National Commission on Orthotic and Prosthetic Education
(NCOPE)

Education Summit Report

April 10-11, 2015

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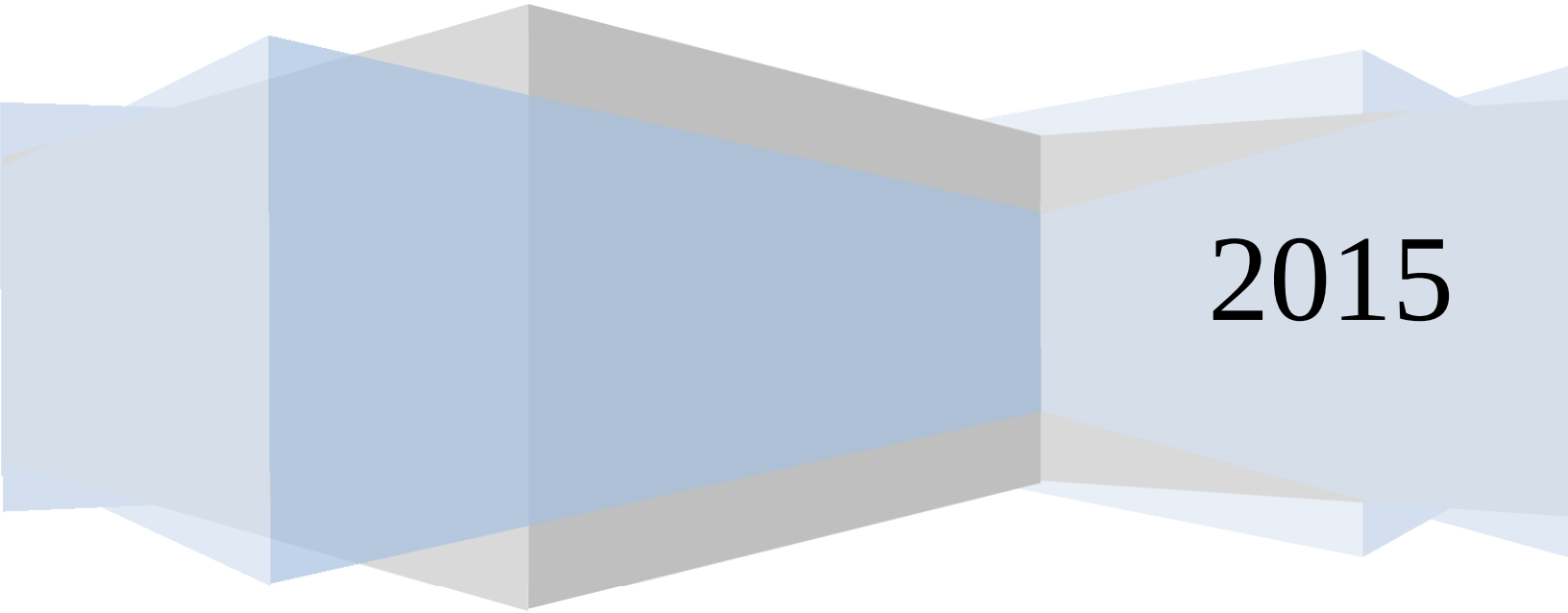

2015

National Commission
On Orthotic & Prosthetic Education
Education Summit
April 10-11, 2015 ● Tampa, Florida

On April 10-11, 2015, invited participants from the O&P educational and leadership community, including members of the board of the National Commission on Orthotic & Prosthetic Education, and NCOPE staff members, met in Tampa, Florida, for the Education Summit proposed during NCOPE's strategic planning discussions July 12-13, 2013, in Victoria, BC, Canada. The strategic objective: "Convene an all-stakeholders summit meeting focused on O&P education and the future of the profession." Appendix IV lists all participants.

The theme of the Summit was "Greater Than the Sum of Its Parts," a phrase recognizing that those present would together exert an influence on the profession of O&P greater than any individuals—even many individuals—would be able to offer. By acting together, those concerned for the O&P profession would be able to speak with a public voice "greater" than their separate voices. In their efforts to attain greater clarity and consensus, participants would affirm that the shared concerns of the profession provide a critical context for the interests of particular sectors. The three priorities of the Summit therefore were (1) Seeking Consensus on Priorities, (2) Articulating Values, and (3) Advancing the Profession.

This summary of the meeting documents that these priorities were addressed and fulfilled.

Although discussions did not always result in consensus, they succeeded in clarifying the important issues and differing perspectives on those issues.

Throughout, a commitment to widely shared values was evident, and, as one result, many of those values are more clearly set forth in this report.

