

# AMERICAN BOARD OF PHYSICAL THERAPY RESIDENCY AND FELLOWSHIP EDUCATION

Description of Fellowship Practice  
Performing Arts  
September 2016

*\*Note: Section VIII. Primary Health Conditions was replaced with Section VIII. Medical Conditions on 10/23/2020*

# AMERICAN BOARD OF PHYSICAL THERAPY RESIDENCY AND FELLOWSHIP EDUCATION

## Description of Fellowship Practice Performing Arts

The *Performing Arts Description of Fellowship Practice* was prepared by the members of the Performing Arts Special Interest Group (PASIG) of the Orthopaedic Section of the American Physical Therapy Association (APTA) and APTA staff. The document was approved by the American Board of Physical Therapy Residency and Fellowship Education (ABPTRFE) of APTA.

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## **Preamble**

The American Board of Physical Therapy Residency and Fellowship Education (ABPTRFE), a board-appointed group of the American Physical Therapy Association (APTA), has created the following Description of Fellowship Practice (DFP) to reduced unwarranted curriculum variability; provide fellows-in-training minimum consistency in learning experiences for that area of practice; and streamline the accreditation process for reporting.

This DFP is based on the analysis of practice results conducted by members of PASIG as part of the petition requirements for seeking ABPTRFE recognition of this area of practice.

While all programs are required to meet the comprehensive curriculum and program requirements as outlined within the *ABPTRFE Quality Standards for Clinical Physical Therapist Residency and Fellowship Programs*, the purpose of the DFP is to: (1) establish a consistent curriculum expectation for fellowship programs within the same area of practice, and (2) provide consistency in program reporting for accreditation processes. The DFP allows flexibility for programs to incorporate additional learning experiences unique to the program's environment that are beyond the minimum standard expectations.

The DFP for each fellowship area will undergo revalidation at least once every 10 years.

### I. Introduction

#### Background

In 2000, a Performing Arts National Advisory Group chaired by Jennifer Gamboa, PT, MPT performed a practice analysis and technical report resulting in a 2004 *Description of Specialized Clinical Practice (DSCP) in Physical Therapy for Performing Artists*.<sup>1</sup> Physical therapy for performing artists, which includes dancers of various genres, musicians, vocalists, gymnasts, ice skaters, circus performers and actors, is a subspecialty practice area within the orthopaedic and sports physical therapy specialties.

The PASIG along with identified physical therapist practitioners within the Performing Arts subspecialty began a revalidation process in 2015 of the DSCP. The primary purpose of the revalidation was to identify current physical therapist practice specific to Performing Arts, as well as identify the knowledge, skills, and attributes required of an expert practitioner in this area of practice. The secondary purpose of the revalidation process was to seek ABPTRFE recognition of this area of practice as a way to promote physical therapist fellowship program development and accreditation.

In December 2015, PASIG petitioned ABPTRFE for recognition of Performing Arts as a fellowship area of practice. The demand for this petition came from various stakeholders including current physical therapists practicing within performing arts, new physical therapists to the field looking for formal and structured educational experiences to advance their knowledge and skills in performing arts, as well as consumers (performing artists and artistic directors) seeking assurance that the clinical knowledge and skills of physical therapists within this area of practice reflect this unique patient population and settings in order to provide effective and efficient care.

Examples of practice considerations that are unique

for this patient population include in-clinic as well as backstage care, biomechanical demands on the artists that affect the nature of their injuries and rehabilitation, performance-specific considerations for therapeutic interventions, assessing choreographic and costume or instrument demands, appropriate communication with artistic directors & staff, and training/performance demands (eg, workload variation, practice/rehearsal schedules, layoffs).

#### Summary

As the field of physical therapy becomes more advanced and specialized through residency and fellowship education and training, there has been a demand for the establishment of formal and structured educational experiences for physical therapists working with unique populations and settings such as performing artists.

