National Commission on Orthotic and Prosthetic Education

ACCREDITATION STANDARDS AND GUIDELINES

FOR ORTHOTIC AND PROSTHETIC RESIDENCY PROGRAMS

ncope.org

NATIONAL COMMISSION ON ORTHOTIC AND PROSTHETIC EDUCATION
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Introduction

An orthotic and prosthetic residency is a clinical education program sponsored by a comprehensive orthotic and/or prosthetic patient care facility, hospital, academic health center, or university. The residency aims to enhance the competencies of graduates from orthotist-prosthetist education programs and students enrolled in Commission on Accreditation of Allied Health Education Programs (CAAHEP)-accredited orthotist-prosthetist programs with integrated residencies. Through clinical, didactic, and professional experiences, residents develop the necessary skills to provide independent patient care.

Upon successful completion, of the residency residents must demonstrate competency in cognitive (knowledge), psychomotor (skills), and affective (behavior) domains. The National Commission on Orthotic and Prosthetic Education (NCOPE) Accreditation Standards and Guidelines for Orthotic and Prosthetic Residency Programs, known as "the Standards," establish the minimum quality requirements that all accredited residency programs must meet or exceed.

Application of the Standards

NCOPE develops and implements accreditation for residency programs. The Standards serve as the foundation for evaluating residency programs, including competency areas, goals, and objectives specific to each program type. These criteria apply to programs seeking initial accreditation or reaccreditation. Policies governing the accreditation process, application, and maintenance procedures are detailed in NCOPE Policies & Procedures – Section III.

Acknowledgment

The Residency Standards incorporate definitions, concepts, and frameworks used in other health professions, including but not limited to programs accredited by the Accreditation Council for Occupational Therapy Education (ACOTE), American Association of Colleges of Nursing (AACN), American Association of Colleges of Podiatric Medicine (AACPM), American Association of Medical Colleges (AAMC), American Board of Physical Therapy Residency and Fellowship Education (ABPTRFE), Accreditation Council for Graduate Medical Education (ACGME), American Psychological Association (APA), and American Society of Health-System Pharmacists (ASHP). The NCOPE Board of Directors, Residency Standards Work Group, and staff believe that aligning principles with professions that collaborate closely with orthotic and prosthetic professionals enhances interprofessional collaboration and improves patient outcomes.

We would also like to acknowledge the invaluable contributions of the NCOPE Residency Standards Work Group and the NCOPE Board of Directors, as well as the many individuals who provided input on the structure of the new Residency Standards. A full list of contributors is available in Appendix E.

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Overview of the Standards

Standard 1: Recruitment and Selection of Residents

Standard 1 guides residency programs in recruiting and selecting residents by defining candidate eligibility requirements and outlining the necessary policies and procedures. The selection process aims to ensure that chosen candidates succeed in the training environment, achieve professional competence, contribute to the advancement of the orthotic and prosthetic (O&P) profession, and uphold the organization's mission and values.

Standard 2: Program Requirements and Policies

Standard 2 details the requirements for residency sites to maintain NCOPE accreditation and the policies they must establish to ensure consistent standard operating procedures. It covers program duration, supervision, required applicant disclosures, site-specific policies and procedures, duty hours, physical resources, organizational partnerships, and compliance expectations.

Standard 3: Structure, Design, and Implementation of the Residency Program

Standard 3 details the essential components of residency structure, design, and implementation. The program's structure must support residents in achieving the program's objectives by developing their skills in required competency areas. It also establishes requirements for the oversight of resident development, evaluation, feedback, and self-assessment.

Standard 4: Requirements of the Residency Program Directors and Mentors

Standard 4 defines the eligibility and qualification requirements for residency program directors (RPDs) and mentors, as well as guidelines for program oversight, continuous improvement, and mentor development. RPDs and mentors play a vital role in the success of both residents and the residency program, serving as the foundation of residency training. Through their professionalism and commitment to advancing the profession, they act as role models for residents.

Standard 5: Orthotic and Prosthetic Services

Standard 5 provides guidance on common practices across the continuum of orthotic and prosthetic patient care. These standards apply to all practice environments unless otherwise specified.

"Guidance" and "How It Will Be Assessed by NCOPE"

Italicized text and boxed sections labeled "Guidance" or "How It Will Be Assessed by NCOPE" provide helpful information but are not independent standards or requirements. They are intended to assist in interpreting and applying the standards.

Standard 1: Recruitment and Selection of Residents

1.1. Residency programs must have a documented procedure for recruiting, evaluating, and ranking applicants, ensuring consistency among all parties involved. The procedure must achieve the following:

1.1a. Advertise the program in a clear, accurate, and transparent manner to help prospective applicants make informed decisions.

1.1b. Establish predetermined objective criteria for selecting applicants to be invited for interviews.

Guidance on Standard 1.1

Integrated residency programs will submit documents to demonstrate compliance with these standards through the recruitment, admissions, and enrollment documentation, as part of a comprehensive review for CAAHEP accreditation.

1.1a. Information must be correct at the time of publication and be revised once any changes to the public information occur. Information must be accurate at the time of publication and updated whenever there are changes. A program should not advertise a residency position unless they intend to fill it and have adequate resources.

1.1b. Objective criteria should be relevant to the knowledge and skills needed to successfully enroll and complete an O&P residency program including but not limited to the following: 1) past technical/clinical experience, 2) educational attainment, 3) evaluations submitted by faculty members on behalf of the applicant, and 4) references.

How It Will Be Assessed by NCOPE

Review of the following information:

- The residency program's criteria for selecting residents.
- For programs seeking renewal, a review of posted configurations in Orthotic/Prosthetic Residency Centralized Application Service (OPRESCAS).

1.2. The applicant selection process for postgraduate residency programs ensures the following:

1.2a. Applicants hold a minimum of a CAAHEP-accredited master's degree in orthotics and prosthetics or a master's degree in orthotics and prosthetics recognized by the World Education Services (WES) if training was completed outside the United States by the start of the residency program.

1.2b. Residents who completed their initial discipline at a different site must successfully complete all requirements for the enrolled discipline before beginning training at the second site.

Please see Standard 3.2b for additional guidance on two-site residency programs.

1.3. The postgraduate residency program adheres to the Rules for the OPRESCAS System (Appendix C).

1.4. Residency programs integrated into the education program demonstrate compliance with recruitment and selection by holding CAAHEP accreditation for the orthotist-prosthetist education program.

Guidance on Standards 1.2 – 1.4

- Any information listed about the residency program on the company website or advertised outside OPRESCAS must direct the applicants to apply through the OPRESCAS system, unless a formal exemption is approved by NCOPE.
- Recruitment, selection, and ranking procedures are made available to all residency program staff and personnel responsible for selecting, hiring, and onboarding applicants.
- Programs ensure that the documented procedures aim to reduce implicit bias throughout the recruitment, selection, and ranking process.
- The applicant selection process should involve the residency program director and others responsible for its implementation.

How It Will Be Assessed by NCOPE

Review of the following information:

- New residency programs
  - A draft of the OPRESCAS branding information to be shared with candidates.
- Existing residency programs
  - Existing advertising materials inside the OPRESCAS system.
- Any public-facing advertising materials used to provide information about the residency program and recruitment process.
- The scoring criteria used to select residents.

Standard 2: Program Requirements and Policies

2.1. Residency program requirements and policies in a written electronic form must be made available to all persons offered a residency position, residency mentors, residency directors, and other personnel responsible for the execution of the residency program.

Guidance on Standard 2.1

- This documentation may be part of a company policies and procedures manual, employee handbook, or residency program-specific document.
- Each item referenced in Standards 2.2 – 2.6 must be included in the documentation.

How It Will Be Assessed by NCOPE

Review of the following information:

- A copy of the documents that define the requirements and policies in the standards will be requested at the time of accreditation.

2.2. The minimum term of residency is 18 months, and the maximum term is 36 months.

Guidance on Standard 2.2

- The residency program term is defined by the residency site at the time accreditation is sought and may not be changed without NCOPE approval.
- A residency program term may be longer than 18 months based on the desired goals and outcomes defined by the residency program.
- Residency program duration beyond the minimum of 18 months must be in three-month increments and cannot be fractions of such increments. Examples of acceptable durations are 18, 21, 24, 27, and 30 months.
- The residency term is determined at the time of application and reflects the intended program length. It does not include any extensions required due to the resident's failure to demonstrate competencies or meet the minimum activity volumes.
  - Extensions of residency programs are defined under Standard 2.4b.
- The duration of the residency program cannot be less than the total duration defined by the residency program at the time accreditation is sought.
- See Standard 2.5 for relevant parameters regarding the resident's weekly hours and how requirements differ for half-time resident schedules.

(Continuation of Guidance on 2.2)

- Residency sites unable to provide residents with access to both orthotic and prosthetic patient populations must define a duration of at least nine months to develop competency and attain the required minimum activity volumes for the approved discipline.
  - A residency site only capable of providing training in a single discipline (orthotics or prosthetics) may define a residency duration of longer than nine months.

How It Will Be Assessed by NCOPE

Review of the following information:

- The program's defined duration, structure, and access to patient populations must ensure that the duration is adequate to demonstrate competency within the defined period.
- Existing programs will also be evaluated based on the following criteria:
  - The number of residents who required an extension due to factors for which the residency site is responsible.
  - The case encounter data entered by former and active residents at the time of renewal.

2.3. The program defines a supervision policy that ensures the residents always receive an appropriate level of supervision based on their training level and the complexity of the orthotic and prosthetic service being provided.

2.3a. Supervision must initially be direct, with the residency mentor or RPD in the same building as the resident.

2.3a.1. Direct supervision must be performed by mentors who meet all requirements to serve as residency mentors and have been formally recognized at the time of accreditation or via a written addendum to the NCOPE residency staff.

2.3a.2. Direct supervision may be performed using real-time audio and visual technology if the following criteria are satisfied:

2.3a.2.1. The resident is providing O&P services in a facility accredited to provide comprehensive O&P patient care and formally recognized as a satellite or partner clinic.

2.3a.2.2. The resident has successfully completed at least one quarter (three months) of the residency program at the residency site.

2.3b. Supervision may be indirect only after the mentor or RPD documents the resident's attainment of competency in NCOPE Tracker necessary to perform a specific orthotic and/or prosthetic service.

2.3b.1. Indirect supervision occurs without the physical presence of a qualified mentor or director, but the mentor or director must be accessible for immediate consultation by the resident throughout the patient encounter.

2.3b.2. If the resident has on-call responsibilities as defined in Standard 2.5., a qualified residency mentor must also be on call to provide consultation or service for any task where the resident has not yet documented competency.

2.3c. The supervision policy must comply with defined facility accreditation standards if the residency site is accredited by an agency that accredits comprehensive orthotic and prosthetic patient care facilities.

2.3d. If the residency site is not accredited to provide comprehensive orthotic and prosthetic services, it must adopt a supervision policy that, at minimum, meets the direct and indirect supervision requirements defined by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics.

2.3e. Supervision requirements must comply with applicable state licensing requirements in states where licensing or registration is required for orthotic and prosthetic practice.

Please reference the American Board for Certification (ABC) Scope of Practice for more guidance on the certified practitioner's role in training students/residents and requirements for direct and indirect supervision: Scope of Practice Developed by ABC.

Guidance on Standard 2.3

- The supervision policy must comply with facility accreditation requirements and the certifying/licensing body's scope of practice, where applicable.
- The most stringent supervision policy should be observed when multiple supervision requirements are defined by regulatory bodies.
- The resident reserves the right to decline performing an orthotic or prosthetic service under indirect supervision if they believe they have not yet attained competency or if documentation is not on file with NCOPE.
  - Failure to demonstrate all competencies by the conclusion of the residency prevents the resident from being recognized as having successfully completed the program.

2.3a.1.

- All formally recognized mentors at postgraduate residency sites will be listed in the NCOPE residency program directory.
- The RPD at an accredited residency site can add additional mentors by submitting the NCOPE Residency Faculty Add-On with appropriate supporting documentation.

2.3a.2.

- An NCOPE-recognized mentor must be present in the same building as the resident when O&P services are being performed during the first quarter of the resident's commencement at the residency site.
- Direct supervision using real-time audio and visual technology is not permissible if the resident is providing services at a location that is not a satellite or clinical partner formally recognized by NCOPE. This includes patient residences, hospital emergency rooms or inpatient units, skilled nursing facilities, and physical therapy clinics.

2.3b.

- Specific observable skills, behaviors, and knowledge are defined in the NCOPE evaluation forms for each required competency.

How It Will Be Assessed by NCOPE

Review of the following information:

- The program's supervision policy.
- Submission of competency documentation to NCOPE prior to when the resident transitions to indirect supervision.
- Feedback from residents, mentors, or site personnel identifying variances in the supervision policy.

2.4. Policies define the amount of time residents are allowed to be away from the program.

2.4a. Time away from the residency program may not exceed the greater of (a) 37 calendar days per 52-week training period (year) or (b) the minimum number of days allowed by applicable federal and/or state laws (allotted time).

2.4a.1. The residency program must be extended to make up for any absences that exceed the defined maximum time away.

2.4b. Policies define whether the extension of the program is permitted by the residency site, subject to the requirements of any applicable federal and/or state laws.

2.4b.1. Residency sites that permit program extension beyond the planned duration must specify the maximum duration allowed and the status of salary and benefits during the extension, if applicable.

2.4b.1.1. Residency sites approved to offer a single discipline must permit extensions to ensure residents can complete their training in the enrolled discipline before transitioning to the second site.

2.4b.2. For residency sites that do not permit extensions, policies state that residents who take leave in excess of the allotted time or who fail to demonstrate competency within the original duration will not be allowed to complete the residency program.

2.4c. Integrated residencies must have leave policies that comply with institutional accreditor and CAAHEP requirements and that are no more restrictive than those for persons employed in the state where residency training occurs.

Guidance on Standard 2.4a.

- For the purposes of the Standards, time away from the program is defined as the total number of days taken for vacation, illness, interview, personal days, religious observances, jury duty, bereavement leave, military leave, parental leave, leaves of absence, and extended leave.
- Time away refers to days away from a resident's typical schedule and does **not** include observed federal holidays or weekends.
- The Standards **do not** define the amount of paid leave that must be offered to residents; organizations should follow their routine paid time away policies and procedures.
- The Standards **do not** require programs to offer residents 37 days of paid time away from the program.
- The number of days referenced is based on the assumption that the resident will work a five-day work week.
- The values for the number of days must be adjusted if the resident works full-time but for fewer than five days per week.
- To fulfill the requirements of the Standards, if a resident exceeds 37 days away from the program, the program must be extended by the number of days the resident is away from the program in excess of 37. If the organization cannot extend the residency program, the resident will not be eligible to complete the residency at the site.

How It Will Be Assessed by NCOPE

- Review of the residency program leave policies.

2.5. Programs ensure the resident's expected duty hours are defined.

2.5a. The full-time resident is on duty a minimum of 37.5 hours per week and a maximum of 60 hours per week serving as an orthotist and/or prosthetist.

