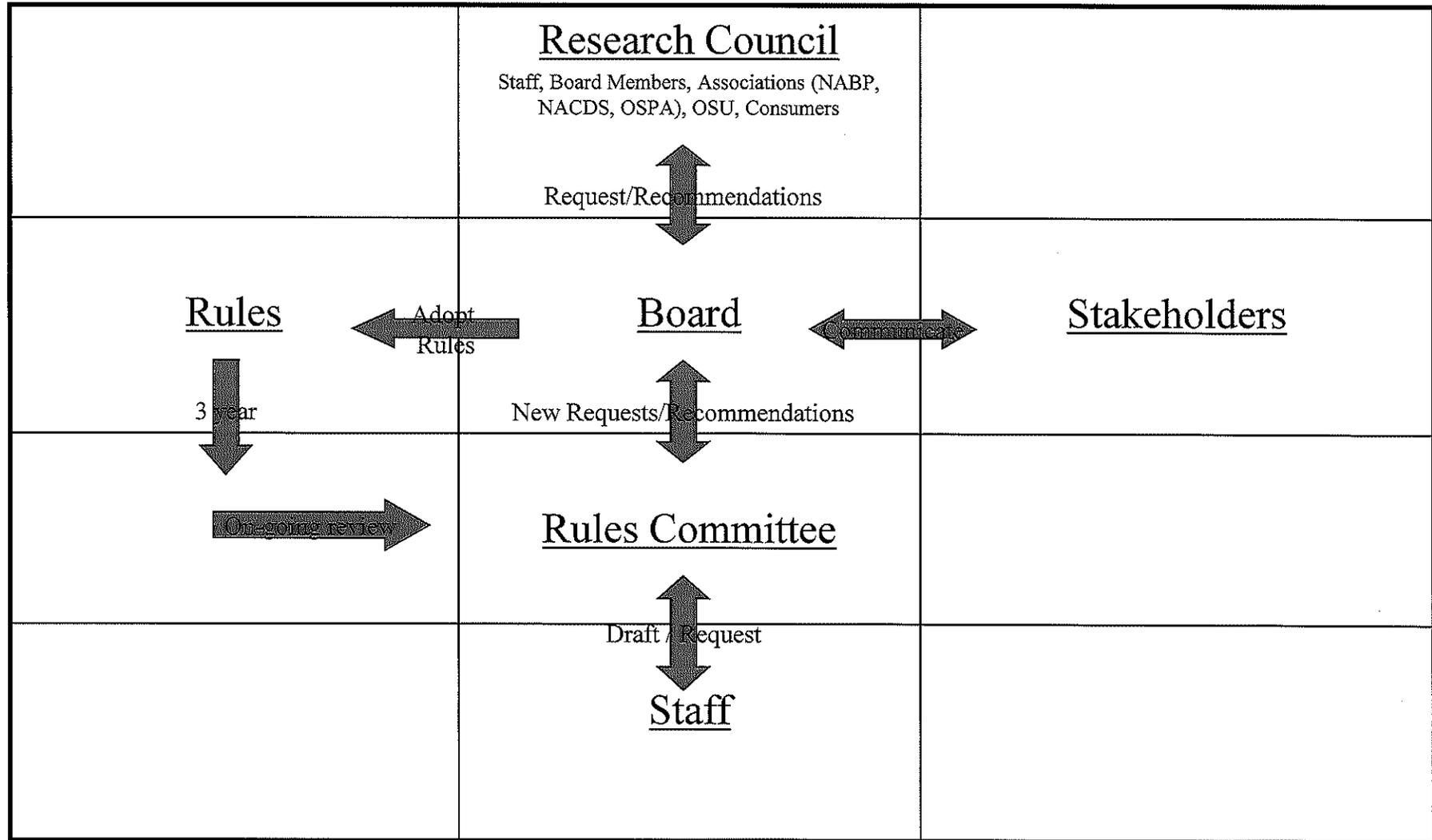
2. **The Stakeholder Group.** The Executive Director authorizes this Group, either when directed by the Board or when he believes it will enhance staff work. It is convened by staff to assist staff in rule review and research and may be used in the development of policy proposals for staff or the ED to present to the Board. It may also be used to provide input to staff on specific issues of concern. There will not normally be a Board member on this group, which is lead and managed by a designated member of staff. If structured this way, this meeting is usually not subject to Public Meeting laws.