Participants agreed at the close of the Summit that their discussions had indeed advanced the profession. They had achieved greater understanding of present realities, found considerable unanimity in a vision of positive change, considered strategies that might offer a bridge from the present to the future, and agreed on certain short-term steps that could provide a platform for more ambitious reform in the future.

THE STRUCTURE OF THE SUMMIT

In their planning for the Summit, the board approved a format balancing intensive table-based discussion with broader plenary discussion intended to yield useful perspectives and potentially actionable recommendations.

The Summit began with an opening plenary dedicated providing contexts for the discussions to follow. Following a welcome to Tampa Bay by Arlene Gillis, Chair of the

NCOPE Board of Directors, Robin Seabrook, NCOPE Executive Director, provided an informative overview of the Commission's and O&P educational development over time. Arlene Gillis then turned the perspective to the future by describing the aspirations of the board for the Summit, i.e., "what we hope to achieve." Immediate past-chair Jennifer Richards provided a further important perspective in reviewing NCOPE's strategic plan, and the facilitator provided a preview of the agenda.

Following this introductory session, the Summit embarked on a five-module agenda. Each module consisted of an introduction to the issue to be discussed, table discussions, and plenary sessions dedicated to hearing, considering, refining, and recording the results of those discussions. This systematic approach was interrupted only for periodic assessments of progress and for one brief session that invited participants to imagine boldly ways in which the future of O&P might improve on the present. Following an overview of several overarching issues that surfaced regularly throughout the course of the discussion, session-by-session reports will summarize the emphases of each.

Inevitably, some repetitiveness will be evident. However, repetitiveness is preferable to ignoring what may in fact represent genuine shades of meaning or nuances in emphasis. In the interest of comprehensiveness, the raw notes appear as Appendix II following the "Parking Lot" issues listed in Appendix I.

OVERARCHING ISSUES

Because the responses and recommendations listed session by session vary in specificity, in intent, and in the contexts they assume, the several overarching issues they reveal are worth noting at the start.

- Although it is important to understand and respect the realities of the moment, O&P must interpret these realities as prompts for positive change rather than as unyielding impediments.

- O&P must become more "proactive," less "reactive."

- At the heart of every Summit discussion are three priorities. In order, they are (1) the welfare of the patient, (2) the interests of students being educated for the profession, and (3) the viability of the profession itself. (Note that this consensus echoes the NCOPE mission statement: "NCOPE develops, implements, and assures compliance with standards for orthotic and prosthetic education through accreditation and approval processes that promote exemplary patient care.")

- O&P must redefine itself to policy makers, the public, and its own internal constituencies as a profession that offers a broad spectrum of care, not one that "provides widgets."

- While there appears to be general agreement that O&P should simplify the number and definition of caregiver levels in order to interpret itself more effectively to the public and to policymakers, there is as yet little consensus as to what levels should be redefined, consolidated, or "let go." Two levels in particular, those of Fitter and Assistant, are particularly problematical.
  - Raising educational and training expectations for the position of Fitter would require broad policy support that may be difficult to obtain in the near term. In the meantime, it must be acknowledged that there are few incentives at present for aspiring Fitters to meet such expectations and that, as a result, many receive only minimal training and then operate largely independently of certifiable professional oversight.
  - Similarly, while the landscape of O&P might in some sense be simplified by drawing multiple levels of care beneath the title of Assistant, the result might well be further confusion concerning that level of care in particular. The combination of the fitter and assistant levels will require restructuring of the standards and educational requirements. At present, there is some clarity in this regard, as Assistants may offer a variety of caregiving services under the supervision of a CPO. Including additional levels of care might raise questions concerning educational requirements, practical or technical preparation, and possible certification.

  In sum, O&P is a complex profession, and its nomenclature must to an extent reflect that complexity. But the profession's opacity to the public and policymakers has serious consequences in federal and state policy inconsistency, in insurer policy, and in a broad lack of awareness of what the profession does and can do.

THE SESSIONS

A1

What are the indicators—pro and con—that the profession should develop more explicit descriptions, definitions, and requirements for the educational pathways leading to the different levels of provider?

Are the defined levels within O&P appropriate? Or should the profession consider merging skill/ knowledge sets and levels.

Should the professional doctorate be a part of the conversation?

- Indicators arguing for simplifying the landscape of O&P abound. Misunderstanding of the profession at policy-making level leads to inconsistencies state to state regarding licensure and to a lack of appropriate respect for what the profession does and what it can accomplish. Public misunderstanding can lead to poor choices by patients and to underutilization of the unique expertise and capability of the profession. Even some of those *within* the profession may not understand the full range of its capabilities. There are risks in oversimplification, as the range of credentials must continue to reflect the

increasing complexity and diversity of the challenges the profession must address. But there are great risks in remaining opaque.