The artists and artistic directors also seek confidence in the practitioners they are working with to understand the demands of their field for effective and efficient care. The revalidated DASP in conjunction with this document serve as a guide as well as necessary requirements for the development of fellowship-level education to help meet these needs.

### II. Results of the Analysis of Practice

#### Analysis of Practice

To capture physical therapists who work with performing artists, PASIG petitioning project team solicited input from specific healthcare and/or performing arts organizations, including the Orthopaedic Section of APTA and members of their PASIG; the International Association for Dance Medicine & Science; the Performing Arts Medicine Association; and Dance USA.

The survey instrument was fielded via electronic mail, website announcement, and newsletter

<sup>1</sup>*Description of Specialized Clinical Practice (DSCP) in Physical Therapy for Performing Artists*. Alexandria, VA: Orthopaedic Section of the American Physical Therapy Association; 2004.

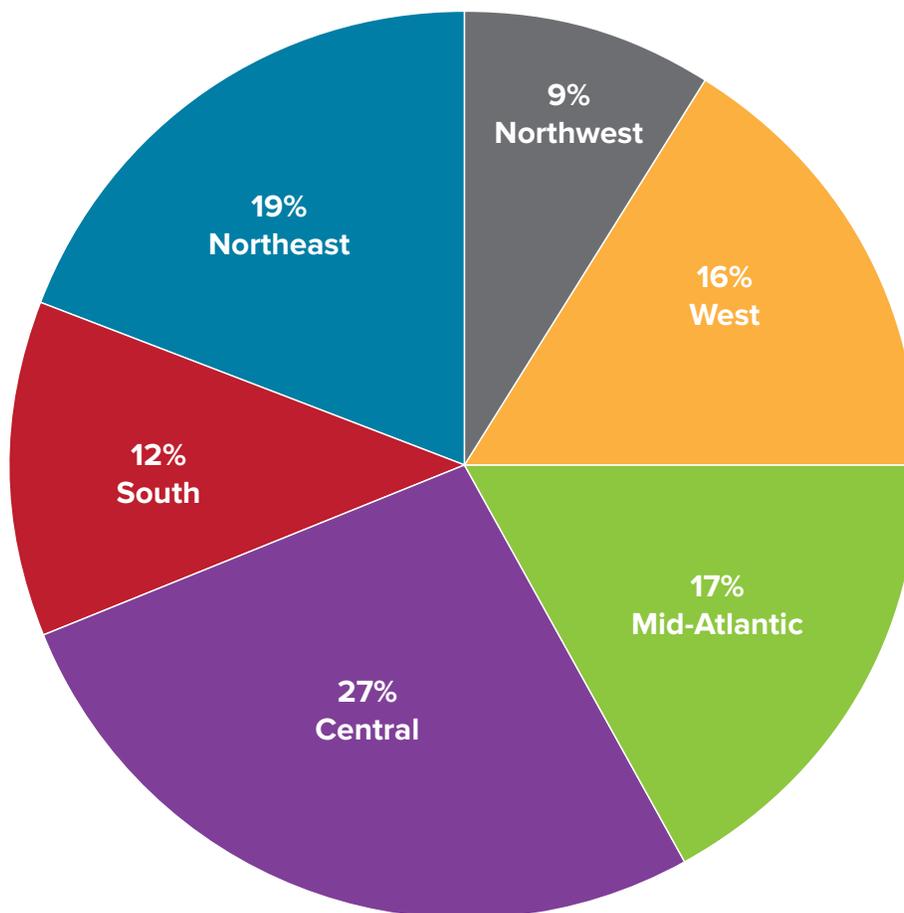
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announcements to approximately 600 physical therapists practicing in performing arts. Notification of the analysis of practice survey process to other physical therapists that treat performing artists was achieved through formal announcements through social media. In addition, members of the project team personally informed colleagues in the field of the survey.