3. **The Rules Advisory Committee.** This committee is authorized by the Board and may contain one Board member. The purpose of the committee is to assist staff by reviewing existing or proposed new rules and advising staff on the potential effects of rules on specific practice settings. The committee should also advise on the potential fiscal impact of a rule, and may suggest alternative ways to accomplish the Board's intention. This committee structure should also be used to conduct any required review of new rules. This committee may make recommendations to the Board and its meetings are subject to the Public Meetings law.

Each of these entities will have a "charter" that will be approved by the Executive Director or the Board and will consist of:

- Mission (the Charge)
- Chair or lead staff person
- Membership (including named Board member if any)
- Expected outcomes
- Expected completion date
- Public Meeting Law requirements

Administrative Rules Management



**BOARD OF PHARMACY
AY17 CASH FLOW
Of Appn 30235**

Budget Objects	REVENUE & EXPENDITURES	LAB ORBITS BUDGET	Rstars Financial Plan	EBoard or Adj Budget or Salary Pot	Adjusted Financial Plan	ACTUALS To Date	Unobligated Balance	% Expended
REVENUE			REV Proj as of 1/31/16					
0205	Other Business Licenses	4,924,832	5,012,583		5,012,583	1,909,761	3,102,823	38%
0210	Other NonBusiness Licenses and Fees	65,855	127,584		127,584	100,198	27,385	79%
0505	Fines and Forfeits	270,000	360,573		360,573	233,798	126,775	65%
0605	Interest and Investments	35,000	43,095		43,095	24,498	18,597	57%
0975	Other Revenue	29,700	37,811		37,811	22,219	15,592	59%
SubTotal Revenue		5,325,387	5,581,646	0	5,581,646	2,290,474	3,291,172	41%
TRANSFERS								
2443	Transfer out to OHA--Workforce Data	65,855	65,855		65,855	28,983	36,873	44%
2443	Transfer out to OHA--PDMP program	283,590	283,590	0	283,590	-	283,590	0%
SubTotal Transfers		349,445	349,445	0	349,445	28,983	320,463	8%
TOTAL REVENUE & TRANSFERS		5,674,832	5,931,091	0	5,931,091	2,261,491	2,970,709	38%
PERSONAL SERVICES			PS Proj from OSPS Detail					
3110	Regular Employees	2,872,872	2,738,826	142,105	2,880,931	991,238	1,918,853.70	34%
	Board Member Stipends		29,160		29,160			
3160	Temporary Appointments	24,322	-		0	-	-	0%
3170	Overtime Payments		-		0	120	(120)	0%
3190	All Other Differential O/Class Lead Work	176,911	174,819		174,819	65,466	109,353	37%
3210	Employment Relations Board Assessment	880	900		900	324	576	36%
3220	Public Employees Retirement Contrib	478,038	431,197	22,438	453,635	152,381	301,254	34%
3221	Pension Bond Contribution	176,574	173,715	2,878	176,593	63,666	112,927	36%