- One source of confusion lies at the level of the credentialed Therapeutic Shoe Fitter vis-à-vis that of Pedorthics. The two credentials might be more closely aligned—perhaps more clearly sequenced (Therapeutic Shoe Fitter→ Certified Pedorthist?)—or merged. The merging of the therapeutic shoe fitter and pedorthists simplifies this important aspect of the orthotic discipline. At the same time, the public must be educated to understand that shoe fitters who are not credentialed may not be qualified to provide adequate patient care.

- An alternative approach would combine the categories of and preparation for the roles of fitter and technician. I.e., fitters would be regarded as technicians with a particular mandate.

- Issues of reimbursement and insurer policy are among the priorities of the profession but must not determine the values and direction of the profession.

- Public education and promotion of the profession may prove at least as important as the internal reforms under consideration. Such promotion should make clear the important move from "commodity providers" to "service providers" within the health care system. We need to define "who we are."

- It is time to begin serious consideration of the professional doctorate within O&P but far too early to begin thinking of the doctorate as a requirement for entry to the profession. Perhaps this is a 10 year plan!

  - Before moving forward in terms of policy regarding the doctorate, the profession must understand its present credentials more fully—the continuum of education from technical training to the master's degree.

  - An interim step prior to defining a doctoral degree might be to define an intermediate increment such as the master's + a "fellowship" in one or more areas of specialization.

  - The first and most obvious application of a professional doctorate in O&P would be in education. What additional benefits would a clinical doctorate offer to practices?

  - In time, the professional doctorate might become a threshold degree, as in medicine. There one first earns the doctorate, then focuses on a specialty.

A2

What is the definition of the Assistant? What level of responsibility is appropriate?

How does this level fit in with other levels of care already defined within O&P? Can O&P as a profession sustain all these different categories?

Should NCOPE take the lead in defining in greater detail the educational standards that should be required for recognition (certification? licensure?) as an Assistant?

- CAAHEP draft guidelines offer a point of departure. They assume a broad variety of assigned responsibilities as appropriate for an Assistant but clarify the expectation that such responsibilities will be exercised only under the authority of and with supervision by a certified practitioner in O&P.,. (It should be understood that changes, while necessary, will take time and will require some level of "grandfathering" to protect those now engaged in a wide variety of patient care responsibilities.)

- Perhaps there should be but three levels of education and credentialing in O&P:
  - Associate degree → Certified O&P Technician (includes fitter).
  - Bachelor's degree in O&P → Certified O&P Assistant.
    A one-year bridge program might enable the recipient of a bachelor's degree to qualify as an Assistant.
  - Master's Degree in O&P → Certified practitioner

- An alternative might offer a slightly different nomenclature: Technician (AS), Assistant (BS or AS + one year of specialized training in O&P, Clinician (MS in O&P). Under this approach, Fitters would be considered as Assistants rather than as Technicians. That would clarify the expectation that Fitters should work under the supervision of a CPO.

- A third alternative would be to align O&P according to two levels:
  - Assistant (comprising the Technician, the Fitter, and other O&P services performed under supervision).
  - Practitioner: the orthotist/prosthetist.

- Pedorthics might also become a category within the Assistant credential. That is, a CPED would be credentialed as an Assistant. Again, that would clarify the expectation that Pedorthic work should take place under supervision.

- Over time, it may be necessary to "let go of" certain lower-level service providers.

- Over time, O&P may want to focus on providing custom therapies rather than on supplying prefabricated devices. 3D printing may eventually offer a convenient means of producing devices, but the appropriate application of emerging technology will depend on well-qualified practitioners. Such technologies are opportunities for—not threats to—the profession.

B1

How can NCOPE assist the profession in developing strategies to encourage the retention of existing residency positions and the expansion of such positions?

What can the profession do additionally to collaborate with and provide support for residency sites?

What would help the profession make data driven decisions on data collected at residency sites?

- There are at present 506 accredited residency sites. Of these, only 231 are currently accepting residents. Why? An important first step towards improving residencies would be to gather reliable information on *existing* residency issues. (Current information is not satisfactory.) How satisfied are sites that are regular recipients? What are their principal issues? Why do some registered sites only accept residencies periodically? Why are some sites that once accepted residents no longer doing so?

- A cost/benefit analysis of residency programs commissioned by NCOPE might go a long way towards persuading reluctant, resistant, or intermittent sites to consider accepting residencies, expanding their residency programs, or moving to a regular rotation. A simply longitudinal study spanning three or four years could prove highly persuasive.

- Sites that are conspicuous success stories should be recruited to testify persuasively to the value of residency programs—not simply in economic terms, but as an endorsement of important shared values of the profession. Essentially, strong residency programs strengthen O&P in general.