The survey was available in October 2015. A reminder email was circulated about one month after the initial distribution of the survey, and the survey closed in November 2015. A total of 88 responses was received representing a 15% response rate. Of the 88 responses, 41 were completed in its entirety.

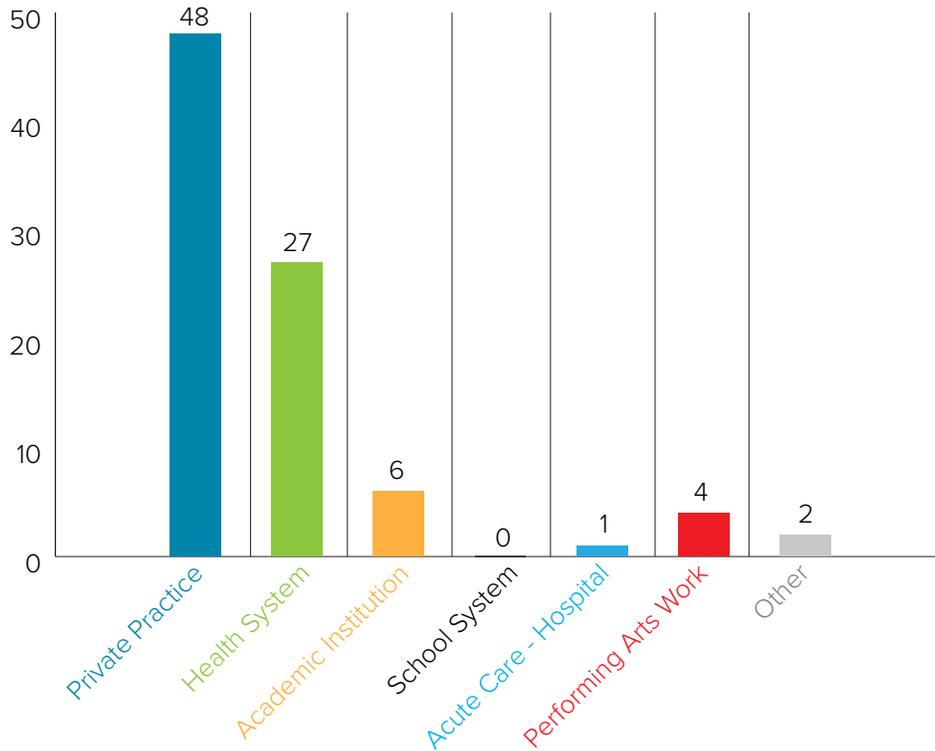
### Respondent Demographics



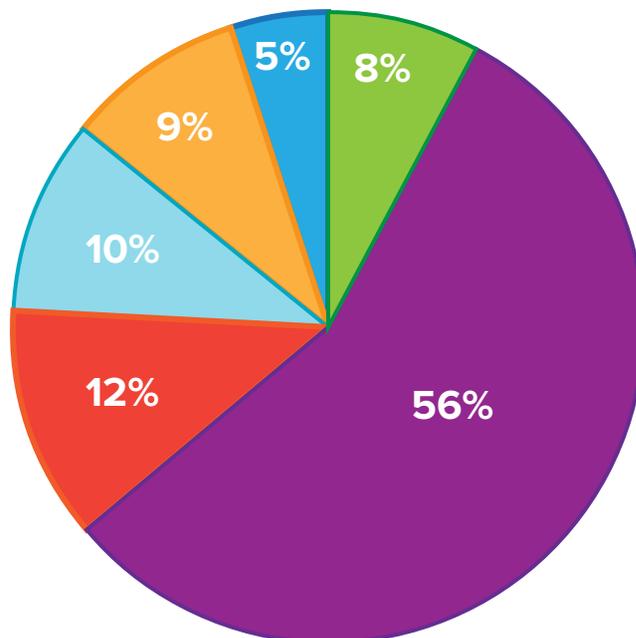
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### Practice Setting