3230	Social Security Taxes	235,168	220,874	10,871	231,745	76,585	155,159	33%
3240	Unemployment Assessment				0	3,171	(3,171)	0%
3250	Workers' Compensation Assessments	1,380	1,339		1,339	438	901	33%
3260	Mass Transit Tax	18,445	17,482	853	18,335	6,337	11,998	35%
3270	Flexible Benefits	610,560	565,389	21,680	587,069	198,656	388,412	34%
3455	Vacancy Savings-ORBITS only				0		-	0%
3465	Reconciliation Adjustment-ORBITS only				0		-	0%
3470	Undistributed Personal Services-ORBITS		204,746		204,746		204,746	0%
3991	PERS Policy Adjustment-ORBITS				0		-	0%
SubTotal Personal Services		4,595,150	4,558,448	200,825	4,759,273	1,558,382	3,200,890	33%
SERVICES AND SUPPLIES			Proj all					
4100	InState Travel	106,639	106,639		106,639	30,467	76,172	29%
4125	Out of State Travel	19,985	19,985		19,985	4,707	15,278	24%
4150	Employee Training	48,559	48,559		48,559	4,256	44,304	9%
4175	Office Expenses	119,463	119,463		119,463	38,841	80,623	33%
4200	Telecommunications	36,349	36,349		36,349	10,984	25,365	30%
4225	State Govt. Service Chgs.	72,769	72,769		72,769	35,608	37,161	49%
4250	Data Processing	56,060	56,060		56,060	23,701	32,359	42%
4275	Publicity & Publications	37,593	37,593		37,593	8,742	28,851	23%
4300	Professional Services	116,711	116,711		116,711	55,328	61,383	47%
4315	IT Professional Services	78,096	78,096		78,096	18,900	59,196	24%
4325	Attorney General	314,038	314,038		314,038	151,574	162,464	48%
4375	Employee Recruitment & Develop	200	200		200	-	200	0%
4400	Dues & Subscriptions	4,419	4,419		4,419	1,336	3,083	30%
4425	Facilities Rent & Taxes	217,606	217,606		217,606	63,684	153,922	29%
4475	Facilities Maintenance	49	49		49	-	49	0%
4525	Medical Supplies and Services	1,070	1,070		1,070	231	839	22%
4575	Agency Program Related S&S	221,248	221,248		221,248	59,162	162,086	27%
4650	Other Services & Supplies	292,293	292,293		292,293	108,410	183,883	37%
4700	Expendable Property	10,124	10,124		10,124	-	10,124	0%
4715	IT Expendable Property	40,285	40,285		40,285	6,958	33,327	17%
5550	Data Processing Software	271,077	271,077		271,077	-	271,077	0%
5600	Data Processing Hardware	8,000	8,000		8,000	-	8,000	0%
SubTotal Services and Supplies		2,072,633	2,072,633	-	2,072,633	622,888	1,449,745	30%
SPECIAL PAYMENTS								
6085	Other Special Payments	11,563	11,563		11,563	-	11,563	0%
6443	Special Payments to OHA-HPSP	176,899	176,899		176,899	90,141	86,758	51%
SubTotal Transfers		188,462	188,462	0	188,462	90,141	98,321	51%
Total Expenditures Budget		6,856,245	6,819,543	200,825	7,020,368	2,271,411	4,748,957	32%
					7,057,070			
LAB % PS		67%			68%		Target	100%
LAB % S&S		30%			30%			
LAB % SP		3%			3%			