- Sites that regularly accept and supervise residents might be given appropriate recognition and offered some form of incentive.

- In some environments, sites might collaborate for either or both of two reasons—to give residents a richer educational experience than any one site could provide and to give sites an opportunity to participate in a residency program without an all-year commitment. A richer experience might also be made accessible to all residents through supplementary “e-grand rounds” and webinars.

- Experienced sites (with 3-5 years of accreditation and at least 2-3 residents through the program) might be designated and recognized as mentor sites for sites new to accepting residents. Similarly, NCOPE might offer consultants to enable residency sites with start-up.

- An approved and currently offered clinical mentor program is developing an online course that will offer CEUs to new mentors that complete it. Similarly, might NCOPE offer CEUs to residency mentors as recognition for their work?

- Records keeping for residents should emphasize holistic growth in patient care rather than "device-driven" standards.

B2

What prominent emerging trends in residency programs offer alternatives to traditional practice? Are there useful models of "best practice"? Should NCOPE consider providing a clearinghouse for information on useful models?

On the basis of the preceding discussion, does the group believe there are principles that should guide the development of alternate approaches to residency? Are there approaches worth considering that may not yet appear in practice?

- It is important to keep in mind throughout this discussion that the needs of the student are paramount.

- NCOPE must strive to "keep it simple" while recognizing that flexibility (both on the part of NCOPE and on the part of residency sites) is key—for two reasons. First, flexibility is essential to exploring opportunities for innovation. Second, only a flexible approach can serve an array of providers as diverse as that in O&P. "One size will not fit all" and oranges and apples should not be compared.

- What might be open to review? The 12-month duration of a residency? Approaches taken by other professions? (Many engineering programs enable their students to alternate academic education with practical experience in the field.) How oversight and supervision are organized and evaluated?

- Recognition of realities is also important. Student financial burdens may be greater under the "unified" than the "independent" model. (See below.) But the student receives in return a convenient, virtually guaranteed residency placement. Logistical considerations—where the student can move for a residency, what housing might be made available, etc.—must also be kept in mind.

- The idea broached in the earlier session, that of consortium sites, deserves serious consideration. We should develop several models for distributing costs, locus of coordination, etc. Such models would have to take into account current constraints evident in VA or other government policies. There are existing examples of collaborative residency sites that could offer useful guidance.

- Should NCOPE recognize both the "unified" (academic program and residency are aligned) and the "independent" (academic program and residency are discrete) approaches as models? If two different systems evolve, would that be disadvantageous to the profession? Discussion included the need to be flexible. Even if two systems do evolve, might the alignment between academic program and residency in the

"independent" approach be made more secure? "There is too much of a disconnect at present."

- While structure is important, content is more important. NCOPE must continue to exercise oversight of the quality of teaching and supervision in residency sites. Enlisting ABC/BOC to expand their accreditation site visits to include compliance with NCOPE standards for residency sites, would be an example of how this might be accomplished.

B3

In reflecting on the discussions that have taken place over two days and the perspectives and recommendations that have been offered and recorded, what are the priorities that NCOPE should take away from the Education Summit? What are the next steps?

- Develop for further consideration straightforward recommendations for simplifying the categories of caregiver and provider: the educational expectations, responsibilities, and relative autonomy of each. Such recommendations should benefit from consultation with comparable allied health organizations and O&P professional organizations.

- Gather the recommended data concerning residencies and use the data to create a business case for accepting residents regularly and educating them thoroughly. Will Typhon ever have the capacity to gather the required information?

- Respond to the emphasis in the current strategic plan by creating additional capacity in the NCOPE office and then expanding oversight of residencies consistent with clearer standards for quality and effectiveness. At a minimum, in 2016 hire a clinical practitioner to coordinate oversight of residencies.

- Schedule a follow-up education summit no later than 2020.

- Develop and utilize the data from Typhon, tying ICD-9/ICD-10 codes to device type.

- Consider changing the name: Orthotics and Prosthetics? Sure. But don't do it! There is emerging name recognition. Orthotic and Prosthetic Practitioner keeps the brand.

- Sponsor work leading to consistent standards for fabrication—lest the FDA have the last word. Or *let* the FDA have the last word and follow it.

IN CONCLUSION

Each time I work with NCOPE, I find the experience more enjoyable and satisfying. A shared sense of commitment to the values of a critically important profession guides discussion of important issues towards substantive recommendations for positive change. I will quote my 2013 statement that Jennifer Richards introduced early in the Education Summit:

"Having worked once before with NCOPE, I was not surprised by the level of professional focus or by the deep awareness of factors influencing the profession of orthotics and prosthetics. However, what I again found notable was the commitment to collegiality, to sustained civility, and to achieving results."