2.5b. The half-time resident is on duty a minimum of 20 hours per week and a maximum of 30 hours per week serving as an orthotist and/or prosthetist.

2.5b.1. The residency program duration for a half-time resident is a minimum of 36 months and a maximum of 48 months.

2.5c. The resident must be granted a minimum of 10 hours of time off to rest between shifts.

2.5d. The resident must not exceed 12 consecutive hours on duty, including seeing patients, engaging in technical services or administrative services, and traveling between clinical sites.

2.5e. The site has a defined process for monitoring compliance on a monthly basis, overseen by the RPD or designated mentor, which includes the following:

2.5e.1. Compliance with duty hour requirements including hours worked, hours free of work, outside employment, and frequency of all on-call programs.

2.5e.2. Process for assessing instances of noncompliance and actions to prevent exceeding duty hours.

2.5f. Documentation of supplementary employment policy, if applicable.

2.5g. Documentation of the type and requirements of on-call programs, if applicable.

Guidance on Standard 2.5

2.5b.

- The residents unable to serve as an orthotist or prosthetist resident for at least 20 hours per week (i.e., less than half-time) may only enroll if an individualized residency program is defined by the resident and the residency director, submitted to the NCOPE residency staff, and approved.
- Intermediate levels of effort/employment between half-time and full-time (such as a three-quarter-time residency program) must be completed over a minimum of 36 months.

2.5c.

- If the resident is present in a remote satellite or partner clinic and it is not possible to grant 10 hours of rest due to the travel time to their home, the residency program should provide nearby temporary housing or revise the resident's duty hours to ensure adequate rest.
  - A company-provided vehicle is not considered satisfactory temporary housing.

2.5g.

- During on-call activities, the resident is provided with supervision appropriate for their current level of abilities and the complexity of the patient requiring on-call care.
  - The resident is bound by the ABC Code of Professional Responsibility, and care must always be guided by concern for the physical, emotional, social, and economic welfare of the patient, as defined in code Section C2.2.
    > The supervising mentor must provide care for a patient in any instance where the resident's knowledge, skills, and experience do not enable them to provide appropriate care.

(Continuation of Guidance on Standard 2.5g.)

- This level of supervision must comply with the following:
  - > Any facility supervision requirements tied to the facility's accreditation.
  - > Applicable state laws in states where licensing or registration of orthotists and/or prosthetists is required.
  - > Any laws, regulations, or rules in place for facilities funded by the federal government (Veterans Health Administration/Department of Defense) or state government.

How It Will Be Assessed by NCOPE

Review of the following information:

- The on-call policy, including any reference to how time spent on call is accounted for relative to the duty hours requirement in Standard 2.3a.
- A sample schedule for on call, if required for the resident.
- Review of the supplemental employment policy, if one exists.

2.5h. The resident must not be required to drive more than 100 miles or two hours in a single day between clinics or affiliated clinical organizations including, but not limited to, hospitals, skilled nursing facilities, and rehabilitation centers, except in the following circumstance(s):

2.5h.1. The resident is in transit to a remote satellite or partner clinic as defined in Standard 5.1b to participate in patient care activities needed to attain minimum activity volumes (MAVs).

2.5h.2. The resident is in transit to participate in a state, regional, or national-level O&P meeting.

2.5h.3. The resident is participating in a residency program providing care via mobile clinics as defined in Standard 5.1b.6.

2.5i. Residency programs that require the resident to travel between different locations during a single shift must have written documentation of a vehicle/work travel policy that identifies the vehicle that is used and expense reimbursement, if applicable.

Guidance on Standard 2.5h

- Clinical service models sometimes require the resident to travel to gain necessary experience or ensure patients receive timely care. However, NCOPE does not consider actual travel time to be an essential educational experience required to achieve competency.
- If the residency program is aware of common travel patterns performed by residents among clinical facilities, this should be clearly identified when a position is offered to enable the resident to seek housing in a location that provides access to all facilities.
- The 100-mile maximum distance and two-hour maximum duration include all travel that occurs from the start of the workday until the end of the workday when the resident can return to their residence.
  - Time spent in transit during the workday, where the resident's home is not a departure point or destination, counts toward the resident's duty hours.
- Neither the 100-mile distance nor the two-hour duration applies to the distance traveled by the resident from their home to the primary residency site clinic, or vice versa, as a commute is required for all employees.
- The two-hour duration applies to the typical or average time it takes to travel a fixed distance. It does not penalize the residency site when the drive is extended due to factors beyond the facility's control such as traffic delays due to accidents or construction.

How It Will Be Assessed by NCOPE

Review of the following information:

- The distances between identified clinical satellites and partners.
- The average transit time between identified clinical satellites and partners.
- Typical travel times between the satellite and partner clinics during normal working hours.

2.6. The residency program identifies whether the site can meet all requirements, including access to the patient populations and orthotic/prosthetic treatments for both disciplines, to successfully complete the residency.

Guidance on Standard 2.6

- Any site unable to meet all requirements for residency completion (such as being unable to provide access to all required activities for prosthetic care) must clearly disclose this within OPRESCAS and any advertising materials related to the residency program.

How It Will Be Assessed by NCOPE

- Review of the program's OPRESCAS application materials and marketing materials for residency positions.

2.7. Transfer of the post-academic resident prior to completion.

2.7a. A transfer can only occur within the same enrolled discipline(s).

2.7b. Residency programs must identify whether they accept residents who have completed a minimum of one quarter of training at a different NCOPE accredited residency site.

2.7c. The residency program director or a designated mentor must evaluate the resident's progress toward achieving the required competencies and achievement of the program's defined goals.

2.7d. Residents who transfer to a different residency must be evaluated and have an individualized residency plan created. The resident is responsible for meeting all requirements defined by the residency to complete a single discipline or both disciplines.

2.7e. Residency sites must identify whether they accept residents who have successfully demonstrated all competencies and achieved all MAVs at a residency site eligible to offer training in one discipline.

Guidance on Standard 2.7

- A transfer occurs when the resident does not complete training, including all competencies and MAVs, and must complete training at a different site.
- This standard **does not apply** to residents who have demonstrated all required competencies and achieved all minimum activity volumes at a residency site eligible to offer training in one discipline and are seeking training in the opposite discipline.

2.7a.

- The resident can only request a transfer to a different site if they continue training in the same enrolled discipline(s).
  - The resident enrolled in a single-site combined O&P residency may only transfer to a site eligible to host combined O&P residency training.
  - The resident who does not finish training at a site focused on orthotic training must continue their training in orthotic management only.
  - The resident who does not finish training at a site focused on prosthetic training must continue their training in prosthetic management only.

(Continuation of Guidance on 2.7a.)

- Registering for a transfer into different disciplines than those previously enrolled in will be treated as a new registration, and any previously completed training will not be applied toward the completion of residency.

2.7b.

- The residency site is not required to define a policy for transfer of residency. However, if such a policy does not exist, the site is not eligible to accept a transferring resident.

2.7c.

- The residency program director or designated mentor is not required to recognize any time spent at a previous residency site after assessing the resident's abilities and reviewing prior case logs.
- If the resident seeking a transfer does not demonstrate the knowledge and skills needed to successfully complete a single quarter of residency, the resident will be registered as a new resident and be required to complete all requirements, including any documentation submitted at the previous site.

How It Will Be Assessed by NCOPE

- Review of program's transfer and second site enrollment policies.

2.8. To achieve program completion, a residency site must submit all required documentation defined in Appendix D and all required deliverables, including the following:

2.8a. Documented attainment of all required competencies.

2.8b. Identification of required experiences and associated MAVs.

2.8c. Any additional requirements or goals as defined by the program, if applicable.

Nothing in the Standards restricts programs from formulating requirements beyond the minimum activity volumes, competencies, and deliverables defined in Appendices A, B, and D.

2.9. Requirements for certification

2.9a. Residents are granted time away to take the certification exams administered by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics or state licensing agencies that require examination for licensure.

2.9b. The program identifies policies for payment and/or reimbursement of examination fees.

Guidance on Standard 2.9

2.9a. Exam release time only applies to exams administered during the residency program. The residency standards do not apply to any exam administered after the residency, such as the written simulation or clinical patient management exam.

2.9b. While the residency site is not required to fund or reimburse examination fees and/or associated travel expenses, it must be transparent with its related policy to applicants and residents.

How It Will Be Assessed by NCOPE

- Review of the program's leave and examination policies.

2.10. Residency-specific remediation/disciplinary policy.

2.10a. Documented policy detailing actions for residents lacking progress or failing to demonstrate appropriate competencies.

2.10b. Specific behaviors and conduct that trigger the organization's disciplinary process.

Guidance on Standard 2.10

- Program policies appear in written electronic resources accessible by the resident, residency mentors, residency director, and other residency stakeholders at the residency site as defined in Standard 2.1.
- The residency-specific remediation/disciplinary policy is intended to address issues not specifically covered by the organization's disciplinary policy (e.g., plagiarism, unprofessional behavior).
- The policy defines and addresses the procedure followed for a resident's failure to progress or failure to demonstrate competency as expected during the residency, including when failure to progress would result in either the withholding of the certificate of completion, extension of the program, or dismissal from the residency program.
- Programs that offer extensions specify the status of salary and benefits during that period. If the program is extended, policies must describe the maximum extension allowed and whether the resident will be paid during the extension.
- Programs may link residency-specific policies to the organization's disciplinary policy. Residency-specific policies should be reviewed by the human resources department to ensure consistency with the organization's policies. For international programs, such policies are also consistent with policies of applicable accrediting bodies.

How It Will Be Assessed by NCOPE

- Residency-specific remediation/disciplinary policy.

2.11. The residency program identifies the process for raising concerns with the residency program and/or personnel associated with the delivery of the residency program.

2.11a. Processes for raising concerns internally must be defined.

2.11b. The program identifies NCOPE Policy Section III: 4.0 - Rules & Procedures Regarding Complaints against NCOPE Accredited Residency Programs for concerns that need to be escalated beyond internal resources.

2.12. For the resident participating in a two-site residency, a documented procedure verifying that the incoming resident has successfully completed all requirements at the initial site is required.

Guidance on Standard 2.12

- Residents entering their second residency site can generate a competency matrix and report on office visits, populations served, and services provided at the initial residency site using the NCOPE Tracker system, which is adequate for verification.

How It Will Be Assessed by NCOPE

- Residency-site protocol for verifying successful attainment of required experiences and competencies at the first residency site.

2.13. The RPD, or designated personnel, provides resident applicants invited to interview with the following information and policies in writing at the time the invitation to interview is extended or at the time an offer is extended if an interview is not part of the selection process:

2.13a. Duty-hour policies.

2.13b. Requirements for successful completion of the program.

2.13c. Benefits eligibility.

2.13d. Transportation requirements and associated policies.

2.13e. Residency extension policies.

2.13f. Restrictive covenants and nondisclosure agreements, if applicable and legal in the clinic's area of operation.

2.13g. Post-residency employment and hiring information, if applicable.

2.14. The program complies with all laws on labor, nondiscrimination, disability, and privacy.

2.15. The resident submits a resident registration form at least 14 days prior to the residency start date.

2.15a. For residents seeking a two-site residency pathway, a second registration form must be submitted 14 days prior to the first day of residency at the second site.

2.16. RPD or designee reviews program policies with the resident and documents the review within 14 days from the start of the residency.

Guidance on Standards 2.14 & 2.16

2.14. Compliance with local and federal laws is often demonstrated via facility accreditation and the associated policies/procedures manual at the organization.

2.16. The policies/procedures manual should include any policies that exist for all employees in addition to any resident-specific policies.

How It Will Be Assessed by NCOPE

- The resident's evaluation of the site confirming that they have reviewed all policies and procedures associated with residency and employment at the residency site.

2.17. The residency director must submit a Resident Status Change Form whenever a resident experiences or initiates any of the following:

2.17a. Requires an extension of residency.

2.17b. Requires a change of program structure different from what the site was accredited to offer.

2.17c. Takes a leave of absence for a period of time equal to or greater than 14 days.

2.17c.1. The leave of absence may not extend beyond one year (365 days) in duration.

2.17d. Returns to the residency after a leave of absence.

2.18. The site identifies the residency program accreditation status and has an action plan to seek reaccreditation if required while a resident is registered to the site.

2.19. The residency program provides adequate resources to residents, including the following:

2.19a. A work area that is safe and conducive to concentrating without frequent interruptions.

2.19b. Access to technology necessary to perform work functions.

2.19b.1. For the resident working remotely or in a mobile practice, appropriate technology and equipment are provided to allow the fulfillment of program responsibilities and ensure appropriate patient care.

2.20. The residency site ensures that evaluations of the resident, evaluations of the residency site, and evaluations of the mentor are submitted within 30 days of the final day of each quarter.

2.21. The final evaluation of the resident must be documented by the RPD or a designated associate residency director.

2.21a. The final evaluation of the resident requires live interaction between the resident and the residency program director or designated associate director during the final week at the residency site.

2.21b. The Final Evaluation of the Resident Form must be submitted within 30 days of the final day the resident is at the residency site.

Guidance on Standard 2.21

- The final evaluation of the resident is designed to be a cumulative assessment of the resident's knowledge and skills, integrating input from all relevant mentors, the resident, and the director.
- Any criteria or objectives defined in the residency program structure/curriculum beyond the Standards should be evaluated during the final evaluation.
- The certificate of completion from NCOPE is issued only after the resident has met all NCOPE residency program requirements for both the orthotic and prosthetic disciplines. This certificate is provided by NCOPE to the resident who has successfully completed the program's requirements, as demonstrated via documentation and recommendation by the residency program director.
  - **Certificate of Completion for One-Site Residency Program:** A certificate of completion will be issued to recognize a single residency site only if the resident fulfills all requirements at a site that is approved for both the orthotic and prosthetic disciplines.
  - **Certificate of Completion for a Two-Site Residency Program:** A certificate of completion will be issued to recognize both enrolled residency sites only if the resident fulfills all requirements, competencies, and minimum activity volumes for both the orthotic and prosthetic disciplines.
- For the resident pursuing a one-site residency program, only a single final evaluation must be submitted after the successful completion of all rotations.
- For the resident pursuing a two-site residency program, a final evaluation of the resident must be completed at the conclusion of the training at each residency site.
- The resident must demonstrate all competencies defined in Appendix B and meet all defined minimum activity volumes for the enrolled discipline at each of the two sites to complete each residency program.

How It Will Be Assessed by NCOPE

Review of the following information:

- Residency site goals and objectives that meet or exceed the NCOPE residency standards.
- Residency site protocol for verifying successful attainment of required experiences and competencies at the first residency site.

2.22. **Program Compliance Maintenance:** A program is required to uphold compliance with the current Standards, which is the responsibility of the RPD and may require the input of additional designated personnel at the residency site.