AY15 Ending Cash Balance	Cash	5,094,726
Revenue less Expenditures	Actuals	
Total Revenue & Transfers	2,261,491	
Total Expenditures	(2,271,411)	
Total Revenues & Transfers less Expenditures	(9,920)	(9,920)
AY17 Cash Balance after the Fiscal Month Closed		5,084,806
Budgeted Revenues not yet received less Estimated Transfers to OHA-PMP & Workforce Data program to be made		2,970,709
Budgeted Expenditures not yet spent		(4,748,957)
AY17 Estimated Cash Balance		3,306,559
Cash Balance Contingency (Months)		11.57 months

**BOARD OF PHARMACY
AY17 CASH FLOW
Of Apnn 30235**

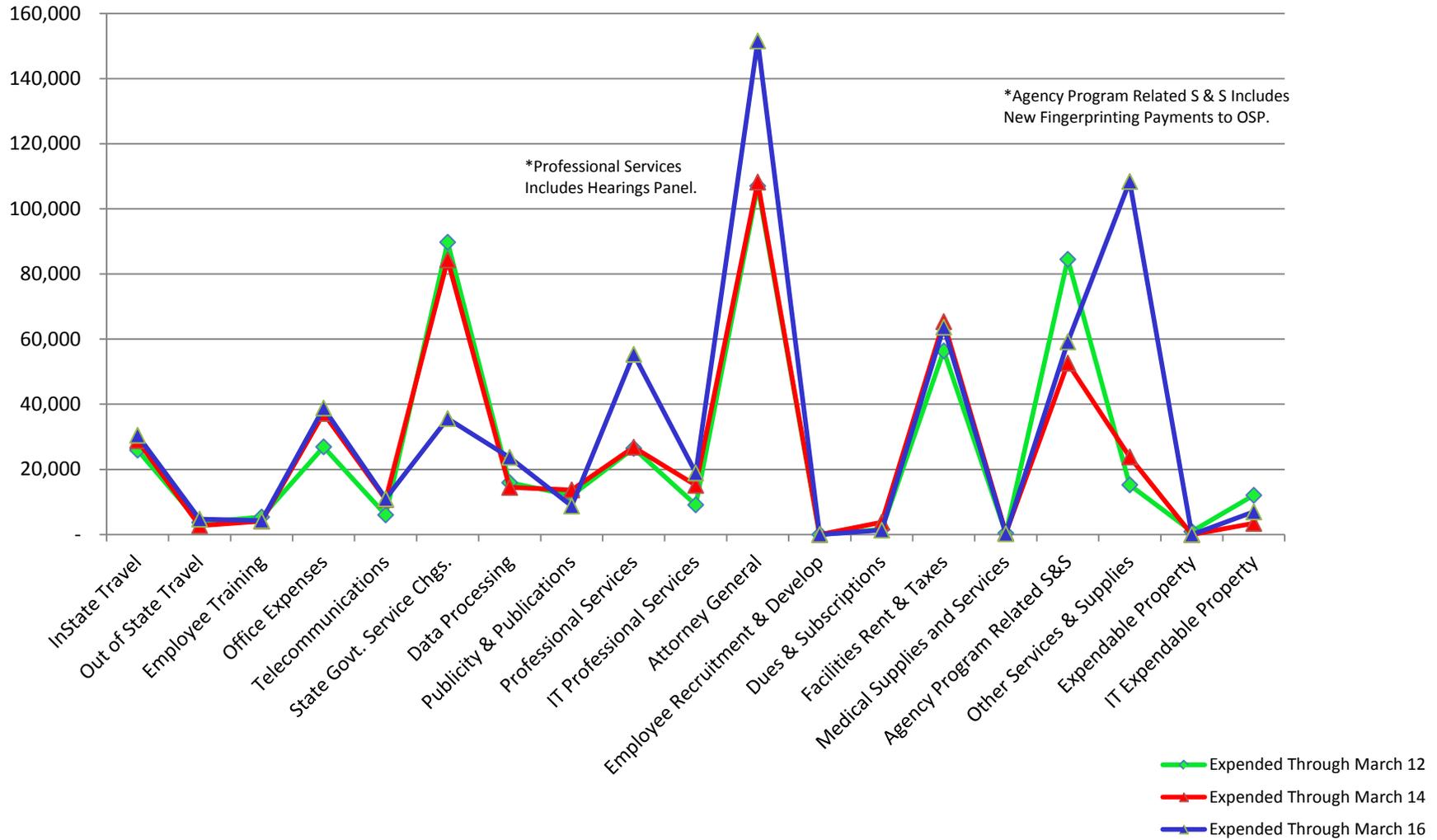
Budget Objects	REVENUE & EXPENDITURES	LAB ORBITS BUDGET	Rstars Financial Plan	EBoard or Adj Budget or Salary Pot	Adjusted Financial Plan	ACTUALS To Date	Unobligated Balance	% Expended
REVENUE			REV Proj as of 1/31/16					
0205	Other Business Licenses	4,924,832	5,012,583		5,012,583	1,957,931	3,054,653	39%
0210	Other NonBusiness Licenses and Fees	65,855	127,584		127,584	111,029	16,554	87%
0505	Fines and Forfeits	270,000	360,573		360,573	264,852	95,720	73%
0605	Interest and Investments	35,000	43,095		43,095	27,634	15,461	64%
0975	Other Revenue	29,700	37,811		37,811	24,124	13,688	64%
SubTotal Revenue		5,325,387	5,581,646	0	5,581,646	2,385,570	3,196,076	43%
TRANSFERS								
2443	Transfer out to OHA--Workforce Data	65,855	65,855		65,855	47,053	18,803	71%
2443	Transfer out to OHA--PDMP program	283,590	283,590	0	283,590	-	283,590	0%
SubTotal Transfers		349,445	349,445	0	349,445	47,053	302,393	13%
TOTAL REVENUE & TRANSFERS		5,674,832	5,931,091	0	5,931,091	2,338,517	2,893,683	39%
PERSONAL SERVICES			PS Proj from OSPS Detail					
3110	Regular Employees	2,872,872	2,805,031	142,105	2,947,136	1,102,338	1,873,958.18	37%
	Board Member Stipends		29,160		29,160			
3160	Temporary Appointments	24,322	-		0	-	-	0%
3170	Overtime Payments		-		0	120	(120)	0%
3190	All Other Differential O/Class Lead Work	176,911	174,819		174,819	72,678	102,141	42%
3210	Employment Relations Board Assessment	880	899		899	361	538	40%
3220	Public Employees Retirement Contrib	478,038	439,730	22,438	462,168	168,729	293,438	37%
3221	Pension Bond Contribution	176,574	177,688	2,878	180,566	70,222	110,343	39%
3230	Social Security Taxes	235,168	225,766	10,871	236,637	85,464	151,173	36%
3240	Unemployment Assessment				0	3,298	(3,298)	0%
3250	Workers' Compensation Assessments	1,380	1,329		1,329	489	841	37%