That was the case this time as well—to the second power! I'm grateful for the opportunity serve NCOPE.

Paul L. Gaston
Facilitator and Consultant

APPENDIX I: "PARKING LOT" ISSUES

So as to maintain focus on the assigned issues, the table discussions had the option of recommending for later discussion emerging issues not on the agenda. The chart below quotes these recommendations verbatim and indicates in some cases how advocates for such issues wish to see them addressed.

ISSUE	ADDRESSED HOW?
Come on . . . • Combine ABC and BOC (Both are vested in the O&P community and combined provide a stronger professional recognition.) • Combine the Academy and AOPA Work from the top down and things will fall in line. Bottom up could take a lot longer. We are the generation that needs to make it happen.	Possible strategic objective in next round of planning
Survey residency directors (phone) on what they need to improve their residency [programs]. What could NCOPE do to help them?	No entry
Bring residency directors and educators together to discuss what they would like from each other interns of what to teach students and residents.	Possible strategic objective in next round of planning
The Fellowship specialty training and its relationship with specialty certification	Board should gather and make information available
The impact of state licensure on the levels of practice (Assistant)	Possible strategic objective in next round of planning
"Fellowships" (maybe call it something else) for specialization in pediatrics, spinal orthotics, research, etc.	Possible strategic objective in next round of planning
Residencies	NCOPE should consider adding an annual renewal fee for all "active" residency sites
Low numbers of technicians pursue certifications with ABC. This has an impact on the analysis of the Dobson-DaVanzo Study.	No entry
ABC – merge all your Fitters into one that can do what all three do	ABC action
How to elevate CP, CPOs, Cos with BS degrees to have a reasonable route to achieve MPO status? Having more MS level practitioners lends much more power when confronting all the legislative restraints on what we are allowed to do, the value of our clinical notes, etc.	Possible strategic objective in next round of planning
Opportunities for working practitioners to obtain master in P&O through distance programs	Possible strategic objective in next round of planning
How can NCOPE assist the schools in retaining and expanding their clinical sites?	Board should gather and make information available

Just a note: If it is decided to drop "fitter" (as credential with separate standards) and put it into the "assistant" standards, we can't just reference the fitter standards in the assistant standards. Each piece would need to be laid out specifically in the assistant standards.	No entry
In 2025 we want to see more applicants for O&P education programs to increase selectivity. Currently 189 applicants for 13 programs is a red flag.	Possible strategic objective in next round of planning
IDEA: NCOPE hosts a few interview days at a few different locations throughout the country so students do not have to fly to as many different locations for interviews.	Board should gather and make information available

APPENDIX II: UNEDITED RESPONSES FROM TABLE DISCUSSIONS

The summaries of issues discussions attempt to integrate related positions, to clarify their relationship, and to support decision-making. There is always the possibility that editing may misunderstand and therefore mischaracterize an idea as it was presented. Hence this appendix provides the responses as they were transcribed during the sessions.

A1

Therapeutic shoe fitter (now credentialed—but should be merged with pedorthics): CPED and therapeutic shoe fitter should be differentiated clearly. Is shoe fitter as currently defined clearly sufficiently professional threshold for patient care? No.

Indicators:
Legislative misunderstanding of provider levels.
A lack of misunderstanding within the public and the profession concerning levels of practice.
Variation in state credentialing policies.

What is best for long-term interests of the profession? Emphasis must be on service to patients. Credentials must recognize the increasing complexity of the challenges the profession must address.

Reimbursement policies have been a driver of "lower categories of care." Tail wagging the dog? Vague categories protect access to avenues of service.

Abolish "fitter" as a category? OP not "widget providers" but health care professionals. A priority: educate the public with respect to what is required in order to provide OP care. But ask the question: what IS the profession? What are the standards it seeks to honor given present realities? Be careful not to exclude people who are providing OP care. "Because it is there" is not a rationale for future action.

The future is not as "suppliers."

How do we want to envision and realize the appropriate role for O&P in the health care complex?

Issues of reimbursement policy and priorities of the profession are related but must sometimes be separated for action.

Profession must become less reactive, more proactive in terms of federal policy and public understanding. Tough decisions may be required.

Public education and promotion of the field at least as important as internal reforms. Make clear the important move from "commodity providers" to "service providers" within the health care system. We need to define "who we are."

Do we take the moral high ground and align fitter/technician? Even while recognizing limitations imposed by current reality.

One resolve: a more robust communications plan is critical. Who are the audiences? What are the priorities? Timeline? Support? Who involved?

But something deeper is required. For communication to be effective, O&P must be organized more clearly and "transparently." We must have something easy to understand. O&P must be "understandable" to be understood.