2.23. **NCOPE Tracker Usage and Maintenance:** The program must use the NCOPE Tracker for effective management and maintenance of the residency program. This includes documenting the following key evaluations and achievements prior to the final evaluation of the resident:

- **2.23a.** Initial self-evaluation of the resident within the first 30 days at the residency site.
- **2.23b.** Quarterly evaluations, as outlined in Standards 3.6 and 3.7.
- **2.23c.** Submission of clinical or research track activities.
- **2.23d.** Submission of a professional activity.
- **2.23e.** Tracking of residency competency achievement.
- **2.23f.** Tracking of residency MAVs.

A comprehensive list of required documentation and deliverables can be found in Appendix D.

2.24. A secure record of each resident's program application, acceptance letter, documented acceptance of program policies, and deliverables must be maintained. Documentation of requirements is maintained for not less than three years from the end of the residency, or longer if required by institutional policy, state, or federal law.

2.25. When more than one organization shares responsibility for the clinical, financial, and/or management aspects of the residency program via a formal agreement (i.e., consortium or partnership), the organization holding the greatest responsibility is considered the Program Sponsor.

- **2.25a.** The Program Sponsor maintains authority for the residency program and responsibility for meeting the Standards.
- **2.25b.** The RPD must be employed by the Program Sponsor.
- **2.25c.** **Collaborative Oversight and Coordination:** The single Program Sponsor is responsible for maintaining a signed agreement with the additional organization(s) serving as clinical partner(s) that specifies the responsibilities for all aspects of the residency program. These responsibilities include the following:
  - **2.25c.1.** Defining the RPD's responsibilities and ability to provide oversight across multiple organizations.
  - **2.25c.2.** Creating a documented consensus mechanism for the RPD to evaluate and rank residency applicants.
  - **2.25c.3.** Implementing a mechanism for communication and collaboration between mentors at the partner site(s) and the sponsor organization(s) where the RPD is employed.
  - **2.25c.4.** Developing a coordination method for the residency program's conduct across all organizations.

Guidance on Standard 2.25

- The organizations participating in the agreement are collectively **recognized as a single residency site.**
- Accreditation is contingent on the maintenance of the agreement, and the termination of the agreement requires the participating organizations to seek new accreditation.
- A collaborative agreement is established between two organizations that enables access to all required activities and attainment of all competencies.
- An agreement does not require that all organizations independently hold NCOPE residency program accreditation **if** the secondary organization meets the definition of a local partner as defined in Standard 5.1b.1.
- Agreements can exist between two independently accredited NCOPE residency programs.
  - Independent accreditation as a primary site is required for the remote partner and satellites as defined in 5.1b.1.
- Common items within a collaborative agreement include the following:
  - The legal operating name of each organization.
  - The roles and responsibilities of each organization.
  - Any limitations that exist within the agreement.
  - Factors that make the agreement null or void, such as an expiration date or an organization changing ownership.
  - Insurance coverage for residents.
  - Responsibility for compensation of the faculty and resident(s) if applicable.
- NCOPE is not a state or federal agency able to offer in-depth guidance on collaborative agreements, employment laws, and associated regulations. Residency directors, mentors, and administrators should contact qualified employment/legal professionals to ensure collaborative agreements are in compliance with regulations outside the scope of the residency standards.

How It Will Be Assessed by NCOPE

- Written collaboration agreements submitted at the time of residency application.

2.26. **Program compliance maintenance:** A program is required to uphold compliance with the Standards, which includes, but is not limited to, the responsibilities of the RPD.

2.27. The program must periodically assess its effectiveness in achieving the defined competencies, goals, and objectives defined in Standard 3.2b.

2.27a. Outcomes assessments must include, but are not limited to, the following:

2.27a.1. National credentialing examination(s) performance.

2.27a.2. Successful completion of residency in a timely manner.

2.27a.3. Resident satisfaction scores.

2.27a.4. Resident access to required orthoses/prostheses, patient populations, and visit types.

2.28. Program leaders must address any deficits identified during an effectiveness assessment within 30 days.

2.29. On an annual basis, the residency program director submits the Residency Program Annual Report (RPAR), which includes the program outcomes, revisions to the residency program structure, and overall compliance with the NCOPE residency standards.

Guidance on Standards 2.26 – 2.29

The residency program director and key personnel can reference the RPAR for assistance determining compliance with the Standards.

Residency Program Annual Report Information.

How It Will Be Assessed by NCOPE

- Written collaboration agreements submitted at the time of residency application.

Standard 3: Structure, Design, and Implementation of the Residency Program

3.1. The residency program must enable residents to demonstrate competencies and achieve minimum activity volumes over a time frame equal to or greater than the minimum durations defined.

3.1a. **Residency programs with the infrastructure to offer training in both the orthotic and prosthetic disciplines** may seek accreditation to offer the following:

3.1a.1. Combined orthotic and prosthetic training for a minimum duration of 18 months.

3.1a.2. Training in the discipline of orthotic practice for the resident who has already demonstrated all competencies and prosthetic MAVs at a different NCOPE-accredited site and wishes to complete training in the discipline of orthotic practice for a minimum duration of nine months.

3.1a.2.1. The resident may not exceed more than one day per week offering prosthetic services when pursuing training in orthotic practice.

3.1a.3. Training in the discipline of prosthetic practice for the resident who has already demonstrated all competencies and orthotic MAVs at a different NCOPE-accredited site and wishes to complete training in the discipline of prosthetic practice for a minimum duration of nine months.

3.1a.3.1. The resident may not exceed more than one day per week offering orthotic services when pursuing training in prosthetic practice.

3.1a.4. Training in the discipline of orthotic practice for the resident beginning their O&P residency training who wishes to complete their prosthetic training at a different NCOPE-accredited residency site after demonstrating all required competencies and MAVs for a minimum duration of nine months.

3.1a.4.1. The resident must focus their training exclusively on the enrolled discipline of orthotic practice.

3.1a.5. Training in the discipline of prosthetic practice for the resident beginning their O&P residency training who wishes to complete their orthotic training at a different NCOPE-accredited residency site after demonstrating all required competencies and MAVs for a minimum duration of nine months.

3.1a.5.1. The resident must focus their training exclusively on the enrolled discipline of prosthetic practice.

Guidance on Standards 3.1a

3.1a.1.

- Residency programs with the infrastructure to meet all requirements for both the orthotic and prosthetic disciplines are encouraged to register residents for a one-site residency, training them in both disciplines.
  - Residents who enroll at a single NCOPE-accredited residency program to complete training in both disciplines are said to participate in a **one-site residency**.
- One-site residency enables the most flexibility to structure and sequence rotations (see Standard 3.2 for additional guidance) and may integrate rotations where the resident focuses exclusively on prosthetic practice, exclusively on orthotic practice, or on orthotic and prosthetic practice concurrently.

3.1a.2.

- The resident who undertakes training in a second discipline after successfully demonstrating all competencies and meeting all MAVs in the first discipline will complete the O&P residency once all competencies are demonstrated and MAVs are attained for both disciplines.
  - Residents who enroll at two separate NCOPE-accredited residency programs to complete training in both disciplines participate in what is known as a **two-site residency.**

(Continuation of Guidance on 3.1a.2.)

- NCOPE recognizes the value for residents in continuing to provide prosthetic care while enrolled in the orthotic discipline at a second residency site or vice versa, but the site must not have the resident provide care in the initial discipline more than one day per week during the residency.
  - Allowing the resident to continue practicing in the initial discipline previously completed is only allowed at a residency site accredited by NCOPE to offer training in both the orthotic and prosthetic disciplines.

3.1a.4., 3.1a.5.

- Enrolling the resident for training in a single discipline at a site capable of training in both orthotic and prosthetic management should only be done if the resident desires to pursue subsequent training in the opposite discipline at a different NCOPE-accredited residency site.
- The resident will not be recognized as having completed residency training after demonstrating all competencies if the resident has only met the MAVs for a single discipline.
  - Residents who enroll at two separate NCOPE-accredited residency programs to complete training in both disciplines participate in what is known as a **two-site residency.**

3.1b. **Residency programs with the infrastructure to offer training only in the discipline of orthotic practice** may seek accreditation to offer:

3.1b.1. Training in the discipline of orthotic practice for the resident who has already demonstrated all competencies and prosthetic MAVs at a different NCOPE-accredited site who wishes to complete training in the discipline of orthotic practice for a minimum duration of nine months.

3.1b.1.1. The resident must focus their training exclusively on the enrolled discipline of orthotic practice.

3.1b.2. Training in the discipline of orthotic practice for the resident beginning their O&P residency training who wishes to complete their prosthetic training at a different NCOPE-accredited residency site after demonstrating all required competencies and orthotic MAVs for a minimum duration of nine months.

3.1b.2.1. The resident must focus their training exclusively on the enrolled discipline of orthotic practice.

Guidance on Standards 3.1b

3.1b.1.

- Enrolling the resident for training in the orthotic discipline after successfully demonstrating all competencies and meeting all MAVs in the prosthetic discipline will result in completion of O&P residency once all competencies are demonstrated and MAVs are attained for the prosthetic discipline (at the previous site) and orthotic discipline (at the second site).
  - Residents who enroll at two separate NCOPE-accredited residency programs to complete training in both disciplines participate in what is known as a **two-site residency**.
- Residency sites only approved by NCOPE to offer training in the orthotic discipline must have the resident focus their training exclusively on orthotic practice regardless of previous attainment of competency and MAVs in the opposite discipline.

3.1b.2.

- Enrolling the resident for training in the orthotic discipline at a site only capable of training a single discipline may only be done if the resident is willing to pursue subsequent training in the opposite discipline at a different NCOPE-accredited residency site.
- The resident will not be recognized as having completed residency training after demonstrating all competencies if the resident has only met the MAVs for a single discipline.
  - Residents who enroll at two separate NCOPE-accredited residency programs to complete training in both disciplines participate in what is known as a **two-site residency**.

3.1c. **Residency programs with the infrastructure to offer training only in the discipline of prosthetic practice** may seek accreditation to offer:

3.1c.1. Training in the discipline of prosthetic practice for the resident who has already demonstrated all competencies and orthotic MAVs at a different NCOPE-accredited site who wishes to complete training in the discipline of prosthetic practice for a minimum duration of nine months.

3.1c.1.1. The resident must focus their training exclusively on the enrolled discipline of prosthetic practice.

3.1c.2. Training in the discipline of prosthetic practice for the resident beginning their O&P residency training who wishes to complete their orthotic training at a different NCOPE-accredited residency site after demonstrating all required competencies and prosthetic MAVs for a minimum duration of nine months.

3.1c.2.1. The resident must focus their training exclusively on the enrolled discipline of prosthetic practice.

Guidance on Standards 3.1c

3.1c.1

- Enrolling the resident for training in the prosthetic discipline after successfully demonstrating all competencies and meeting all MAVs in the orthotic discipline will result in the completion of O&P residency once all competencies are demonstrated and MAVs are attained for the orthotic discipline (at the previous site) and prosthetic discipline (at the second site).
  - Residents who enroll at two separate NCOPE-accredited residency programs to complete training in both disciplines participate in what is known as a **two-site residency**.
- Residency sites only approved by NCOPE to offer training in the prosthetic discipline must have the resident focus their training exclusively on prosthetic practice regardless of previous attainment of competency and MAVs in the opposite discipline.

3.1c.2

- Enrolling the resident for training in the prosthetic discipline at a site only capable of training a single discipline may only be done if the resident is willing to pursue subsequent training in the opposite discipline at a different NCOPE-accredited residency site.
- The resident will not be recognized as having completed residency training after demonstrating all competencies if the resident has only met the MAVs for a single discipline.
  - Residents who enroll at two separate NCOPE-accredited residency programs to complete training in both disciplines participate in what is known as a **two-site residency**.

3.2. Program structure and design: The residency program must have a defined structure or sequence of rotations (learning activities) that ensures the resident is provided with access to a wide range of diagnoses, patient demographics, and orthoses/prostheses to meet the requirements and minimum activity volumes defined in Appendix A.

3.2a. The program structure is documented and includes the following:

3.2a.1. A required learning experience that facilitates resident orientation to the residency program and practice environment(s) at the beginning.

3.2a.2. A list of all required and elective rotations, if applicable.

3.2a.3. The planned duration of each rotation.

Guidance on Standard 3.2

- The program structure is defined by the residency site at the time accreditation is sought.
- Multiple program structures may be identified if the residency site has adequate resources to enable more than one structure.
- The resident must be informed at the time an offer is extended of the program structure for their training.
- The program structure may be adjusted or modified to address changes in resources at the residency site or the unique needs of the resident, as long as it is performed under the supervision of qualified mentors at satellite and partner clinics with the aim of achieving all required competencies, activities, and goals.

3.2a.1.

- The initial learning experience scheduled for the resident includes orientation to the residency program and practice environment. Orientation to the residency program includes, at a minimum, the following:
  - Organization- and residency-specific policies and procedures defined in Standard 2.
  - Residency purpose, as documented in the Introduction to the Standards.
  - The Standards themselves.
  - Competency areas, minimum activity volumes, goals, and objectives of the residency program.
  - Description of required and, if applicable, elective learning experiences.

3.2a.2.

- Rotations may correlate to the following categories:
  - Geographic locations (e.g., the Rochester Hills office).
  - Patient populations (e.g., idiopathic scoliosis).
  - Treatment categories (e.g., upper limb prosthetic care).
  - Disciplines (e.g., immersive pediatric orthotic experience).
- Naming of rotations is consistent among manuals, promotional materials, and information posted on OPRESCAS.
- Programs are not required to offer elective learning experiences.
- The program is encouraged to develop achievement of competency while considering factors relevant to the clinical practice, including patient populations served and setting.
- The program may adjust the education to an individual resident based on their unique educational needs.

(Continuation of Guidance on 3.2a.2.)

- NCOPE does not require or endorse any one program structure over another and recognizes there are many approaches to achieve competency and successfully complete all residency requirements.

3.2a.3.

- The following are examples of rotations with residents' time scheduled on a recurring basis:
  - **Technical Fabrication:** Tuesday and Thursday afternoons (half-day each), for 12 weeks.
  - **Single-Discipline Followed by Dual-Discipline Time:** Six months of focused orthotic patient care, six months of focused prosthetic patient care, and a final six-month span during which care is provided to both orthotic and prosthetic populations.
  - **Research-Directed Study:** Up to two days per month may be dedicated project days until the project is presented at the start of the 12th month.
  - **Upper Limb Prosthetic Care:** Every Monday and Thursday for four to six weeks.

See the NCOPE website for additional examples of program structure documentation.

How It Will Be Assessed by NCOPE

- Review of the following information:
  - Documented structure in program and promotional materials.
  - Residents' schedules in NCOPE Tracker.
  - Learning experience orientation description.

3.2b. Competency areas, goals, and objectives.

3.2b.1. The program's structure facilitates the achievement of all required competencies and MAVs in Appendix A.

3.2b.1.1. All required activities are assigned to at least one required learning experience or a sequence of learning experiences to allow sufficient practice for their achievement.