3260	Mass Transit Tax	18,445	17,879	853	18,732	7,042	11,690	38%
3270	Flexible Benefits	610,560	563,881	21,680	585,561	221,598	363,964	38%
3455	Vacancy Savings-ORBITS only				0		-	0%
3465	Reconciliation Adjustment-ORBITS only				0		-	0%
3470	Undistributed Personal Services-ORBITS		204,746		204,746		204,746	0%
3991	PERS Policy Adjustment-ORBITS				0		-	0%
SubTotal Personal Services		4,595,150	4,640,928	200,825	4,841,753	1,732,338	3,109,415	36%
SERVICES AND SUPPLIES			Proj all					
4100	InState Travel	106,639	106,639		106,639	35,579	71,060	33%
4125	Out of State Travel	19,985	19,985		19,985	4,707	15,278	24%
4150	Employee Training	48,559	48,559		48,559	7,921	40,638	16%
4175	Office Expenses	119,463	119,463		119,463	46,747	72,716	39%
4200	Telecommunications	36,349	36,349		36,349	12,666	23,683	35%
4225	State Govt. Service Chgs.	72,769	72,769		72,769	35,629	37,140	49%
4250	Data Processing	56,060	56,060		56,060	24,673	31,387	44%
4275	Publicity & Publications	37,593	37,593		37,593	8,902	28,691	24%
4300	Professional Services	116,711	116,711		116,711	59,707	57,004	51%
4315	IT Professional Services	78,096	78,096		78,096	18,900	59,196	24%
4325	Attorney General	314,038	314,038		314,038	151,624	162,414	48%
4375	Employee Recruitment & Develop	200	200		200		200	0%
4400	Dues & Subscriptions	4,419	4,419		4,419	1,486	2,933	34%
4425	Facilities Rent & Taxes	217,606	217,606		217,606	71,600	146,006	33%
4475	Facilities Maintenance	49	49		49		49	0%
4525	Medical Supplies and Services	1,070	1,070		1,070	231	839	22%
4575	Agency Program Related S&S	221,248	221,248		221,248	67,103	154,145	30%
4650	Other Services & Supplies	292,293	292,293		292,293	109,144	183,149	37%
4700	Expendable Property	10,124	10,124		10,124	1,660	8,464	16%
4715	IT Expendable Property	40,285	40,285		40,285	9,823	30,462	24%
5550	Data Processing Software	271,077	271,077		271,077		271,077	0%
5600	Data Processing Hardware	8,000	8,000		8,000		8,000	0%
SubTotal Services and Supplies		2,072,633	2,072,633	-	2,072,633	668,103	1,404,530	32%
SPECIAL PAYMENTS								
6085	Other Special Payments	11,563	11,563		11,563		11,563	0%
6443	Special Payments to OHA-HPSP	176,899	176,899		176,899	113,092	63,807	64%
SubTotal Transfers		188,462	188,462	0	188,462	113,092	75,370	64%
Total Expenditures Budget		6,856,245	6,902,023	200,825	7,102,848	2,513,533	4,589,315	35%
					7,057,070			
LAB % PS		67%			68%		Target	100%
LAB % S&S		30%			29%			
LAB % SP		3%			3%			