Who are we? We must move beyond categories to shared convictions about the profession and the determination to articulate those convictions effectively.

Doctorate not required for entry to practice but appropriate (required?) for teaching.
Insufficient traction at present, but profession needs to raise up professionals as teachers.
Clarify distinction between professional doctorate and the Ph.D.
Recall medical model: education to the profession first, to the specialty later.
Not enough evidence at present. Gather and assess information from advance to master's.
Not prepared to define standards. But begin now to consider guidelines. A timely discussion—in some ways already under way. Consider deferring mandatory status while making the option available.
What would be the purpose of the professional doctorate? We must be aware of the rewards? We should first "figure out the master's degree." And consider alternatives such as "fellowship in . . . ."

A2

Like definitions in CAAHEP draft guidelines. Perhaps three levels of education? Associate—tech. BS→Assistant. MS→CP. Perhaps conflate Associate and Bacc degrees as one category, MS clinician as the other?
Three levels: clinician, technician, assistant (care extender with technical savvy). Associate + year → baccalaureate over time for Assistant. Fitter within assistant level. Assistant comparable in some ways with resident but informed by incremental learning.
Technical knowledge might not require enrollment in technical program.
Do assistants sometimes enjoy too much autonomy?
CPED →Assistant category?
Recall need for "grandfathering" existing practitioners.
By virtue of their being considered as assistants, orth fitters would in time be able to operate only under supervision. Consider effect on remote locations unable to support OP practices.
CPEDs evolving →podiatry.
Include pedorthics within Assistant umbrella?
CPED as a credential qualifying individual as assistant?
Realities of practice may not allow simplification—at least in the short term.
Rural territories offer a particularly challenge because of a shortfall.
Focus on CPO as caregiver, a health care professional, can be misconstrued if profession allows confusion with lower level specialties.
TWO LEVELS?
(1) Assistant (with technician background) or with technician certification
(2) Practitioner
May be necessary eventually to disown independent, non-certified fitters: Cf PT letting go of massage therapy, respiratory therapy
Assistant as an OP extender of care
Board to define OP Assistant and education required (somewhere between AS and BS)
*Assistant does not "fit in" with other levels of care. By definition, an assistant does **not** exercise autonomy. Assistant standards need not incorporate standards for fitter, etc. Perhaps "Assistant" is the wrong term? Rather, incorporate fitter and fitter-like standards as clearly distinct from standards for the assistant.*

Orthotic fitter—a particular problem, given how limited are the educational expectations. Perhaps NCOPE need not concern itself with fitters.
A different path: require fitters to qualify at a level commensurate with the assistant.
ALTERNATE CAREER TRAJECTORIES?
Technician/ CPED [Fitters]. . . . Assistant → Practitioner
Is certified OP increasingly limited to custom therapy—as opposed to the provision of prefab. Might O&P "let go" of prefab provision.
There is some control . . .
Concern re 3-D printing . . . will O&P attempt to regulate? Or let it go? Recall that technology to serve well requires well qualified practitioners.

B1

506 accredited residency sites on record of which 231 have residents—how to convert registered sites to receiving sites? Survey non-receiving sites as a platform for creating strategies to encourage broader participation. Ask why accredited sites choose not to recruit residents. Ask re: use of residencies. (NCOPE has circulated info re ways in which resident sites benefit from residents.)
Mobilize NCOPE members, especially business owners, who might offer testimony regarding advantages of residency programs.
Commission a cost/benefit analysis for residency programs. Consider a simple longitudinal study over 3-4 years. Such information could be persuasive exclusive of qualitative considerations—which also should be considered.
Target BOTH former (now inactive) sites and potential sites.
NCOPE considering levels of accreditation for residency sites that reflect frequency and regularity of demand for residents.
OP-RESCAS (centralized application service for students seeking residencies)
Consider offering and promoting comprehensive residency experiences through cooperating sites offering varying centers of specialization. Might NCOPE facilitate such collaboration? Create a road map to assist students who might take the initiative
Create incentives for regularly participating sites by offering occasional fee relief, etc..
Consider benchmarking sites so as to promote qualitative competition?
Create "e-grand rounds" or webinars to improve the residency experience?
Designate experienced programs as mentoring resource for new residency sites?
Might NCOPE offer consultants to enable residency sites with start-up?
Approved clinical mentor program now developing an online course (offering CEUs) as a resource for new mentors.
Offer CEUs to mentors as a reflection of their work. Or offer some other form of recognition? Seal of approval.
Records keeping for residents should place less emphasis on "device driven" outcomes.
Is data available for potential scrutiny? No, because NCOPE had analyzed the data and pronounced it junk. But better data is on the way.