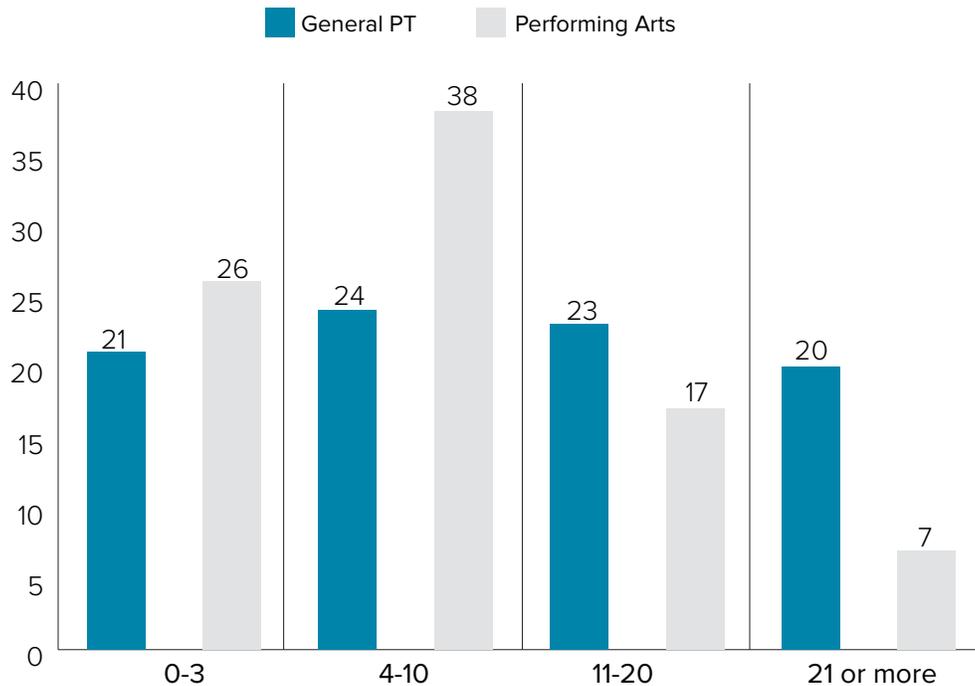
### Percent of Time in Professional Roles



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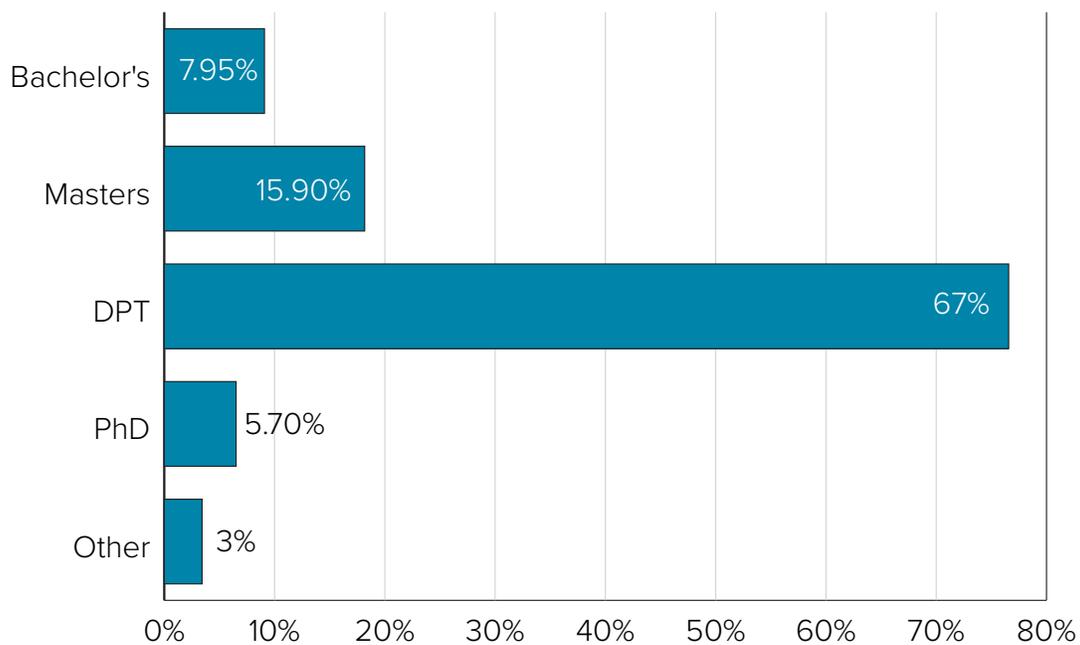
## Description of Fellowship Practice Performing Arts