3.2b.2. Objectives within the residency program must enable the resident to demonstrate progressive engagement culminating in independent clinical practice.

Guidance on Standards 3.2b.2

- Resident engagement is documented within NCOPE Tracker case logs generated by the resident.
- The levels of engagement are defined below.

Engagement Definitions

Observe

The resident does not provide any component of care and exclusively observes a qualified healthcare professional providing all aspects of care during patient visits.

Assist

The resident aids in providing care in the presence of a qualified healthcare professional during patient visits. The majority of the critical patient care tasks is performed by the treating healthcare professional, such as aligning the patient's anatomy during casting, finalizing dynamic alignment, or assessing the patient's ability to effectively use the prosthesis/orthosis outside the clinic.

Independent

The resident directly provides patient care; the majority of the critical patient care tasks are performed by the resident, such as aligning the patient's anatomy during casting, finalizing dynamic alignment, or assessing the patient's ability to effectively use the prosthesis/orthosis outside the clinic. An NCOPE-qualified residency mentor must provide direct supervision of the resident providing independent care until minimum competency is documented for the service(s) being provided. After minimum competency is achieved by the resident in a service, the mentor must provide indirect supervision for all subsequent care provided by the resident.

How It Will Be Assessed by NCOPE

- Review of the following information:
  - The program's structure, resident schedules, and learning experience descriptions.
  - NCOPE Tracker documentation submitted by the resident, director, and mentor(s).

3.2c. Program design requirements for orthotic and prosthetic residencies

3.2c.1. Residents gain experience and progress to independent practice with a variety of orthoses/prostheses and health conditions and a diverse range of patients to demonstrate competence as defined in Appendix A and Appendix B.

3.2c.2. Residents participate in full episodes of care, including evaluation, formulation of treatment plan, implementation of care, and follow-up.

3.2c.3. No more than one-fifth (20%) of total direct patient care experiences may be dedicated to the provision of off-the-shelf orthoses that can be applied and self-adjusted by the patient.

3.2c.4. Residents are provided with sufficient opportunities to provide direct patient care to patients with the required orthoses/prostheses and patient populations defined in Appendix A.

Guidance on Standards 3.2c

3.2c.1

- The Standards **do not** define a percentage of time to be spent in each discipline.
- The Standards **do** require that the residency program defines a structure that enables the achievement of competency and attainment of minimum activity volumes.

3.2c.2

- The aim of residency is to enable the resident to provide comprehensive orthotic and prosthetic management across full episodes of care from the initial evaluation and fittings to delivery, patient/caregiver education, and ongoing follow-up care.
- The residency Standards **do not** define a maximum amount of time the resident may spend being engaged in fabrication; however, the goal of the resident's engagement in fabrication should be to provide the resident with a sound understanding of the technical requirements for the fabrication of orthoses/prostheses, not for the resident to achieve competency in fabrication-related skills not typically performed by the orthotist-prosthetist.
- The residency Standards define competencies aligned with direct patient care. Technical fabrication should be used to complement patient care activities but will not count toward the achievement of any MAVs.

3.2c.3

- The goal of residency is to develop the knowledge and skills needed to function as an independent orthotist-prosthetist.
- Off-the-shelf (OTS) orthoses by definition require minimum adjustment and may be self-applied by the patient **without any modification or adjustment by an orthotist or other qualified healthcare professional**.

(Continuation of Guidance on Standard 3.2c.3.)

- Custom-fit orthoses that require professional expertise to adjust, modify, and apply are **not considered OTS orthoses**.
- Any orthosis that has an OTS code counts toward the volume of OTS fittings even if the facility bills for the service using a split code or custom-fit code.
- The resident must log all patient encounters, including OTS fittings. Not logging OTS patient visits fails to demonstrate compliance with Standard 3.4.

Please reference 42 CFR, §414.402 for additional guidance on OTS orthoses.

How It Will Be Assessed by NCOPE

- Review of the following information:
  - The program's structure, resident schedules, and learning experience descriptions.
  - NCOPE Tracker documentation submitted by the resident and faculty.

3.3. Pathways to completion.

3.3a. One-site pathway is a residency program completed at a single residency site that meets all NCOPE residency standards. It provides all the necessary experiences for residents to achieve competencies, minimum activity volumes, and requirements. An accredited residency site offering a one-site pathway allows residents to complete training in both orthotic and prosthetic disciplines.

Guidance on Standard 3.3a

- A one-site pathway is intended for any residency site that offers adequate access to all required patient populations across orthotic **and** prosthetic practice for the resident to demonstrate all required competencies and MAVs.
- Sites that were eligible to offer either a combined orthotic and prosthetic (dual-discipline) residency or **both** the single-discipline orthotic **and** single-discipline prosthetic residency prior to July 1, 2025, are encouraged to participate in the one-site pathway.

(Continuation of Guidance on Standard 3.3a.)

- NCOPE does not endorse a specific structure or sequence for rotations and recognizes local factors must be weighed when developing a residency program. The following examples are possible structures that may be completed via a one-site residency pathway:
  - **Example 1, Combined (Dual-Discipline) Training Throughout the Entire Residency:**
    - > For an 18-month duration, the resident provides orthotic and prosthetic services with the ability to see both orthotic and prosthetic patients on any given day.
  - **Example 2, Combined (Dual Discipline) Training on Specific Days for the Entire Residency:**
    - > For an 18-month duration, the resident provides orthotic services on Monday, Wednesday, and Friday and provides prosthetic services on Tuesday and Thursday.
  - **Example 3, Focused Single-Discipline Training:**
    - > For a nine-month duration, the resident provides only orthotic services; this is followed by an additional nine-month duration when the resident provides only prosthetic services.
  - **Example 4, Blended Single-Discipline and Dual-Discipline Training:**
    - > The resident provides only prosthetic services for the first siwx months, which is followed by a six-month period when the resident provides only orthotic services and a final six-month duration when the resident provides both orthotic and prosthetic services.

Any of the structures/sequencing above may occur over a minimum of 18 months and may be extended based on the proposed rotations and structure defined by the residency program faculty.

How It Will Be Assessed by NCOPE

- Review of the program's structure, residents' schedules, and learning experience descriptions.

3.3b. Two-site pathway describes a residency program where training occurs across two separate NCOPE-accredited residency sites and the resident focuses on a single discipline at each residency site. Residents enrolled in this pathway must/will achieve the following:

3.3b.1. Demonstrate all required competencies and meet MAVs for the enrolled discipline at the initial site.

3.3b.2. Spend a minimum of nine months at both the initial and second sites.

3.3b.3. Obtain a certificate of residency completion only after training in both disciplines is completed.

3.3b.4. Generate a report to document attainment of all required training at the initial site and share it with the RPD at the second site.

3.3b.5. Submit separate resident registration forms at least 14 days before the start date at each residency site.

Guidance on Standard 3.3b

- Residency sites capable of offering residency training in both disciplines are encouraged to operate the program as a one-site residency but may opt to register residents in a single discipline as defined in Standards 3.1a.2 – 3.1a.5.
- Residency sites may develop program structures longer than nine months to achieve the required competencies, minimum activity volumes, and program-specific goals.
- **No** certificate of completion is awarded after training concludes at the initial site.
  - A final evaluation related to the first discipline completed will be submitted by the director at the initial site to confirm all requirements tied to the initial discipline have been met.
- The second site in which the resident enrolls must be approved for the opposite discipline.
- If the resident completed their initial discipline training at the same site where they ultimately pursue the opposite discipline, all requirements defined under Standard 3.2b must still be met.
  - The flexibility of the program's sequencing and structure allowable for a one-site residency defined in Standard 3.2a can only be leveraged if the resident registers for a single-site residency prior to beginning any residency training.
- While pursuing the training in the second discipline, the resident is only allowed to provide care in the initial discipline if the second site is approved for both orthotic and prosthetic residency training.
  - The resident must dedicate at least 80% of their time to the second enrolled discipline as defined in Standard 3.1a.3.
- The resident is the sole party responsible for securing positions at each residency site. Neither NCOPE nor any NCOPE-accredited residency site can guarantee subsequent acceptance into a position at a second residency site to complete the opposite discipline.

How It Will Be Assessed by NCOPE

Review of the program's structure, residents' schedules, learning experience descriptions, and advertising materials.

3.4. Rotations/learning experiences and sequencing create a structure for the residency program to ensure all competencies and minimum activity volumes are achieved.

3.4a. Rotation/learning experience descriptions are documented and include the following:

3.4a.1. A general description, including the practice area(s) and anticipated number of exposures for the disciplines available.

3.4a.2. The role of designated mentors in the practice area.

3.4a.3. Expectations of residents.

3.4a.4. Objectives assigned to the learning experience.

Guidance on Standard 3.4a

3.4a. Mentors are involved in the development of learning experiences and rotations.

3.4a.1. The description of the practice area may include types of patients, members of the healthare team, patient care focus, and typical patient load.

3.4a.2. A certified orthotist, certified prosthetist, or certified prosthetist-orthotist may serve as a mentor, supervising residents in the discipline(s) in which they hold certification. The mentor's role encompasses responsibilities in both direct and indirect patient care experiences.

3.4a.3. In addition to daily or weekly clinical responsibilities, expectations of residents should include required clinical track activities, topic discussions, projects, assignments, and meeting attendance.

3.4a.4. At least one objective is assigned to each rotation.

- **Example 1:** Capture lower limb anatomy using a non-weight-bearing casting with the patient in the desired alignment needed to fabricate an ankle-foot orthosis for a pediatric patient with a neuromuscular diagnosis.
- **Example 2:** Assess body-powered upper-limb prosthesis fit and function to ensure proper actuation of the terminal device, wrist rotation, and elbow joint function.

How It Will Be Assessed by NCOPE

- Review of the program's structure, residents' schedules, learning experience descriptions, and advertising materials.

3.4b. At the beginning of each learning experience/rotation, mentors orient residents to the experience.

3.4c. Mentors grant residents a safe and appropriate level of engagement based on each resident's progression through the learning experience.

Guidance on Standard 3.4c

- The mentor role may vary based on the resident's progress:
  - Direct instruction at a level appropriate for the resident, when needed.
  - Modeling of practice skills described in the educational objectives.
  - Coaching skills described in the educational objectives, thereby providing regular ongoing feedback.
  - Facilitation that allows the resident to assume increasing levels of responsibility for performance of skills with indirect support by the mentor as needed.

How It Will Be Assessed by NCOPE

Review of the following information:

- Learning experience descriptions.
- Discussion with residents, mentors, and RPD if a site visit is required to attain accreditation.

3.5. Resident documentation.

3.5a. The resident must log each patient visit in NCOPE Tracker no more than 14 days after the visit occurred.

Guidance on Standard 3.5

- NCOPE Tracker is used to log individual patient visits, and only activities where the patient is present in the office are included.
  - The resident is not required to log activities commonly performed when the patient is not present, such as insurance correspondence or fabrication. The resident must still be assessed by the primary mentor for competency with technical procedures and practice management skills.
- All visits must be logged using NCOPE Tracker irrespective of the duration the patient was present for orthotic and prosthetic services.
- These case logs are essential to report on the resident's progress toward MAVs by the resident, mentor/director, and NCOPE staff.
  - For additional information on MAVs, please see Appendix A.

How It Will Be Assessed by NCOPE

- Review of resident case logs within NCOPE Tracker.

3.6. Monitoring of the resident.

3.6a. Each resident documents a self-assessment within the first 30 days of the residency program and after completing each quarter until the residency is completed.

3.6b. The RPD, designated associated director, or mentor regularly assesses reports to determine whether the program provides the resident with appropriate access to required patient populations and orthoses/prostheses and revises the residency structure to enable diverse clinical experiences.

3.6c. The RPD and the resident must maintain independent records related to residency progress, including copies of any forms submitted by the resident, the residency mentor, or RDP.

3.7. Evaluation of the resident and progression.

3.7a. Assessment and feedback

3.7a.1. Mentors provide ongoing verbal feedback to residents about their progress and how they can improve.

3.7a.1.1. Feedback for the resident not making adequate progress is to be documented in writing consistent with the resident-specific disciplinary policy defined in Standard 2.7.

3.7a.2. The resident who is not meeting the program's expectations must receive more frequent written feedback. Specific recommendations for improvement and achievement of objectives are documented within NCOPE Tracker and any documentation systems defined by the residency site.

3.7a.3. The quarterly evaluation includes the extent of the resident's progress toward the achievement of competencies based on a rating scale.

3.7a.4. The mentor documents qualitative written comments specific to the evaluated competencies.

3.7a.5. The mentor and resident meet to discuss each quarterly evaluation at an appointment dedicated exclusively to the resident's progress and the residency program overall.

3.7a.5.1. The RPD or a designated associate director must be present during the quarterly evaluation meeting if the primary mentor was not the RPD or a designated associate director.

3.7a.6. If more than one mentor is assigned to a learning experience, all mentors engaged during a quarter provide input into the resident's evaluation.

3.7a.7. The RPD and mentors must make appropriate adjustments to learning activities based on the resident's progress.

3.7a.7.1. The resident's clinic schedule must be revised as necessary to enable the timely attainment of competencies, MAVs, goals, and objectives.

Guidance on Standard 3.7a

3.7a.1.

- Feedback to the resident is frequent, specific, and constructive.
- The frequency of ongoing feedback varies based on **the resident's** progress and is defined at the beginning of the residency program and again with each rotation when feedback varies across different rotations.
- Qualitative written comments have the following attributes:
  - Are specific and actionable.
  - Use criteria related to specific educational objectives.
  - Recognize the resident's skill development.
  - Focus on how the resident may improve their performance.

3.7a.4.

- Examples of adjustments to resident activities include adjusting the number of patients assigned, expectations for projects and presentations, and expectations for resident check-ins with the mentor.

3.7a.5.1.

- Feedback provided in a quarterly evaluation must occur when the primary mentor, resident, and RPD (as necessary) can discuss the resident's progress toward the attainment of competency.

How It Will Be Assessed by NCOPE

- Review of documented feedback.

3.7b. Final evaluation of the resident.

3.7b.1. The residency program director or designated associate director completes a final evaluation of the resident at the conclusion of training at the residency site.

3.7b.2. The documented final evaluation includes the extent of the resident's progress toward achievement of competence based on a defined rating scale.

3.7b.2.1. The mentor documents qualitative written comments specific to the evaluated competencies.

3.7b.2.2. The director or designated associate director and resident discuss the final evaluation.

3.7b.2.2.1. If the director was not the clinician serving as the resident's primary mentor, the primary mentor(s) must also participate in the discussion of the final evaluation.

3.7b.2.3. Input is sought from all mentors who participate in the resident's training and incorporated into the resident's final evaluation so that the report represents the whole of the resident's experience.