B2

Flexibility is important—both on the part of NCOPE and on the part of residency sites. Flexibility is essential to exploring opportunities for innovation.
Consider greater use of consortium sites—one module at one location, another module at another. In such collaboration, one sponsoring site to coordinate? Cost might be distributed among sites. Draw on current examples. One model draws on two sites at present but may expand.

A particular advantage to residency sites no longer able or willing to receive residents for 12 months—more limited residency periods.
Impediment: restrictions vs. private practice in collaboration with VA or other government facilities.
Should teaching/training remain discrete from residency or should they (as in Baylor model) be integrated? (CAAHEP standards now more permissive.) Concern that "two different systems" may evolve.
Terminology needs attention. Paid fellowship = residency.
Financial considerations cannot be overlooked. Cost of clinical coordination. Logistical considerations also matter. Some students are place bound. Few programs can offer housing after the Baylor model.
One size does NOT "fit all." Flexibility should allow different models for different situations.
Emphasis might fall on how to make existing sites more responsive to student needs. Too little awareness of effective teaching and resident management. NCOPE might offer "true training workshops" to enable experienced, effective programs to mentor others. Offer a hands-on approach.
Revisit the resident standards and pare down to essentials.
Move away from being "device driven" to tracking student learning and application more effectively relative to patient care.
What's open to review? The 12-month duration? Perhaps look at a different model altogether. E.g., PT, which sequences residency experience and instruction.
Seek government subsidies for residencies?
Important to "keep it simple." Two models at present. Important to choose? Compare PA, PT.
Avoid comparing apples and oranges. Baylor's situation may be unique in some ways.
"One model: two delivery systems."
Present model may not be sustainable. Consideration of new approaches vital.
Remember that costs are not reduced by Baylor model, which shifts costs to students.
12-month residencies can lead to pressure to hire. Three-month residencies may be immune from this pressure.
Remain open to multiple solutions. Maintain consistent standards across multiple pathways. One important standard: institutional oversight of residencies. NCOPE might exert a larger role in maintaining such oversight.
Current model is unique in CAAHEP, in requiring "two graduations," from educational program and residency. Too much of a disconnect at present. They are not independent entities. But there may be more than one approach to aligning the two.
Reflect on summit objective: what is in the student's best interest? Ten years from now? Change is difficult—but futuristic thinking should look 10 and 15 years out. And consider useful models that might serve as examples. A paradigm shift may be required.
Improving current practice may be preferable to bold paradigm shift.
Some value in monitoring preparation of programs other than O/P?
What's best for student? For the resident? But not just the educational benefit. Also financial considerations. Student debt must remain a concern. Enforced mobility would be another concern.

B3

Technician credentialing and curriculum still relevant to Assistant? Formalized technician training could be /might not be platform for credentialing as Assistant.
Seek to elevate the technician, recognize their importance.
Board needs to wrestle with and resolve this issue.
NCOPE should commit to defining credentials for the Assistant. Might there be alternate paths with opportunities for specialization?

Take advantage of data to substantiate issue regarding Residencies. Conduct cost/benefit analysis to persuade reluctant sites and to analyze and assess residency models. Build business case for hosting resident site.
2-year technical vs. clinical path to Assistant (AA + one year) curriculum.
NCOPE needs to grow in human resources, finances, support. This would allow additional functions, e.g., residency oversight and support.
1 Residency. Create a system for standardized quality.
2 Seek collaboration with sister organizations to reach consensus on different levels of provider.
3 Schedule education summits every five years.
NCOPE's first priority: review six academic program standards in the light of consensus: (1) need for consolidation of programs and levels (2) shift from "devices" to health care.
Related priority: associate degree might qualify recipient both as technician and assistant (the "technical assistant") trained clinically and technically.
Also, develop and utilize the data from Typhon, tying ICB-9 codes to device type.
Consider changing the name O/P? No! There is considerable name recognition of the profession. Risky to change an emerging brand.
Consider "practitioner" as add-on.
Consider identifying three pathways only: CPO / Assistant / Technician. Strengthen technician level through certification.
Right away: Approved Clinical Mentor program. Consider templates for memos of understanding with respect to residencies.
Goal in 2016 to investigate . . .
Minimum: hire a clinical practitioner to support expert oversight of projects.
Review residency standards in 2016.
Consider granting certificates to graduates of technician programs. Aspire to certify a target % of technicians.
Achieve consistent standards for fabrication so as to disarm FDA concerns. Or seek to abide closely by FDA standards.
Seek tighter collaboration between NCOPE and ABC (and AOPA) in defining credentials (and all related organizations)
Create a strategy to pursue national credentialing requirements (rather than state-by-state). Perhaps work through regional chapters of the academy?