### Years of Practice



### Professional Development

#### Highest-Earned Academic Degree

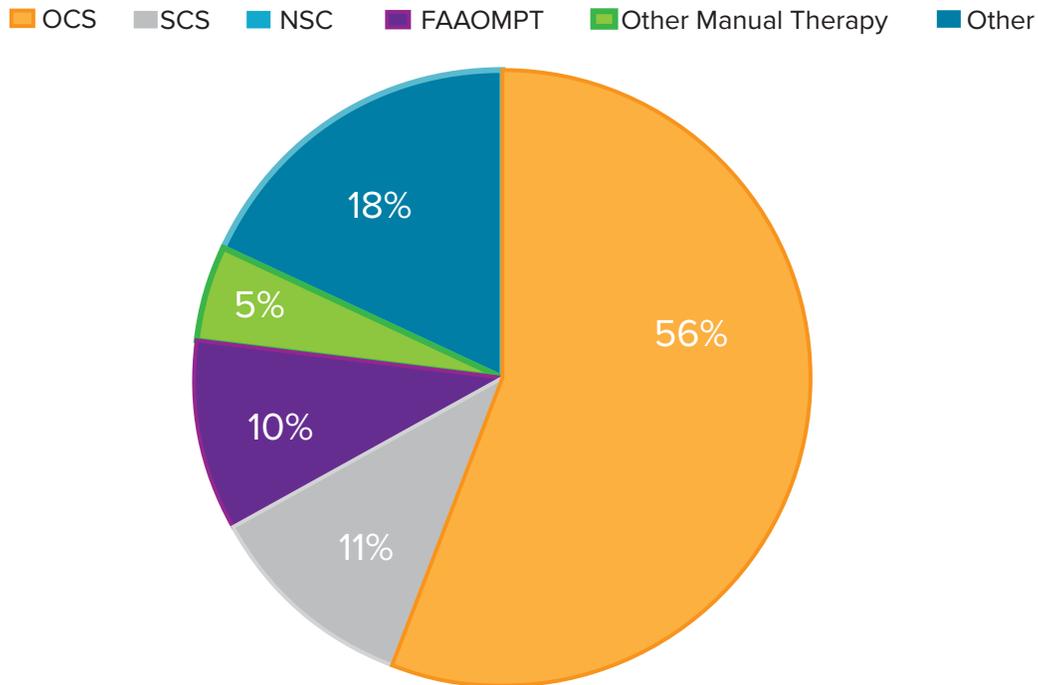


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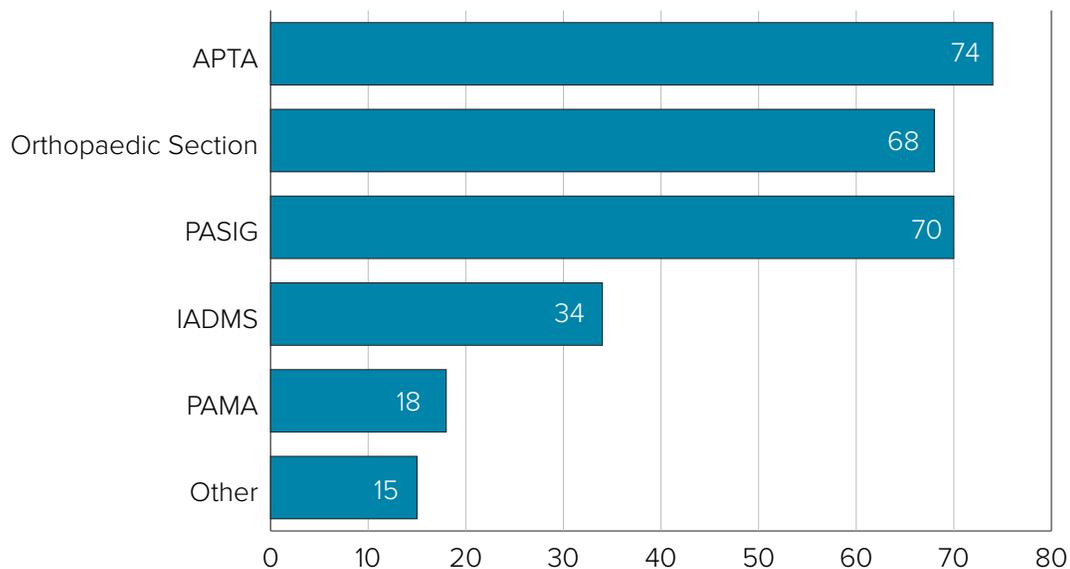
Of the 88 respondents, 13 (15%) indicated they were a graduate of an APTA accredited residency or fellowship program while 75 (85%) of respondents were not.