AY15 Ending Cash Balance	Cash	5,094,726
Revenue less Expenditures		
Total Revenue & Transfers	Actuals	2,338,517
Total Expenditures		(2,513,533)
Total Revenues & Transfers less Expenditures		(175,016)
AY17 Cash Balance after the Fiscal Month Closed		4,919,710
Budgeted Revenues not yet received less Estimated Transfers to OHA-PMP & Workforce Data program to be made		2,893,683
Budgeted Expenditures not yet spent		(4,589,315)
AY17 Estimated Cash Balance		3,224,078
Cash Balance Contingency (Months)		11.29 months

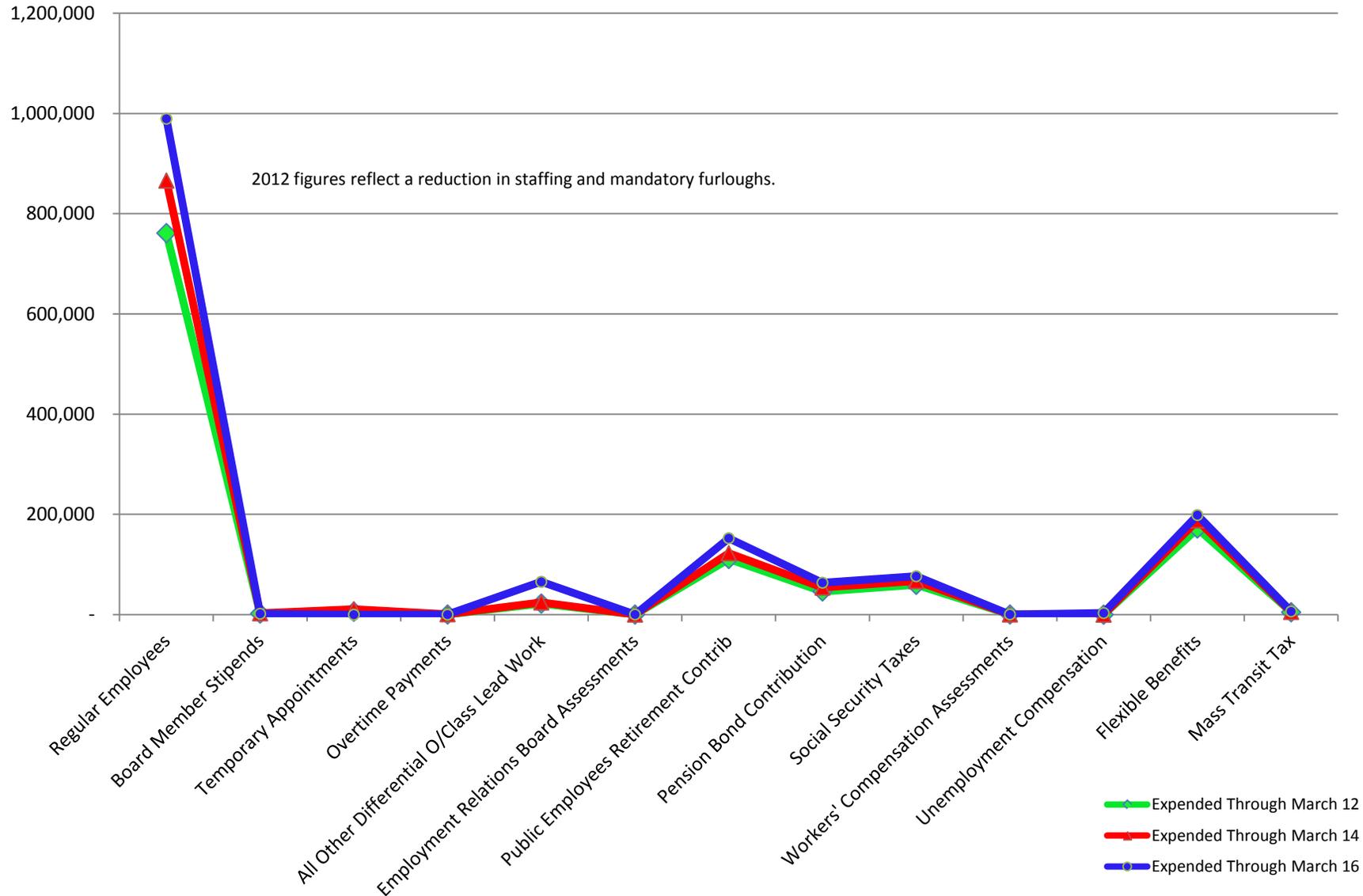
Board of Pharmacy 2011-2017 Expenditure Comparison