Guidance on Standard 3.7b

- The mentor cannot fill out the final evaluation; only the director or designated associate director may complete the final evaluation.
- The forms within NCOPE Tracker ensure competency is documented and qualitative feedback is shared.
- Identify in the final evaluation all mentors and any personnel who offered input.
- Prompts for qualitative/narrative input are included inside associated NCOPE Tracker forms.
- If the residency director or designated associate director is not physically located at the clinic where the resident is principally gaining clinical experience at least 50% of the time, feedback from primary mentors should be weighed more heavily during quarterly and final evaluations of the resident.

How It Will Be Assessed by NCOPE

- Review of the following information:
  - Timely submission of the final evaluation.
  - Qualitative feedback provided in the final evaluation.

3.8. Evaluation of the mentor and rotation/learning experience.

3.8a. The resident documents an evaluation of their primary mentor each quarter and discusses the results at quarterly meetings.

3.8b. The resident documents and discusses an evaluation of each rotation at least once per quarter.

Guidance on Standard 3.8

- Submission of these forms should not be the only time feedback is provided by the resident.
- The resident may determine whether the Evaluation of the Mentor Form will be provided to the mentor, but they are always encouraged to do so to ensure multisource feedback.

How It Will Be Assessed by NCOPE

- Timely submission of the forms by the resident and the assigned mentor.

3.9. Evaluation of the CAAHEP-accredited master's-level O&P education program for postgraduate residents.

3.9a. The resident registered in a postgraduate residency program must submit an Evaluation of the CAAHEP-Accredited Education Program by the Graduate Form within the first 12 months of residency training.

3.9b. The primary mentor or residency director supervising the resident enrolled in a postgraduate residency program submits an Evaluation of the CAAHEP-Accredited Education Program by the Employer Form during the first 12 months of residency training.

Guidance on Standard 3.9

3.9.

- These standardized forms are provided by NCOPE and are available within NCOPE Tracker. The results are disseminated to all accredited O&P education programs in a deidentified manner.
  - Education programs are allowed to request additional information from graduates and their employers using their own surveys/tools.

3.9a.

- The resident must submit the Evaluation of the CAAHEP-Accredited Education Program by the Graduate Form once at each site they are registered.
  - Residents pursuing a one-site residency will complete this form once.
  - Residents pursuing a two-site residency will complete this form once at each site for a total of two submissions.
    - > This is required because the survey requests feedback on discipline-specific knowledge and skills.

3.9b.

- The mentor must submit the Evaluation of the CAAHEP-Accredited Education Program by the Employer Form.
  - Residents pursuing a one-site residency will have a single mentor complete this form once.
  - Residents pursuing a two-site residency will have a mentor at each site complete this form once for a total of two submissions, as the form requests discipline-specific information.

How It Will Be Assessed by NCOPE

- Timely submission of the forms by the resident and the assigned mentor.

3.10. Evaluation of pre-residency training for integrated residents.

3.10a. The resident registered in an integrated residency program must submit an Evaluation of Pre-Residency Training Form during the resident's first rotation.

3.10b. The primary mentor during the first rotation supervising the resident enrolled in an integrated residency program must submit an Evaluation of Pre-Residency Training Form at least 45 days after the resident began their rotation at the site.

Guidance on Standard 3.10

- Integrated residency programs reserve the right to request that mentors at rotation sites beyond the NCOPE-mandated initial rotation complete the Evaluation of Pre-Residency Training Form.

3.11. The program offers either a clinical track or a research track.

3.11a. A clinical track residency requires the resident to participate in one of the following activities quarterly and to submit relevant documentation prior to the end of each quarter:

3.11a.1. Critically assessed topic.

3.11a.2. Journal club presentation.

3.11a.3. Resident case presentation.

3.11a.4. Resident-hosted professional in-service.

3.11a.5. Presentation at state, regional, national, or international meetings.

Guidance on Standard 3.11a

- Performing a variety of clinical track activities enhances the knowledge and skill set of the resident. Residents should perform each of the activities listed in Standards 3.11a.1 – 3.11a.5, but in instances where an activity must be repeated, each activity type should be completed no more than twice.
- A professional in-service is defined as an O&P presentation to other healthcare professionals to inform them about O&P management within their relative scope.
  - Presentations to students or other people with the intent to educate them about pathways into the profession are not considered in-service.

A comprehensive list of required documentation and deliverables is listed in Appendix D.

3.11b. A research track residency is performed under the supervision of a qualified research advisor as defined in Standard 4.7 and culminates in the creation of a directed study deliverable related to orthotics and/or prosthetics appropriate for one or more of the following:

3.11b.1. Dissemination as a peer-reviewed manuscript.

3.11b.2. Poster presentation.

3.11b.3. Free paper presentation at a scientific meeting.

3.11c. Each quarter, the resident enrolled in the research track must provide a research update until the directed study is successfully submitted and approved in writing by the resident's research advisor.

3.11c.1. Integrated residents enrolled in the research track residency may be exempted from the quarterly submission if the RPD or designated associate program director provides methods to track progress at the institutional level.

3.12. The program requires the completion of at least one community engagement activity and associated documentation of such activity selected from the following options:

3.12a. Provide an O&P awareness presentation to middle school, high school, or college students.

3.12b. Volunteer for a professional or humanitarian organization that supports O&P patients or professionals.

3.12c. Contribute or moderate a patient support group for persons who require orthotic and/or prosthetic care.

Standard 4: Requirements of the Residency Program Directors, Mentors, and Other Professionals

4.1. Each residency site must appoint a single residency program director who is the authorized leader responsible for the entire program's conduct. The RPD and any persons identified as a designated associate director must meet the following qualifications:

4.1a. Didactic Education: To qualify as an RPD, the candidate must meet one of the following criteria:

4.1a.1. Have completed an NCOPE/CAAHEP-accredited orthotist and/or prosthetist education program at the bachelor's, postbaccalaureate certificate, or master's level.

4.1a.2. Have completed an International Society for Orthotics and Prosthetics (ISPO) accredited orthotist and/or prosthetist education program at the level of orthotist-prosthetist at the bachelor's, postbaccalaureate certificate, or master's level based on WES evaluation.

4.1a.3. Be actively serving as a residency director on July 1, 2025, the date the Standards were implemented.

4.1b. Credential Requirement: To qualify as an RPD, the candidate must be one of the following:

4.1b.1. Certified as an orthotist and/or prosthetist by ABC.

4.1b.2. Certified as an orthotist and/or prosthetist by the Board of Certification/ Accreditation (BOC).

4.1b.3. Licensed as an orthotist and/or prosthetist if the state(s) where the program operates has a license act for the practice of orthotics and prosthetics.

4.1c. Experience Requirement: To qualify as an RPD, the candidate must have held certification or licensure as an orthotist and/or prosthetist for a minimum of four years.

4.1d. NCOPE-Mandated Training: To qualify as an RPD, the candidate must have completed one of the following:

4.1d.1. The Approved Clinical Mentor training course within the past three years.

4.1d.2. The online residency development course within the past three years.

4.1d.3. An online residency refresher course within the past three years.

4.1e. No more than three associate directors can be identified in any accredited residency program.

Guidance on Standard 4.1e

- An associate RPD should be designated at sites that have a large number of concurrent residents or where the residency program director does not work primarily at the clinic where residency training is occurring.

4.2. Residency program director oversight and quality assurance.

4.2a. A formal program evaluation is conducted annually and includes the following:

4.2a.1. Assessment of methods for recruitment.

4.2a.2. End-of-year input from residents who complete the program.

4.2a.3. Input from resident evaluations of mentors and learning experiences.

4.2a.4. Input from mentors related to continuous improvement of the program.

4.2a.5. Documentation of program improvement opportunities and plans for changes to the program.

4.2b. Improvements identified through the assessment process are implemented.

4.2c. Appointment and reappointment of residency program mentors:

4.2c.1. Mentor appointment and reappointment decisions are documented at the time of accreditation application.

4.2c.2. The addition or subtraction of mentors between accreditation applications must be identified by the program director or designated associate residency program director(s) to the NCOPE staff via email within 30 days of the start or end of an appointment.

4.2c.2.1. Proof of formal education and completion of online training defined in Standard 4.4 must be provided for all additional mentors.

4.2d. The RPD is permitted to delegate certain oversight and administrative responsibilities to one or more associate residency program directors, who must be duly NCOPE-recognized mentors at the program's location.

4.3. Residency mentors meet or exceed the defined qualifications:

4.3a. Didactic Education: To qualify as a mentor, the candidate must meet one of the following criteria:

4.3a.1. Have completed an NCOPE/CAAHEP-accredited orthotist and/or prosthetist education program at the bachelor's, postbaccalaureate certificate, or master's level.

4.3a.2. Have completed an ISPO-accredited orthotist and/or prosthetist education program at the level of orthotist-prosthetist at the bachelor's, postbaccalaureate certificate, or master's level based on WES evaluation.

4.3a.3. Be actively serving as a mentor on July 1, 2025, the date the Standards were implemented.

4.3b. Credential Requirement: To qualify as a mentor, the candidate must be one of the following:

4.3b.1. Certified as an orthotist and/or prosthetist by ABC.

4.3b.2. Certified as an orthotist and/or prosthetist by BOC.

4.3b.3. Licensed as an orthotist and/or prosthetist if the state(s) where the program operates has a license act for the practice of orthotics and prosthetics.

4.3c. Experience Requirement: To qualify as a mentor, the candidate must have held certification or licensure as an orthotist and/or prosthetist for a minimum of two years.

4.3d. NCOPE-Mandated Training: To qualify as a mentor, the candidate must have completed one of the following:

4.3d.1. The Approved Clinical Mentor (ACM) training course within the past three years.

4.3d.2. The online residency development course within the past three years.

4.3d.3. An online residency refresher course within the past three years.

4.4. Mentors' responsibilities: Mentors must demonstrate the ability to supervise residents' learning experiences as evidenced by the following:

4.4a. Content knowledge/expertise in the area(s) of orthotic and/or prosthetic practice mentored.

4.4b. Contribution to orthotic and/or prosthetic practice in the area mentored.

4.5. Mentors routinely perform patient care in the practice area in which they are training the resident.

4.5a. Mentors actively participate and guide learning when mentoring residents.

Guidance on Standard 4.5

- Mentors provide day-to-day resident oversight and guidance. Mentors are fully qualified clinicians who impart the benefits of their knowledge and experience to residents.
- Besides the defining number of years of required experience, mentors only differ from residency directors in administrative responsibilities to the residency program and resident(s), such as the capacity to sign forms.

How It Will Be Assessed by NCOPE

- NCOPE staff may request documentation of a mentor's clinical schedule with PHI redacted to confirm they are actively caring for patients relevant to the orthotic and prosthetic residency.

4.6. Research advisors provide oversight and guidance to research-track residents on their directed study projects. To qualify as a research advisor, the candidate must have the following:

4.6a. Completed research ethics training and be up to date via the completion of refresher courses as required by the institution or training body.

4.6b. At least two peer-reviewed manuscripts in publication or a documented record of service as a reviewer and editor for a peer-reviewed scientific journal.

4.6c. At least two peer-selected scientific presentations relevant to orthotics and/or prosthetics at state, regional, national, or international meetings.

4.6d. Time dedicated to supporting resident research efforts to enable the timely completion of deliverables.

4.7. Non-orthotist-prosthetist personnel (e.g., technicians, pedorthists, administrative professionals) may contribute to the O&P residency per the following requirements:

4.7a. Direct patient care learning experiences are scheduled after the RPD or designated mentor assesses and determines that the resident is ready to engage in practice within the scope of non-orthotist-prosthetist personnel.

4.7b. The RPD or designated mentor works closely with the non-orthotist-prosthetist personnel to select, and be responsible for, the educational objectives and activities for the learning experience.

At the end of each quarter, input from non-orthotist-prosthetist personnel is solicited by the primary mentor (defined in Standard 4.4) or RPD (defined in Standard 4.3) and reflected in the quarterly evaluation of the resident.

Guidance on Standard 4.7

- NCOPE recognizes that personnel including technicians, administrative staff, clinician assistants, and practitioners who do not meet all requirements to serve as a formal mentor often bring value to the professional development of the resident.
- A qualified mentor must still provide direct supervision as defined in Standard 2.3a while the resident is engaged with non-orthotist-prosthetist personnel.
- Personnel who do not meet the requirements to serve as a mentor or director cannot be granted access to NCOPE Tracker.

Standard 5: Orthotic and Prosthetic Services

5.1. Orthotic and prosthetic leadership and compliance.

5.1a. Facility accreditation.

5.1a.1. Postgraduate residency programs may be sponsored by the following:

5.1a.1.1. Comprehensive orthotic and/or prosthetic clinical facilities that hold facility accreditation for custom orthotic and prosthetic services from one of the following entities or meet the following criteria:

5.1a.1.1.1. The American Board for Certification in Orthotics, Prosthetics, and Pedorthics.

5.1a.1.1.2. The BOC.

5.1a.1.1.3. Comprehensive orthotic and/or prosthetic clinical facilities that hold a state orthotic and prosthetic facility license.

5.1a.1.1.4. International clinical practices that meet all qualifications to provide comprehensive orthotic and prosthetic care as determined by the local governing authorities and equivalence to ABC facility accreditation standards for comprehensive orthotic and prosthetic care.

5.1a.2. Integrated residency programs:

5.1a.2.1. Are operated at institutions with a CAAHEP-accredited orthotist-prosthetist degree program and require completion of an NCOPE-accredited residency program to have the degree conferred. The sponsor of the residency program is the academic institution that hosts the orthotist-prosthetist education program.

5.1a.2.2. At all academic partner clinics must meet the standards defined in 5.1a.1 and provide resident supervision via compliance with Standard 4.4.

5.1b. Qualified locations for clinical training:

5.1b.1. The organization sponsoring the residency site may leverage multiple clinical locations to deliver the orthotic and/or prosthetic residency training, including the following:

5.1b.1.1. **Primary Clinics** owned and operated by a facility accredited for comprehensive orthotic and/or prosthetic services where the resident spends most of the residency.

5.1b.1.2. **Local Satellite Clinics** owned and operated by a facility accredited for comprehensive orthotic and/or prosthetic services (5.1a.1.1) **within one of the following**:

5.1b.1.2.1. A 50-mile radius of the primary clinic.

5.1b.1.2.2. A 75-mile radius if both the primary clinic and the satellite are located in a designated rural area.

5.1b.1.3. **Local Partner Clinics** owned and operated by a different organization than the sponsoring institution **and** that meet the following criteria:

5.1b.1.3. 1. Within a 50-mile radius of the primary clinic, ***or***

5.1b.1.3. 2. Within a 75-mile radius if both the primary clinic and satellite are located in a designated rural area.

5.1b.1.3. 3. A formal agreement must be in place between the residency site and the partner clinic that clearly identifies the roles and responsibilities of all parties and any other requirements to enable the resident to participate in direct patient care as defined by federal, state, or local jurisdiction.

Please see Standard 2.28 for additional information regarding partnerships and shared responsibilities between two separate organizations.