### Certifications of Respondents



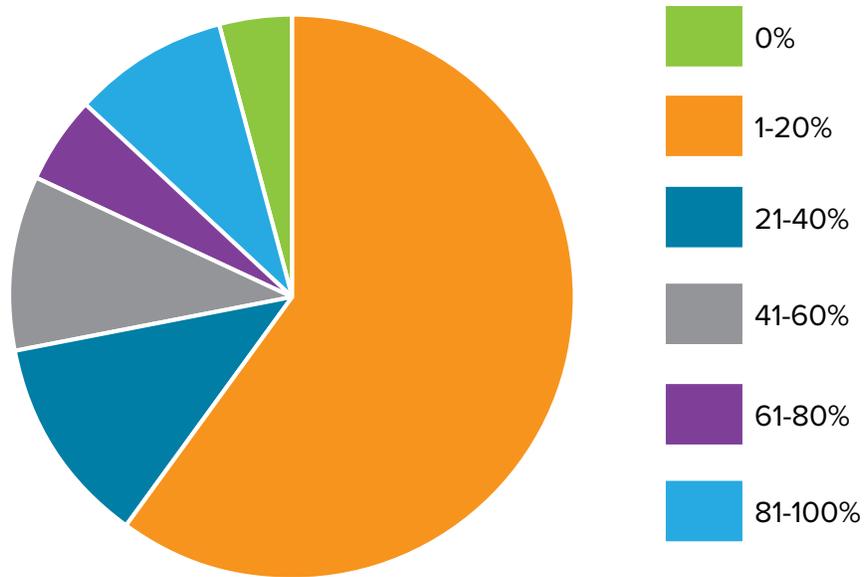
Respondents were requested to identify their professional membership in either APTA, the Orthopaedic Section of APTA, PASIG, International Association for Dance Medicine & Science (IADMS), Performing Arts Medicine Association (PAMA), or other related professional organizations.