Budget Objects	EXPENDITURES	Expended To Date Mar 12	Expended To Date Mar 14	Expended To Date Mar 16	15-17 % Increase over 13-15
PERSONAL SERVICES					
3110	Regular Employees	761,274	866,113	989,468	14%
	Board Member Stipends	2,220	2,670	1,770	-34%
3160	Temporary Appointments	5,894	10,906	-	-100%
3170	Overtime Payments	286	830	120	-86%
3190	All Other Differential O/Class Lead Work	22,128	24,299	65,466	169%
3210	Employment Relations Board Assessments	243	271	324	20%
3220	Public Employees Retirement Contrib	111,061	122,590	152,381	24%
3221	Pension Bond Contribution	46,287	53,962	63,666	18%
3230	Social Security Taxes	59,497	67,005	76,585	14%
3250	Workers' Compensation Assessments	299	433	438	1%
3231	Unemployment Compensation	-	-	3,171	0
3270	Flexible Benefits	171,880	188,053	198,656	6%
3260	Mass Transit Tax	4,760	5,511	6,337	15%
SubTotal Personal Services		\$1,185,827	\$1,342,640	\$1,558,382	16%
4100	InState Travel	25,900	28,807	30,467	6%
4125	Out of State Travel	3,707	2,718	4,707	73%
4150	Employee Training	5,361	4,116	4,256	3%
4175	Office Expenses	26,917	37,187	38,841	4%
4200	Telecommunications	6,014	10,774	10,984	2%
4225	State Govt. Service Chgs.	89,758	84,342	35,608	-58%
4250	Data Processing	15,930	14,471	23,701	64%
4275	Publicity & Publications	11,950	13,704	8,742	-36%
4300	Professional Services	26,456	26,801	55,328	106%
4315	IT Professional Services	9,100	15,100	18,900	25%
4325	Attorney General	107,035	108,239	151,574	40%
4375	Employee Recruitment & Develop	-	-	-	0
4400	Dues & Subscriptions	1,585	3,753	1,336	-64%
4425	Facilities Rent & Taxes	56,379	65,379	63,684	-3%
4525	Medical Supplies and Services	403	441	231	-48%
4575	Agency Program Related S&S	84,502	52,608	59,162	12%
4650	Other Services & Supplies	15,243	23,834	108,410	355%
4700	Expendable Property	903	-	-	0
4715	IT Expendable Property	12,044	3,408	6,958	104%
SubTotal Services and Supplies		499,188	495,682	622,889	26%

Services and Supplies 2011-2013, 2013-2015, 2015-2017 Through Mar (Qtr 3)



Personal Services 2011-2013, 2013-2015, 2015-2017 Through March (Qtr 3)



OREGON BOARD OF PHARMACY STRATEGIC PLAN

JUNE 2016 / E

THE MISSION OF THE OREGON STATE BOARD OF PHARMACY

TO PROMOTE, PRESERVE AND PROTECT THE PUBLIC HEALTH, SAFETY AND WELFARE BY ENSURING HIGH STANDARDS IN THE PRACTICE OF PHARMACY AND BY REGULATING THE QUALITY, MANUFACTURE, SALE AND DISTRIBUTION OF DRUGS.

STRATEGIC OBJECTIVES			
Licensees' operating excellence: "At the top of their license."	No adverse impact on patient safety due to the workplace environment	An adequate and safe drug supply for the State of Oregon.	
Objectives 2014 – 2016 / Priority Outcomes			
Technician licensing that is streamlined and workable, resulting in fewer administrative errors by technicians	A valid framework from which to take workplace safety actions that meet the intent of patient safety	A strategy is in place to insure critical drug shortages are avoided	Non-pharmacy dispensing issues are resolved in support of patient safety.
Strategies & Tactics			
<ul style="list-style-type: none"> • Hold an informational hearing on the technician licensing process. If "go": • Draft and adopt administrative rules. • Create a graphic representation to clearly illustrate how technician licensing works. 	<ul style="list-style-type: none"> • Conduct proactive outreach to licensees outlining concerns and issues, and providing prevention advice and education on conditions that could trigger an action / mitigation. • Create a graphic representation of the paths to workplace action. • Draft and adopt administrative rules. 	<ul style="list-style-type: none"> • Staff work with FDA to insure Oregon has/retains the ability to use compounders for shortage drugs. • Obtain a root-cause analysis of drug shortage causes as they relate to Oregon. • Open Division 45. • Establish and implement the strategy. 	<ul style="list-style-type: none"> • Conduct outreach and debrief feedback with stakeholders. Compile and document stakeholders' interests and concerns. • Refine and share our plan and timeline. • Obtain support from legislators, boards and associations. •

Oregon Board of Pharmacy 2014 – 2016 Strategic Plan: MILESTONE CHART

	2014			2015				2016				2017
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Technician Licensing												
Hearing on the technician licensing process.		◆										
Draft and adopt administrative rules			◆ □									
Graphic representation to illustrate how technician licensing works,				◆								
Data shows fewer administrative errors by technicians												◆
Workplace Environment												
Graphic representation of the paths to workplace action.			◆									
Proactive outreach to licensees with advice and education re action triggers							◆					
Administrative rules drafted and adopted.								◆				
Drug Shortage Strategy												
Work with FDA to insure ability to use compounders for shortage drugs.	◆											
Obtain a root-cause analysis of drug shortage causes			◆									
Open Division 45.			◆									
Establish and implement the strategy.				◆	→	→	→	→	→	→	→	→
Dispensing												
Outreach to collect and compile stakeholder feedback		◆										
Refine and share plan and timeline		◆										
Solicit support of legislators, boards and associations			◆									