5.1b.1.4. **Remote Satellite Clinics** owned and operated by a facility accredited for comprehensive orthotic and/or prosthetic services (5.1a.1.1) that meet the following criteria

5.1b.1.4.1. Outside a 50-mile radius of the primary clinic, ***or***

5.1b.1.4.2. Outside a 75-mile radius if both the primary clinic and satellite are located in a designated rural area.

5.1b.1.4.3. The remote satellite clinic must hold independent NCOPE Residency Program accreditation and be recognized as a primary clinic.

5.1b.1.4.4. Remote satellite clinic rotations must not exceed two weeks for a 52-week period unless the resident agrees to an extended placement prior to accepting the residency position.

5.1b.1.5. **Remote Partner Clinics** owned and operated by a different organization than the sponsoring institution that meet the following criteria:

5.1b.1.5.1. Outside a 50-mile radius of the primary clinic, ***or***

5.1b.1.5.2. Outside a 75-mile radius if both the primary clinic and satellite are located in a designated rural area

5.1b.1.5.3. The remote partner clinic must hold independent NCOPE Residency Program accreditation and be recognized as a primary clinic.

5.1b.1.5.4. Remote partner clinic rotations must not exceed two weeks for a 52-week period unless the resident agrees to an extended placement prior to accepting the residency position.

5.1b.1.5.5. A formal agreement must be in place between the residency site and the partner clinic that clearly identifies the roles and responsibilities of all parties and any other requirements to enable the resident to participate in direct patient care as defined by federal, state, or local jurisdictions.

Please see Standard 2.28 for additional information regarding partnerships and shared responsibilities between two separate organizations.

5.1b.1.6. **Academic Partner Clinics** are clinics that serve as clinical experience sites for students enrolled in integrated residency programs. Academic partner clinics have no limitations on the distance from the sponsoring institution.

5.1b.1.7. **Mobile Clinics** are part of an accredited orthotic and prosthetic facility and utilize vehicles equipped with the tools and resources needed to perform all components of patient care including evaluations, formulations of care plans, measuring/scanning/casting, diagnostic fittings, deliveries, and follow-up care.

Guidance on Standard 5.1b

5.1b.

- The residency site must identify all facilities where orthotic and prosthetic patient care is the primary service being performed.
  - A freestanding satellite outpatient O&P clinic should be identified as a clinical site.
  - A comprehensive rehabilitation hospital, for example, where physician and therapist care are the primary services delivered and where the O&P resident performs "hospital calls." does not need to be identified as a clinical site.
- A qualified mentor as defined in Standard 4.4 must be present at all clinics whenever an orthotic/prosthetic resident is present and interacting with patients.

5.1b.1.

- Integrated residency programs are not required to define a primary clinic, as the residency program is coordinated through an accredited academic institution hosting a CAAHEP-accredited, orthotist-prosthetist education program.

5.1b.2.

- Residents may rotate through multiple satellite clinics during a given week as long as they do not exceed the travel limits defined in Standard 2.4f.

5.1b.3.

- Residents must be informed of the potential need to attend local partner clinics prior to beginning the residency.
- Residents may rotate through multiple local partner clinics during a given week so long as they do not exceed the travel limits defined in Standard 2.4f.

5.1b.4.

- The residency site should provide the resident with alternative experiences within the radius defined if requested by the resident prior to the start of the residency unless the residency site covers all travel and lodging expenses needed to attend the remote partner clinic.
  - Should the residency site be unable to offer an alternative experience, they must inform the resident that no alternative experiences exist prior to the resident accepting the residency position.
- The resident cannot attend more than one remote partner clinic each quarter unless they agree to more frequent attendance before beginning the residency or the residency site covers housing and travel expenses.

5.1b.6.

- Academic partnerships may only be defined when one of the parties in the agreement is part of an integrated CAAHEP-accredited orthotist-prosthetist education program.

5.1b.7.

- Resources provided to the resident must enable appropriate patient care and not require the resident to incur additional expenses due to the integration of mobile clinics into a residency site.
- Supervision requirements must fully comply with Standard 2.3.
- Additional information must be provided when documenting the residency program resources for sites that integrate a mobile clinic.

How It Will Be Assessed by NCOPE

Review of the following information:

- Sample resident schedule.
- Map of clinics relative to the primary clinic.
- Review of all identified locations, including the identified mentor(s) and qualifications.
- In-depth review of mobile clinic-specific resources.

5.1c. Personnel: Orthotic and prosthetic leaders oversee the hiring, development, and support of staff by providing/ensuring the following:

5.1c.1. Resources for ongoing professional development for orthotists and/or prosthetists and all staff.

5.1c.2. Validation of the competence of staff through an ongoing formalized process.

5.1c.3. Program administration time to the RPD to support residency training.

5.1c.4. Resources and support for the ongoing management and improvement of the residency program(s).

Guidance on Standard 5.1c

- An effective residency site takes steps to ensure all personnel have ample time and resources for personal development and verifying staff competence.
- Implementing a residency education program requires the residency director(s) and mentor(s) to have adequate time to ensure and document the resident is achieving the defined goals and objectives.
- Standards 5.1c.1 and 5.1c.2 are often required to gain facility accreditation from one of the organizations defined in Standard 5.1a.

How It Will Be Assessed by NCOPE

Review of the following information:

- Staff professional development/education policy.
- Verification that certified and/or licensed professionals are in good standing with national certifying bodies and state licensing agencies.
- At the time of residency site renewal, the program's achieved outcomes, including timely completion of the residency, access to all required populations and services, and resident satisfaction with the residency site and director(s)/mentor(s).

5.1d. Review, verification, and co-signature of documentation generated by the resident is performed in a timely manner and meets the requirements defined by licensing acts, facility accreditors, and third-party payors.

Appendix A: Required Experiences and Minimum Activity Volumes

Minimum activity volumes are determined by a review of aggregate clinical data across all NCOPE residency sites from 2021 to 2024 and expert consensus. The volumes identified are reflective of a comprehensive sample of residency program settings, types, and structures.

The orthotic and prosthetic residency is designed to provide generalist training by granting exposure to a wide variety of orthoses/prostheses, visit types, and patient populations. MAVs may be achieved by a combination of visits where the resident observes, assists, and/or independently performs patient care. A minimum number of visits is defined for specific orthoses/prostheses including minimum quantities for specified levels of engagement and total number of required visits. Within NCOPE Tracker, the resident or their assignment mentor can run a report that tallies the progress the resident has made for each defined MAV category if their case entries are up to date in compliance with Standard 3.4.

A single office visit counts as one activity.

Example: Counting Transtibial Activities

A person with a unilateral transtibial amputation completes a full episode of care as follows:

Week 1 – Initial evaluation

Week 2 – Casting for a definitive prosthesis

Week 3 – Test socket fitting

Week 4 – Delivery of the definitive prosthesis

Week 5 – Initial follow-up visit

TOTAL:

This episode of care involves **five distinct clinical visits**, each representing a unique activity.

Therefore, it would count as five transtibial activities.

Required Procedures/Visit Types

Procedure/Visit Type	Orthotic	Prosthetic
Evaluations	50	35
Casting/Digital Shape Capture	45	35
Diagnostic Fittings	0	35
Delivery Visits	65	35
Adjustment/Follow-Up/ Maintenance Visits	35	45

In the event a patient visit includes components from more than one of the visit types above, the visit should be documented using the type to which the greatest amount of time is dedicated.

For example: A person being seen for a custom fit LSO evaluation, measurement, and delivery requires 45 minutes of the resident's time. The resident spends 10 minutes performing an evaluation, five minutes taking measurements, and 30 minutes performing delivery related activities. This activity would be logged as a delivery visit because the greatest amount of time was spent with delivery-related activities.

Fabrication and pre-visit technical activities (e.g., bench alignment) should be integrated into the residency to ensure technical competency is achieved, though the performance of these activities does not count toward the attainment of MAVs when the patient is not in the clinic for a visit.

Required Patient Populations

No minimum volume is defined for each age group listed below, though the number of visits must be sufficient for the resident to demonstrate the required competencies and goals/outcomes defined by the residency program.

Patient Age Group	Orthotic	Prosthetic
Pediatric (0 – 17 years old)	Yes	No
Adult (18 – 64 years old)	Yes	Yes
Geriatric (65 years old or older)	Yes	Yes

Orthoses – Minimum Activity Volume

The Total column reflects the required number of activities across all engagement levels: observation, assisting, and independent. The Assist and Independent columns specify the minimum activities required for each level. Definitions for engagement levels are provided in Standard 3.1b.2 and guidance below. Activity volumes apply to custom-fabricated made-to-patient model fittings unless stated otherwise.

Required Orthoses

Orthosis	Observe	Assist	Independent	Total**
Foot Orthoses	0	0	15	25
Ankle Foot Orthoses	0	0	25	50
Knee Ankle Foot Orthoses	0	5	0	10
Lumbosacral Orthoses*	0	0	5	10
Thoracolumbosacral Orthoses	0	0	5	10
Wrist Hand Orthoses*	0	0	5	10

* Custom fabricated or custom fit are acceptable for these orthoses.

** The total listed may include activities documented at the observe, assist, and perform levels. Any totals listed in the Assist or Independent column must also be met.

Elective Orthoses: Lower Limb

Orthosis	Observe	Assist	Independent	Total
Diabetic Shoes and Inserts*	There is no minimum number of cases the resident must observe. Observing counts toward the total number of activities.	There is no minimum number of cases the resident must assist with. Assisting counts toward the total number of activities.	At least 5 visits where the critical components of care are performed independently for at least 3 of the orthoses listed.	The total listed in the bottom row may include activities documented at the observe, assist, and perform levels. Any totals listed in the Independent column must also be met.
Supramalleolar Orthoses				
Knee Orthoses*				
Tibial Fracture Orthoses*				
Shoe Modifications				
Clubfoot Orthoses*				
Total across at Least 3 of the orthoses listed above			25	30

* Custom fabricated **or** custom fit are acceptable for these orthoses.

Elective Orthoses: Other

Orthosis	Observe	Assist	Independent	Total
Scoliosis Orthoses	There is no minimum number of cases the resident must observe. Observing counts toward the total number of activities.	There is no minimum number of cases the resident must assist with. Assisting counts toward the total number of activities.	At least 3 visits where the critical components of care are performed independently for at least 3 of the orthoses listed.	The total listed in the bottom row may include activities documented at the observe, assist, and perform levels. Any totals listed in the Independent column must also be met.
Cranial Remolding Orthoses				
Cervical Orthoses/ Cervicothoracic Orthoses				
Pectus Deformity Orthoses				
Shoulder Elbow Wrist Hand Orthoses				
Humeral Fracture Orthoses				
Total across at Least 3 of the orthoses listed above			15	25

Prostheses – Minimum Activity Volume

Required Prostheses

Prosthesis	Observe	Assist	Independent	Total*
Transtibial	0	0	40	60
Transfemoral	0	0	25	45

* The total listed may include activities documented at the observe, assist, and perform levels. Any totals listed in the Assist or Independent column must also be met.

Elective Prostheses: Lower Limb

Prosthesis	Observe	Assist	Independent	Total
Partial Foot **Symes** **Knee Disarticulation** **Hip Disarticulation** **Proximal Femoral Focal Deficiency/Rotationplasty**	There is no minimum number of cases the resident must observe. Observing counts toward the total number of activities.	There is no minimum number of cases the resident must assist with. Assisting counts toward the total number of activities.	At least 3 visits where the critical components of care are performed independently for at least 3 of the prostheses listed.	The total listed in the bottom row may include activities documented at the observe, assist, and perform levels. Any totals listed in the Independent column must also be met.
Total across at Least 3 of the prostheses listed above			10	25

Elective Prostheses: Postoperative

Prosthesis	Observe	Assist	Independent	Total
Rigid Removable Dressings	There is no minimum number of cases the resident must observe. Observing counts toward the total number of activities.	There is no minimum number of cases the resident must assist with. Assisting counts toward the total number of activities.	At least 3 visits where the critical components of care are performed independently for at least 1 of the prostheses listed.	The total listed in the bottom row may include activities documented at the observe, assist, and perform levels. Any totals listed in the Independent column must also be met.
Shrinkers/Gradient Compression				
Immediate Postoperative Prosthesis				
Total across at Least 1 of the services listed above			5	10

Elective Prostheses: Upper Limb

Prosthesis	Observe	Assist	Independent	Total
Partial Hand	There is no minimum number of cases the resident must observe. Observing counts toward the total number of activities.	At least 3 visits where the critical components of care are performed at the assist level for at least 2 of the prostheses listed.	There is no minimum number of cases the resident must perform independently. Independent performance may be applied to the total defined for Assist.	The total listed in the bottom row may include activities documented at the observe, assist, and perform levels. Any totals listed in the Assist columns must also be met.
Wrist Disarticulation/ Transradial				
Elbow Disarticulation/ Transhumeral				
Shoulder Disarticulation				
Interscapulothoracic				
Total across at Least 2 of the prostheses listed above		10		20

Residents are not required to provide independent upper limb prosthetic care, but the resident must assist or independently provide the majority of care for a minimum of 10 visits for a patient with upper limb deficiency or acquired limb loss.

Appendix B: Domains and Competencies

Professionalism

Formation and cultivation of a sustainable professional identity, including accountability, ethical principles, and responsibility to the profession and communities of interest.

Domain	Number	Competency	Example(s)
1. Professionalism/ Ethics	1.1	Demonstrates ethical behavior and professional integrity.	▪ Demonstrates insight into professional behavior in routine situations. ▪ Interprets straightforward situations using ethical principles. ▪ Recognizes the need to seek help in managing and resolving complex ethical situations. ▪ Adheres to the ABC Code of Professional Responsibility.
1. Professionalism/ Ethics	1.2	Practices within the scope of the orthotist/ prosthetist, within the limits of their personal abilities, and in alignment with the organization's mission.	▪ Demonstrates familiarity with the orthotist/prosthetist scope of practice and state license acts when applicable. ▪ Identifies when an interaction requires input from a more experienced professional, ensuring that patient care is handled with the highest level of expertise. ▪ Respects organizational leadership structure and protocols, understanding the importance of following established guidelines. ▪ Acts in alignment with the organization's mission, vision, and goals. ▪ Encourages inclusivity and engagement with the organization.