### Professional Membership

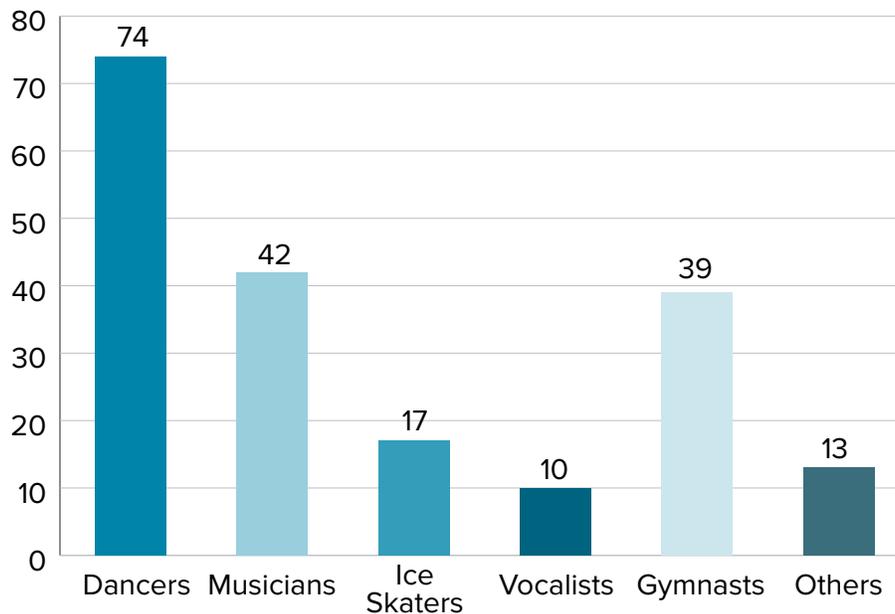


## Physical Therapist Time Dedicated to Performing Arts Caseload

### Performing Arts-Specific

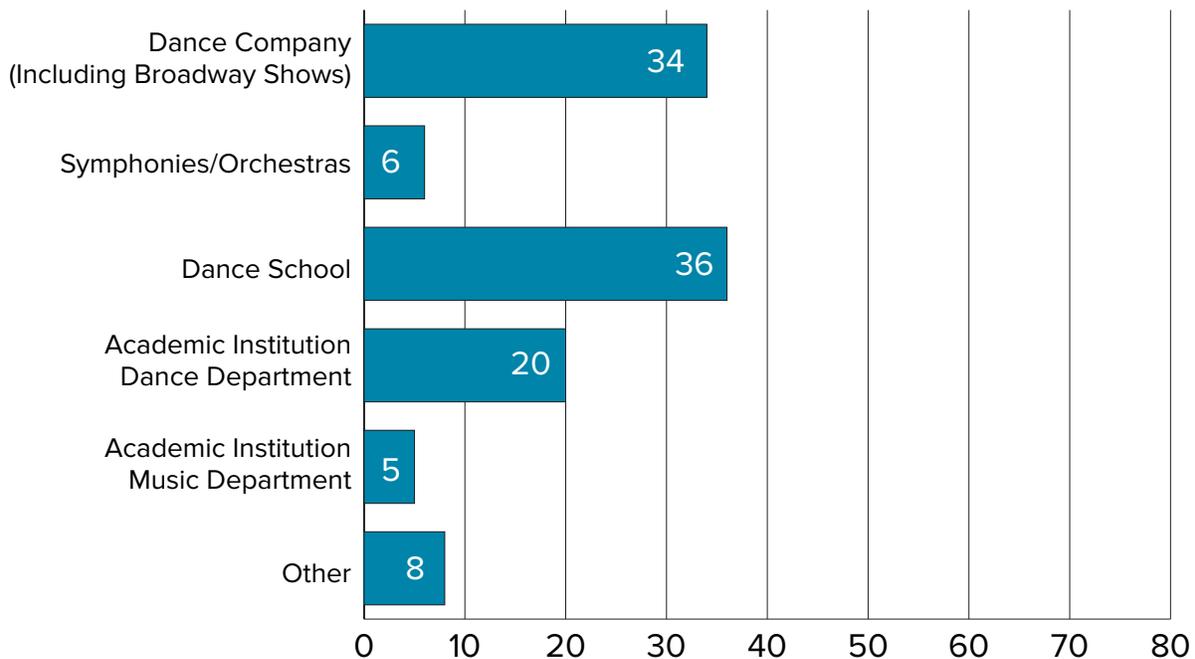


### Types of Performing Artists Treated



The survey identified that 50 (57%) of respondents regularly worked with performing arts companies or groups and that 11 (13%) of responders travel with a performing arts company or group across state lines. Specific information was gathered on the type of performing arts companies or groups these respondents worked with regularly.

### Type of Performing Arts Company or Group



### Survey Summary

The analysis of practice during the revalidation process of Performing Arts outlined the patient population (Types of Performing Artists Treated) and practice settings (Type of Performing Arts Company or Group) relevant to physical therapists in this area of practice.

In addition, the analysis confirmed the professional clinical competencies that are unique to the practice of performing arts physical therapy. These clinical competencies will form the curriculum expectations for all physical therapist fellowship programs in performing arts.

The results of the practice analysis survey categorized competencies into 2 major categories; Technical Professional responsibilities and Non-technical Professional responsibilities. The technical responsibilities were further classified into subcategories of patient care. Many of these competencies are inclusive of orthopaedic physical therapy practice and residency training, however the analysis further defined how the competencies are utilized within the performing arts population.

### III. Type of Program

Performing Arts is a clinical area of practice.

### IV. Required Qualifications for Admissions

All individuals enrolling in a performing arts fellowship program must be a graduate of an accredited orthopaedic or sports residency program and/or hold active board-certification in orthopaedics or sports physical therapy from the American Board of Physical Therapy Specialties.

### V. Learning Domain Expectations

A fellowship program must have a curriculum inclusive of the learning domains identified within that area's current validated analysis of practice.

The following information is based on data from the 2015 analysis of practice for performing arts physical therapy.