K EY: ◆=milestone/task achievement. →=ongoing ◆=goal achievement

Issue	Desired Outcomes	Actions to be Taken	By Whom	By when
Board Process	To improve the board’s process by developing a consistent form of consensus building. As topics are concluded, define who is doing what and by when.	<ul style="list-style-type: none"> • The President and Executive Director will co-facilitate meetings, using the 1-5 consensus tool whenever possible; • The Vice President will assist by clarifying action items and polling the group for consensus. 	The President, Executive Director, & the Vice President of the Board.	February 2016 meeting & onward.
NABP/AACP District Meeting Planning	Support development of a plan for hosting district meeting in Oregon.	<ul style="list-style-type: none"> • Work with NABP to develop agenda for events; • As agenda is developed, keep board members in the loop; • Clarify desired roles for Board members as the events approach. 	Karen MacLean & Marc Watt will coordinate and report to Board.	Ongoing
2017 Legislative Concepts	<p>(1) Review housekeeping related issues and submit those this year;</p> <p>(2) Select three to five policy concepts and have a workgroup focus on these topics with a recommendation submitted by April 15, 2018.</p>	<ul style="list-style-type: none"> • The board will address housekeeping items at the February 2016 meeting. • The board will identify topics if necessary for the 2019 Session. 	<p>The Board</p> <p>The Board</p>	<p>February 2016 meeting, final review at April 2016 mtg for LC submission by 4/15/16.</p> <p>October 2017 for final review at February 2018 meeting.</p>
2016 125th OBOP Celebration	Plan a high impact, low cost event that raises awareness for the Oregon Board of Pharmacy’s 125 th Anniversary.	Invite all previous board members to a celebration event.	Oregon Board of Pharmacy Staff & Board Members	September 2016

Issue	Desired Outcomes	Actions to be Taken	By Whom	By when
Prescription Errors	To improve the reporting of prescription errors through anonymous data collection based on (1) the type of error and (2) the position of the person who committed the error. The goal of this effort is to increase reporting in order to learn lessons and improve pharmacy practices in Oregon—not to find errors in order to penalize practitioners.	Step 1: The staff will review data from ISMP and in April of 2016 a staff member will report findings to the board. Step 2: Marc and Ken will meet with OPSC staff members between now and April to discuss creating an Oregon specific reporting forum and report back to the Board.	Oregon Board of Pharmacy Staff Marc Watt & Ken Wells	April 2016 meeting April 2016 meeting
Interns/Preceptors	To clarify the laws and rules of the intern-preceptor dynamic and to remind the field of the importance of this relationship for professional development.	Staff will write an ‘Intern & Preceptor Good Practices’ article, which will include rules and laws, for the pharmacy Spring 2016 newsletter.	Fiona Karbowicz & Laura Elvers	Spring 2016
How We Do Business ** Need Clarification re: <ul style="list-style-type: none"> • Marijuana possession pre/post new law • Unsworn falsification 	Clarify: (1) how to treat applicants who have marijuana related charges on their record and (2) how to deal with unsworn falsifications on license applications (e.g. failing to report an arrest that happened twenty years ago)?	<ul style="list-style-type: none"> • Staff will rewrite the application portion relating to marijuana possession so that marijuana possession cases will be treated similarly to alcohol impairment cases. • Staff’s authority to sign orders will be placed on the grid. • The grid will be reviewed at June board meeting (including discussion of redefining the application parameters for arrests). 	Staff Marc Watt & Gary Miner Board	June 2016
Technician Rules, Education and Evolution	Examine the duties of pharmacy technicians as outlined in the statute and discuss whether their roles/duties should be further	Staff will provide the various educational options available to technicians for the board to review and discuss any proposed changes	Oregon Board of Pharmacy Staff	2016 Strategic Planning Meeting

	clarified/defined.	at the 2016 Strategic Planning Meeting.		
Medication Reconciliation	<p>(1) Send a clear message to pharmacists and technicians about the Board’s expectations in Medication Reconciliation.</p> <p>(2) Move toward enhanced training for pharmacies in hospital settings.</p> <p>(3) Develop a “Best Practices” article to be distributed in the OPOB and pharmacy newsletters, which cites rules and statutes.</p> <p>(4) A rule needs to be created about Medication Reconciliation.</p>	<ul style="list-style-type: none"> • Staff will draft a clarification article on “Best Practices” in the February 2018 newsletter 	Oregon Board of Pharmacy Staff	After Rule adoption in 12/2017, Feb 2018 newsletter article on best practices.