1. Professionalism/ Ethics	1.3	Acknowledges and applies the patient's rights to informed consent, engagement, and high-quality personalized care.	▪ Models empathy by building rapport, showing genuine understanding and compassion towards patients. ▪ Respects the patient's right to care by ensuring access to necessary care. ▪ Utilizes their knowledge of privacy practices, always protecting patient confidentiality. ▪ Respects the patient's right to refuse care even when indicated.
1. Professionalism/ Ethics	1.4	Practices in an inclusive manner and recognizes health disparities that may impact care.	▪ Exhibits cultural competence and cultural humility by actively seeking to understand and respect diverse cultural backgrounds. ▪ Recognizes and counters biases, making a conscious effort to provide equitable and unbiased care to all patients.
1. Professionalism/ Ethics	1.5	Develops inclusive and collaborative professional relationships.	▪ Recognizes the value each member of the patient care team brings. ▪ Supports peers and colleagues to achieve positive patient outcomes, fostering a collaborative and cooperative work environment. ▪ Shares knowledge and experiences that could benefit colleagues, enhancing the overall competence and effectiveness of the team. ▪ Respects support personnel and actively fosters collaboration, ensuring that everyone works together harmoniously for the best patient care.
1. Professionalism/ Ethics	1.6	Promotes public awareness of and demonstrates advocacy for the profession.	▪ Provides information about consumer organizations (e.g., Amputee Coalition). ▪ Supports outreach groups by volunteering. ▪ Presents to students about the orthotics and prosthetics profession, inspiring and educating the next generation of practitioners. ▪ Participates in public policy forums to stay informed about industry policies and advocate for the profession.

Communication and Interpersonal Skills

Effective and respectful exchange of information and collaboration with patients, their caregivers, and health professionals to establish mutual trust.

Domain	Number	Competency	Example(s)
2. Communication and Interpersonal Skills	2.1	Communicates effectively with patients, their families/ caregivers, and other healthcare providers.	▪ Introduces themself professionally and seeks to build rapport with patients and colleagues. ▪ Uses language that is appropriate for the audience's level of understanding, ensuring clear and effective communication. ▪ Recognizes verbal and nonverbal cues/interactions and adapts communication appropriately.
2. Communication and Interpersonal Skills	2.2	Solicits feedback from and provides feedback to mentors and colleagues.	▪ Asks their mentor about the effectiveness of their patient care and areas for growth and improvement.
2. Communication and Interpersonal Skills	2.3	Recognizes barriers to communication and challenging interactions, and selects appropriate communication strategies to seek positive outcomes.	▪ Recognizes how a related health condition such as a stroke may compromise the patient's oral communication and/or the ability to understand. ▪ Leverages resources, such as a translator, to ensure clear communication. ▪ Seeks the input of appropriate members of the healthcare team to address communication barriers.

Knowledge

Recalling, organizing, and synthesizing established and emerging biomedical, clinical, social-behavioral, and engineering sciences to inform practice.

Domain	Number	Competency	Example(s)
3. Knowledge	3.1	Demonstrates a fundamental understanding of foundational principles including biomechanics, anatomy, materials science, pathophysiology, and normal growth/ development.	▪ Applies knowledge to design orthoses and prostheses that fit and function appropriately. ▪ Applies the principles of normal and pathologic gait.
3. Knowledge	3.2	Demonstrates a fundamental knowledge of orthotic and prosthetic principles including offloading, 3- and 4-point pressure systems, hydrostatic loading, and force couples.	▪ Designs a custom foot orthosis with a metatarsal pad to offload pressure from the patient's forefoot, alleviating discomfort associated with metatarsalgia. ▪ Implements a 3-point pressure system in a knee orthosis to control knee hyperextension
3. Knowledge	3.3	Demonstrates a fundamental knowledge of relevant models and frameworks including the International Classification of Functioning, models of disability, and social determinants of health.	▪ Explains the social model of disability, for example, how the model advocates for changes in policies to enable increased participation and inclusion for individuals with disabilities.

3. Knowledge	3.4	Understands the concepts of culture, cultural awareness, and patient identity.	▪ Understands how cultural factors such as language, religious beliefs, and family dynamics can affect patient care and health outcomes. ▪ Recognizes cultural needs such as a lower limb orthosis/prosthesis that may be worn without shoes for cultures that do not wear shoes within the home. ▪ Recognizes different cultural perspectives and stigmas associated with disability/impairment.
3. Knowledge	3.5	Demonstrates a fundamental knowledge of orthotic and prosthetic clinical principles including indications/ contraindications, prescription criteria, components, alignment, fitting principles, basic troubleshooting, and shape capture.	▪ Recognizes specific criteria for prescribing a knee-ankle-foot orthosis based on the patient's functional goals, such as improved mobility and stability, and selects appropriate components that ensure the achievement of relevant measurable outcomes. ▪ Selects appropriate materials that are durable and can accommodate growth for an active pediatric patient requiring ankle-foot orthoses. ▪ Identifies the advantages and limitations of different shape capture techniques used to implement O&P care. ▪ Recognizes when a person with idiopathic scoliosis will not benefit from orthotic management.

Decision Making

Integration and application of sound clinical rationale to provide optimal care in relation to unique patient needs, patient preferences, and practice settings.

Domain	Number	Competency	Example(s)
4. Decision Making	4.1	Generates a treatment plan by gathering, interpreting, and synthesizing information from multiple sources.	▪ Integrates the inputs of appropriate members of the care team, including the prescribing provider, patient, and other healthcare professionals. ▪ Synthesizes information gathered from insurance coverage and financial data sources to justify the decision-making process for selecting specific orthotic or prosthetic designs/components/ materials. ▪ Ensures the treatment plan addresses both clinical efficacy and financial feasibility.
4. Decision Making	4.2	Makes sound judgments that integrate the best available evidence, professional expertise, patient perspectives/ values, and social determinants of health to address each patient's unique needs and goals.	▪ Evaluates their own expertise and recognizes when it is necessary to consult other clinicians or experts, demonstrating an understanding of the limits of their experience and knowledge. ▪ Develops and justifies a logical rationale for clinical decisions. ▪ Analyzes and identifies the benefits of one treatment component over another. ▪ Synthesizes the patient's personal needs and inputs to create a comprehensive treatment plan. ▪ Designs a care plan that aligns with and supports the treatment goals of other team members, such as physical therapists, physicians, and caregivers.

4. Decision Making	4.3	Anticipates treatment outcomes for selected treatment(s) and defines appropriate intervals for continuing patient care.	▪ Anticipates changes in the volume of the patient's anatomy and designs patient care plans to address expected changes. ▪ Integrates anticipated growth in pediatric patients and typical physiologic changes associated with aging. ▪ Predicts the potential for abandonment of orthotic or prosthetic care and anticipates when ongoing therapy will be necessary to support orthotic or prosthetic treatment goals. ▪ Constructs a follow-up plan based on the patient's needs and the complexity of the condition or treatment.
4. Decision Making	4.4	Evaluates anticipated issues and identifies the probable causes of unanticipated issues in a systematic and efficient manner and makes appropriate modifications to the treatment plan.	▪ Provides appropriate follow-up care for common issues such as sock ply management and hygiene. ▪ Evaluates and addresses unanticipated issues, such as replacing a broken tube clamp, in an expeditious and professional manner. ▪ Makes changes to the treatment plan to enable the achievement of desired outcomes.
4. Decision Making	4.5	Identifies relevant criteria to select appropriate O&P components.	▪ Researches available liner materials to ensure the best fit and function. ▪ Selects heavy-duty components for patients with high-activity needs and integrates design characteristics that accommodate growth in children or changes in health status, such as volume changes in dialysis patients.
4. Decision Making	4.6	Recognizes when a problem cannot be resolved with O&P treatment alone and refers to the appropriate professional(s).	▪ Contacts 911 or the internal cardiac response team when the patient demonstrates signs of an acute cardiovascular condition, such as stroke or heart attack. ▪ Refers the patient to a wound care practitioner when healing cannot be achieved with mechanical offloading alone.

4. Decision Making	4.7	Plans subsequent clinical examinations that are responsive to imminent patient needs and data collected.	▪ Performs a focused evaluation of the body segments identified by the patient during the history. ▪ Modifies the examination based on patient input and any new data obtained during the evaluation.
4. Decision Making	4.8	Develops a hypothesis-driven approach to problem-solving that includes reevaluation and modification for successful outcomes.	▪ Evaluates the prosthesis to find a noise and modifies the prosthesis to eliminate the issue. ▪ Justifies when a component must be replaced rather than refurbished based on the condition and performance requirements of the prosthesis.

Patient Care

Providing compassionate, individualized, evidence-based, appropriate, and effective patient-centered care.

Domain	Number	Competency	Example(s)
5. Patient Care	5.1	Performs a comprehensive patient evaluation that captures subjective information, diagnosis, specific clinical exam techniques, and the administration of appropriate outcome measures.	▪ Identifies previous orthotic/prosthetic care and seeks input about the effectiveness of prior treatments. ▪ Assesses spasticity to determine the flexibility of deformities and desired alignment. ▪ Asks the patient to identify the location and level of pain using a numeric pain scale or Wong-Baker faces. ▪ Performs the 10-meter walk test before and after making adjustments to the patient's prosthesis to determine the effectiveness of the changes in addressing mobility concerns.
5. Patient Care	5.2	Performs appropriate techniques to capture anthropometric data using measuring tools, casting, and digital capture techniques.	▪ Measures linear diameters with a medial-lateral gauge. ▪ Takes circumference measurements with a cloth tape measure at appropriate levels to ensure accurate fitting.
5. Patient Care	5.3	Rectifies anthropometric models using digital and mechanical techniques to optimize the fit and function of the orthosis/prosthesis.	▪ Removes artifacts on the model during the orthotic/prosthetic fabrication process. ▪ Removes material where an increase in force or pressure is indicated, creates voids or reliefs where bony prominences exist, and designs contours and trimlines to facilitate easy donning and doffing.

5. Patient Care	5.4	Integrates requirements defined by component and material manufacturers when providing clinical services.	▪ Performs bench alignment according to manufacturer recommendations. ▪ Adheres to manufacturer recommended oven temperatures and vacuum levels for thermoforming processes. ▪ Selects components with appropriate weight ratings and avoids modifying components in a way that voids warranties.
5. Patient Care	5.5	Performs technical procedures to optimize the fit, function, and lifespan of the orthosis/prosthesis.	▪ Revises trimlines to facilitate increased flexibility when appropriate. ▪ Anticipates the replacement of padding and worn componentry. ▪ Recontours interfaces to better align with the patient's anatomy for improved comfort and functionality.
5. Patient Care	5.6	Evaluates the structural integrity and functionality of the orthosis/ prosthesis prior to performing fittings and at appropriate intervals based on manufacturer recommendations and the patient's needs.	▪ Loads the orthosis/prosthesis to levels comparable to the expected load when worn by the patient. ▪ Evaluates the microprocessor components for the number of cycles performed and sends the components out for service when indicated to ensure optimal functionality and durability.
5. Patient Care	5.7	Performs static/ dynamic alignment and fitting of the prosthesis or orthosis to optimize biomechanical function.	▪ Progresses appropriately from bench alignment to static alignment and then to dynamic alignment as indicated by the patient's needs and functional goals.
5. Patient Care	5.8	Assesses the human-device interface and functionality of the orthosis/prosthesis in relation to treatment goals.	▪ Ensures pressure-tolerant areas are loaded evenly through application of interface pressures both statically and dynamically during functional use for optimal device comfort and effectiveness.

5. Patient Care	5.9	Performs gait and functional training related to orthotic/ prosthetic use to achieve functional mobility goals.	▪ Instructs the patient on how to safely transfer from a sitting to a standing position while wearing their device. ▪ Demonstrates how to shift weight effectively from the left to the right side. ▪ Guides the patient on appropriate step length and assists with maintaining proper posture and positioning of adjacent segments to enable effective gait training.
5. Patient Care	5.10	Educates patients, caregivers, and other healthcare professionals about the care plan.	▪ Outlines recommended usage times for the patient's prosthesis or orthosis. ▪ Teaches the patient how to correctly don and doff the device, ensuring proper application and removal. ▪ Explains the cleaning process for maintaining the device's hygiene. ▪ Defines a follow-up interval to monitor the device's fit and function, ensuring ongoing effectiveness. ▪ Informs the patient about any applicable warranties, detailing coverage and conditions for repair or replacement.
5. Patient Care	5.11	Documents clinical and administration activities in a clear, objective, and timely manner to facilitate communication within the healthcare team in compliance with regulatory and business requirements.	▪ Composes documentation using 3rd-person terminology and appropriate abbreviations. ▪ Provides adequate detail to allow follow-up to be performed by a different clinician.

5. Patient Care	5.12	Integrates clinical care extenders, technicians, and other O&P professionals to provide efficient and cost-effective patient care.	▪ Asks the prosthetic assistant to assist with a transfemoral cast and provides guidance on hand placement/ alignment. ▪ Delegates appropriate tasks to the orthotic assistant to ensure efficient and effective care. ▪ Directs support personnel within each personnel's scope of practice.

Interprofessional Collaboration and Systems-Based Practice

Demonstrating an awareness of and responsibility to the larger context and system of healthcare while engaging with an interprofessional team to optimize safe and effective patient care.

Domain	Number	Competency	Example(s)
6. Interprofessional Collaboration and Systems-Based Practice	6.1	Recognizes the impact that healthcare systems, societal factors, interpersonal concerns, access to care, public policy, regulatory parties, and insurance carriers have on the patient and the communities served.	▪ Recognizes the patient resides in, and seeks care at, a clinic in a community with limited resources. ▪ Encourages the patient to seek appropriate healthcare, including routine visits to their primary care provider. ▪ Suggests the patient engages in healthy habits like staying active and making smart choices about nutrition. ▪ Voices support for public health initiatives that benefit patients served. ▪ Demonstrates familiarity with payor policy and associated components. ▪ Familiarizes themselves with carrier local coverage determinations and what documentation is needed to demonstrate O&P care is medically necessary. ▪ Understands the impact insurance copays might have on the patient's plan of care. ▪ Identifies when the patient may have difficulty with transportation.

6. Interprofessional Collaboration and Systems-Based Practice	6.2	Collaborates on patient care with other healthcare providers while recognizing O&P professional scope boundaries to help achieve interdisciplinary treatment goals defined by the patient.	▪ Recognizes that treatment goals for other providers may be different from those of the O&P clinic. ▪ Seeks input from referring providers about how O&P care enables attainment of treatment goals defined by their specialty, such as Physical Medicine and Rehabilitation (PM&R).
6. Interprofessional Collaboration and Systems-Based Practice	6.3	Directs cost-conscious and effective patient care.	▪ Selects components to achieve treatment goals with the lowest cost to the patient and practice (e.g., selects prefabricated orthoses when they can provide appropriate outcomes versus custom-fabricated orthoses). ▪ Delegates to support personnel for maximum cost-effectiveness.

Professional Development and Well-Being

Committing to personal and professional growth that promotes lifelong learning, resilience, and well-being to allow for meaningful contributions to the profession.

Domain	Number	Competency	Example(s)
7. Professional Development and Well-Being	7.1	Recognizes personal needs, evaluates internal and external resources, and selects self-care measures to achieve well-being.	▪ Engages in self-reflection to inform their learning and professional growth. ▪ Selects personal development opportunities to enhance their skills and well-being.
7. Professional Development and Well-Being	7.2	Critically examines and presents relevant healthcare and scientific literature.	▪ Participates in journal clubs, even when not required for residency. ▪ References PubMed Central for up-to-date manuscripts relevant to patient care. ▪ Shares evidence that can positively affect patient care with fellow O&P professionals.