APPENDIX III: MISSION STATEMENT, GOALS, AND STRATEGIC PRIORITIES

Mission Statement

NCOPE develops, implements, and assures compliance with standards for orthotic and prosthetic education through accreditation and approval processes that promote exemplary patient care.

Goals

a. To promote exemplary patient care by ensuring high quality educational programs for future generations of O&P professionals.

b. *To ensure that O&P programs are comparable in quality and effectiveness by standardizing accreditation and approval processes according to thorough and comprehensive standards.*

c. To apply such standards consistently in the evaluation of educational programs.

d. To establish and implement mechanisms for the continual improvement of residency programs.

e. To continue to strengthen NCOPE staff resources in response to an expanding agenda and a changing health care environment.

f. To manage, develop, and expand appropriate alliances.

Strategic Priorities (2013)

Within the next five years, NCOPE will

- Develop and initiate workshops in residency/ mentorship development (making use of models of effective practice) leading to the award of distinctive recognition.

  →*Seek a consultant to assist in framing a charge to a task force. Identify and invite members of the task force, set a time frame for the task force's recommendations, implement recommendations that are both promising and feasible, and measure results according to a simple standard: have workshops been offered with respect to residency/mentorship, has recognition been provided to participants, and has the quality of the residency experience increased as a result?*

- Study and pursue avenues leading to a paradigm shift in structure, ownership, and governance of residency programs through exploration of alternate models.

  → *Frame a charge to the task force, identify and invite members, set a time frame for the task force's white paper, implement recommendations that are both promising and feasible, and measure results according to a simple standard: have residency models of ownership, structure, and governance changed for the better?*

- Create a task force focused on interdisciplinary collaboration (curricula, residency programs, continuing education), with the aim that all programs will engage with the broad health care spectrum.

  →*Frame a charge to the task force, identify and invite members, set a time frame for the task force's recommendations, implement those that are both promising and feasible, and measure results according to a simple standard: have residency and educational standards changed for the better?*

- Implement more effective assessment of academic programs and residency sites so as to enhance their quality and effectiveness.

  →*Create a database that quantifies clinical exposure at each residency site.*

  →*Implement a robust e-accreditation system.*

- Secure assistance to undertake quantitative and qualitative assessments regarding (1) future workforce needs of the profession and (2) residency programs.

  →*Identify well-qualified assistance in framing a research plan to determine workforce needs and residency program assessment, establish a time frame for the consultation, and bring to the board for consideration the resulting recommendations.*

- Commit to increased collaboration with and liaison to O&P organizations in order to encourage dialogue and to utilize resources more effectively and efficiently.

  →*Identify target organizations and appoint a liaison to maintain regular communication.*

  →*Identify and secure appropriate collaborators within the field. Seek synergies.*

- Convene an all-stakeholders summit meeting focused on O&P education and the future of the profession.

  →*Designate the board as the planning committee or ask the board to appoint a planning committee for the summit.*

→*Conduct a survey of potential participants with regard to possible dates and preferred locations.*

→*Consider retaining an experienced consultant on agenda planning, create a planning schedule, and make tentative arrangements.*

→*Issues for discussion might include the following:*
- *The viability of additional advanced degrees.*
- *The role of the profession within the current and future continuum of care.*
- *The impact on the current and future profession of changing protocols of oversight, reimbursement, etc.*
- *The need for and the desired shape of a collaborative research agenda.*
- *Opportunities in which OPERF might play a supportive role.*
- *The availability of and need for qualified faculty.*

- Leverage information technology, data interpretation, research methodology, and effective dissemination to support positive change in O&P education and in the profession.

  →*Conduct or commission a needs assessment to identify what specific enhancements should take priority, seek cost/benefit analysis for recommended initiatives, and plan implementation of the most urgent.*

- Systematically identify and encourage qualified volunteers to address identified needs and thus ensure continued progress with respect to NCOPE objectives.

  →*Set a "recruitment target" for a specific time frame and create a strategy, e.g., frame one or more means of appeal (a web invitation? brochure? board open letter?) describing opportunities for service and inviting volunteers. Use existing means (newsletters, meetings, etc.) as an opportunity to invite future leaders of NCOPE to take an active role.*

Advisory to the Commission Board

The participants in the planning meeting also offered to the board its broad advice concerning means relevant to the ends it had identified:

- So as to accomplish the above strategic objectives, make sure that staffing remains consistent with the needs of the Commission.

- Place a higher priority on the pursuit of grants in support of NCOPE's mission.

- Where appropriate utilize professional project management expertise.

APPENDIX IV: PARTICIPANTS

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PAUL GASTON, III, PH.D. – FACILITATOR
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