7. Professional Development and Well-Being	7.3	Facilitates self-directed learning to define and achieve development goals that complement the learning facilitated by colleagues and mentors.	▪ Reviews information about pathologies that patients have that may not have been covered in O&P school. ▪ Identifies continuing education opportunities to better meet the needs of patient populations served. ▪ Leverages downtime to perform clinical track activities, such as case studies or critically appraised topics.
7. Professional Development and Well-Being	7.4	Integrates constructive feedback in an effective manner to inform their learning and professional development.	▪ Modifies skills for maximum effectiveness with subsequent opportunities. ▪ Solves new problems through reflection on past performance and feedback from mentors and patients.
7. Professional Development and Well-Being	7.5	Implements learning opportunities for peers and colleagues to transfer knowledge and skills while developing effective mentoring skills.	▪ Moderates a case presentation or journal club session. Provides an in-service to care collaborators, such as teaching ICU nurses how to apply thoraco-lumbo-sacral orthoses. ▪ Facilitates learning for the student shadowing at their clinic.

7. Professional Development and Well-Being	7.6	Participates in professional organizations/ societies, volunteering, activism, and patient support groups.	▪ Joins the Academy or a state/regional O&P professional group. ▪ Volunteers for an outreach group that provides free O&P care. ▪ Participates in patient support groups for common O&P populations, such as persons with spinal cord injuries, traumatic brain injuries, limb differences, or amputations. ▪ Educates high school or undergraduate students about the profession with the aim of introducing O&P as a potential future profession. ▪ Writes letters of support to elected officials involved with drafting and approving legislation related to the patients served. ▪ Participates in the Women for O&P functions and activities.
7. Professional Development and Well-Being	7.7	Seeks appropriate mentorship and serves as a guide for developing professionals and peers.	▪ Demonstrates understanding by building relationships with O&P professionals with similar interests via online resources and professional conference participation. ▪ Presents to current students enrolled in a CAAHEP O&P education program about residency and professional development. ▪ Engages in discourse with former classmates and peers to develop a stronger professional understanding.

Appendix C: Rules for the OPRESCAS System

Introduction

OPRESCAS is a centralized application service for postgraduate residency programs supported by the National Commission on Orthotic and Prosthetic Education and Liaison. It simplifies both the application process for students and the review and admission process for residency sites. Evaluators can review and evaluate applications online, in real time, and effectively manage communications with applicants. OPRESCAS allows for automated reports to be generated based on each site's unique review criteria. The OPRESCAS system has been in place since 2015, and residency programs have been required to use the OPRESCAS system since 2017.

OPRESCAS System Requirement:

A postgraduate NCOPE-accredited residency program must use the OPRESCAS system to advertise openings and accept applications for the residency program.

1. The residency director must confirm access to WebAdMIT Prelaunch and WebAdMIT on an annual basis and add additional users as necessary.
2. The residency program must advertise any residency position they intend to fill for a minimum of 14 days.
3. The residency program can only extend offers to applicants who applied to the program using OPRESCAS.
    a. There are two exceptions to this requirement:
        i. The resident has served as an employee at the company for at least six months prior to the residency start date.
        ii. The residency program sought initial accreditation to host a residency program for a person identified prior to being awarded NCOPE O&P Residency Program accreditation.
4. The residency program advertisement must include all required elements below:
    a. The primary location where the residency program occurs.
    b. The number of residency mentors and directors at the site that meet the requirements defined in Standards 4.1 and 4.4.
    c. Any transportation requirements to participate in the residency.
    d. The program duration.
    e. The timeline the program has for selecting, hiring, and starting residents.
    f. What benefits are extended to residents.
    g. The criteria the residency program uses to select residents.

h. The name, email address, and/or phone numbers for the residency site.

i. The name of the director or a mentor designated to address applicant inquiries and concerns.

5. The residency program may not extend an offer to an applicant until all completed/verified applications have been reviewed.

6. The residency program is not allowed to advertise a position or accept applications for a location that is not NCOPE accredited.

7. The residency program is not allowed to have a position visible on OPRESCAS if the program lacks the funding, resources, or true intention of hiring a resident.

8. To seek an exemption from using the OPRESCAS system by pursuing a data-sharing agreement, the organization must grant access that allows the NCOPE staff to download up-to-date reports about 1) residency program openings, 2) personnel who can access and review applications, 3) applicant demographic information and program preferences, and 4) selected applicants.

   a. This information must be provided in Excel (.xlsx) format using the exact headings, columns, and field types generated by the WebAdMIT system and must be accessible by the NCOPE staff on demand via secure portal or other means.

   b. To request templates/examples of Excel files and learn more about seeking an exemption from the OPRESCAS system, the program director should contact the NCOPE clinical resource director via email.

Appendix D: Required Documentation and Deliverables

The Standards set the minimum requirements for residency, and the following documentation must be submitted within the defined time frame. Residency programs may require submission of additional documentation and deliverables to recognize successful completion of the program.

Person Responsible	Form Name	Due Date	Who Must Complete	Number of Submissions*
Resident	Initial Self-Evaluation Form	30 days after the resident's first day at the site	All residents	1 (one-site) 2 (two-site)
Resident	Self-Evaluation Form	30 days after the final day of each quarter	All residents	6
Resident	Evaluation of the Residency Program Form	30 days after the final day of each quarter	All residents	6
Resident	Evaluation of the Residency Mentor Form	30 days after the final day of each quarter	All residents	6
Resident	Clinical Track Activity Form	30 days after the final day of the quarter the activity was performed	Clinical track residents only	6
Resident	Research Track Update/ Submission Form	30 days after the final day of the quarter the activity was performed	Research track residents only	6
Resident	Professional Activity Form	30 days after the final day of the quarter the activity was performed	All residents	1

Person Responsible	Form Name	Due Date	Who Must Complete	Number of Submissions*
Mentor (Primary)	Evaluation of the Resident Form	30 days after the final day of each quarter	The mentor who primarily supervised the resident during the quarter being evaluated	6
Director	Final Evaluation of the Resident Form	30 days after the final day at the residency site	RPD or designated associate director	1 (one-site) 2 (two-site)
Resident	Graduate Evaluation of CAAHEP Education Form	After the 1st quarter and prior to the final day of the 3rd quarter at the residency site	All residents	1 (one-site) 2 (two-site)
Mentor (Primary)	Employer Evaluation of CAAHEP Education Form	After the 1st quarter and prior to the final day of the 3rd quarter at the residency site	The mentor by whom the resident was primarily supervised during the previous quarter(s)	1 (one-site) 2 (two-site)

* The number of submissions is based on a total residency duration of 18 months or six quarters. Residency programs offered over a longer duration will require additional submissions.

The resident, mentor, or director can generate a Resident Timeline Report at any time to calculate the specific due dates for all documentation identified above. Click here to access the Resident Timeline Report.

Appendix E: Contributors

The individuals listed below include members of the NCOPE Residency Standards Workgroup, Board of Directors, staff, residency directors/mentors, educators, and current/recent residents.

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- **Chris Robinson**, *CPO*
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- **Robin C. Seabrook**, *NCOPE Executive Director*
- **J. Megan Sions**, *Ph.D., PT, DPT*
- **Rebecca Spragg**, *CPO*

Glossary of Terms and Acronyms

Academic Partner Clinic

An orthotic and/or prosthetic clinical facility affiliated with an academic institution hosting an integrated residency program that provides practical training opportunities for students enrolled in an integrated orthotic and prosthetic residency program.

American Board for Certification in Orthotics, Prosthetics, and Pedorthics (ABC)

A credentialing organization that certifies orthotists, prosthetists, and other O&P professionals and accredits facilities in the orthotic, prosthetic, and pedorthic professions, ensuring adherence to established standards of care.

Associate Residency Program Director

A designated individual who meets all qualifications to serve as a program director who facilitates components of the program's administration, resources, curriculum, and quality assurance as defined by the residency program director (RPD). NCOPE defines the qualifications and responsibilities of the director in Standard 4.

Board of Certification/Accreditation (BOC)

A credentialing organization that has historically certified orthotists and prosthetists and accredits facilities in the orthotic, prosthetic, and pedorthic professions, ensuring adherence to established standards of care.

Clinical Track

A residency program that has activity requirements where the resident applies evidence-based practice concepts and submits a unique deliverable each quarter.

Commission on Accreditation of Allied Health Education Programs (CAAHEP)

A national accrediting agency recognized by the Council for Higher Education Accreditation for health science programs, including orthotics and prosthetics, ensuring educational quality and compliance with established standards.

Competence

An individual's capacity to perform a task, function, or role at a level that meets or exceeds established professional standards via a combination of knowledge, judgment, and skill.

Competence does not suggest an expert or mastery level of knowledge, judgment, or skills.

Critical Components of Care

Critical components of care are tasks or procedures that must be performed in a competent manner to ensure patients receive appropriate care. Examples of critical components of care are performing a clinical exam, taking a fiberglass mold of a patient's foot/ankle complex, performing dynamic alignment for the patient with a transtibial prosthesis, performing patient education at the delivery appointment, administering the timed-up-and-go test, or adding pads to a socket to address fitting concerns.

Curriculum

The curriculum is the residency program's unique structure and utilization of its clinical training resources to ensure that the resident achieves the competencies identified in Appendix B.

Domain

A specific area of knowledge, expertise, or practice within the O&P profession, encompassing distinct concepts, skills, behaviors, and responsibilities. O&P residency program domains include Professionalism, Communication and Interpersonal Skills, Knowledge, Decision Making, Patient Care, Interprofessional Collaboration and Systems Based Practice, and Professional Development and Well-Being.

Duty Hours

The scheduled time periods during which the resident is expected to perform clinical and professional responsibilities.

Health Disparities

The preventable differences in the quality of care and health outcomes experienced by distinct populations, often influenced by factors such as race, ethnicity, socioeconomic status, geography, and access to resources.

Inclusivity

The practice of ensuring equal access and opportunities for all individuals, regardless of diverse backgrounds or abilities, within educational and clinical settings.

Indirect Supervision

A supervisory approach where the mentor is not physically present but is available for consultation, applicable once a resident has demonstrated competence in specific procedures.

Integrated Residency

A residency program that is part of an entry-level master's program in orthotics and prosthetics that is facilitated by a CAAHEP-accredited orthotist-prosthetist education program's faculty in collaboration with academic partner clinics.

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Interprofessional Collaboration

Coordinated patient care provided by a team of healthcare professionals effectively working together to achieve positive healthcare outcomes.

International Classification of Functioning

A framework used by the World Health Organization for measuring health and disability at both individual and population levels.

Mentor(ship)

A collaborative relationship where an experienced clinician provides guidance, support, and feedback to a resident, fostering professional growth, skill development, and the achievement of clinical competencies.

Minimum Activity Volumes

The minimum number of specific clinical or procedural experiences required to ensure competency and proficiency in a particular area of practice within a residency or training program.

National Commission on Orthotic and Prosthetic Education

The accrediting body for orthotic and prosthetic residency programs and a committee on accreditation for CAAHEP; responsible for developing and maintaining educational standards for the orthotic and prosthetic profession.

NCOPE Tracker

An online tool used by residents and mentors to document clinical experiences, competencies, and patient interactions during residency.

Off-the-Shelf Orthosis

Prefabricated orthotic devices that are mass-produced and available in standard sizes, requiring minimal fitting and adjustment.

Custom-fit orthoses require professional expertise and skill to appropriately fit and are not considered off-the-shelf orthoses.

On-Call

A designated period during which a resident is available to respond to clinical duties or emergencies outside regular working hours.

On Duty

The time during which a resident is actively engaged in assigned clinical and professional responsibilities.

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One-Site Residency Program

A residency program conducted entirely at a single NCOPE-accredited residency site in both the orthotic and prosthetic disciplines.

Partner Clinic

An accredited orthotic and/or prosthetic clinical facility that provides practical training opportunities for the postgraduate resident that is not owned or operated by the sponsor organization.

Postgraduate Residency

A residency program that is undertaken after the completion of an entry-level master's orthotist-prosthetist education program.

Program Sponsor

The institution or organization that is responsible for the administration and oversight of an O&P residency program that is owned or operated by a clinical organization that provides comprehensive O&P care: a hospital, federal facility, or academic institution.

Quarter

A span of time equal to one quarter of a calendar year or three months. Residents and residency directors/mentors must provide feedback about the resident's progress and the effectiveness of the program and mentors at the end of each quarter. Successful completion of a residency program requires a minimum of six quarters, although the program duration is determined by the residency program director when NCOPE Residency Site accreditation is sought.

Research Track

A residency program that integrates core research and/or development principles and culminates in an inquiry-driven original project, showcasing an understanding of research methodology, data analysis, and effective dissemination practices.

Residency Competencies

Residency competencies are knowledge (e.g., anatomy, corrective force systems), skills (e.g., palpation, dynamic alignment), behaviors (e.g., demonstrating empathy), and clinical judgments (e.g., problem-solving) required to perform essential orthotic and prosthetic services and deliver patient care effectively and safely that meet established professional standards and expectations for independent practice. Each residency competency is aligned to a domain.

Residency Mentor

A certified and/or licensed clinician who has completed formal orthotic and/or prosthetic education and NCOPE-approved mentor training who provides guidance, supervision, and evaluation to residents during their clinical training.

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Residency Program

A structured, immersive real-world education program operated by an NCOPE-accredited residency site designed to prepare residents to provide independent entry-level orthotic and prosthetic care in a safe, effective, and compassionate manner.

Residency Program Annual Report

A mandatory report submitted annually by residency programs to NCOPE that documents program outcomes and compliance with established standards.

Residency Program Director

The authorized leader responsible for overseeing the administration, resources, curriculum, and overall quality of a residency program; this person ensures that residents meet progress requirements, achieve all required residency competencies, and meet minimum activity volumes. NCOPE defines the qualifications and responsibilities of the RPD in Standard 4.

Satellite Clinic

A secondary accredited O&P patient care facility owned and operated by the sponsor organization that is affiliated with a primary facility and offers extended services and training opportunities in different geographic areas.

Social Determinants of Health

The conditions in which people are born, grow, live, work, and age, shaped by factors such as socioeconomic status, education, environment, and access to healthcare, that influence overall health outcomes and quality of life.

Supplementary Employment

Additional work undertaken by the resident outside their primary residency responsibilities; it may require approval to ensure it does not interfere with training.

Two-Site Residency Program

A residency program conducted at two separate NCOPE-accredited residency sites where training in a single discipline is performed at each site. Successful completion of residency requires the resident to demonstrate all competencies **and** meet all minimum activity volumes for both orthotic and prosthetic clinical practice.

Approved by the NCOPE Board of Directors, January 22, 2025.

This standard replaces the previous NCOPE Board of Directors-approved Accreditation Standards for NCOPE Residency Programs (approved 2012). This revision and harmonization of the accreditation Standards is effective July 1, 2025.

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