#### A. Knowledge Areas of Performing Arts Practice

##### Foundation Sciences

- Anatomy, Physiology, Pathophysiology
  - Normal and abnormal human anatomy
  - Physiology and pathophysiology
  - Normal and abnormal growth development
  - Typical anatomical and physiological characteristics of the performer within specific art disciplines (eg, excessive ROM)
  - Impact of anatomical variations (eg, os trigonum) on performers' impairments
  - Impact of concurrent medical conditions (eg, amenorrhea and osteoporosis) on performers' impairments
- Movement Science
  - Biomechanics and pathomechanics relative to movement demands of performing arts, considering single and multi-joint systems
  - Ergonomic and environmental risk factors

specific to various art disciplines

- Principles of balance
- Principles of motor learning/control

##### Behavioral Sciences

- Expected behaviors and social pressures related to injury management within the arts organization and the general performing arts community.
- Psychosocial tendencies in performers relative to compliance, body awareness, pain perception, and performance anxiety
- Psychological/emotional conditions typically seen in the performing arts population
- Impact of behavioral health risk factors (eg, smoking effects on healing rates) on performers' impairments
- Multiple methods, styles and levels of communication and learning

##### Clinical Sciences

(Signs and symptoms, management, and epidemiology of injuries and diseases)

- Pathology, including knowledge of:
  - Specific practice/performance requirements of the performer including functional and aesthetic demands of the various art disciplines (eg, aerobic, ROM, FM coordination, skill level)
  - Typical training demands and progressions within various art disciplines
  - Inconsistency between training demands and performance requirements
  - Risk factors associated with overtraining
- Epidemiology, including knowledge of:
  - Sign/symptom clusters, syndromes, or categories that correlate to physical therapy diagnoses
  - Performer-specific epidemiological injury characteristics
- Medical management, including knowledge of:
  - Application of basic pharmacology, imaging studies and ancillary tests to performing arts specific conditions

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- Orthopedic surgical and nonsurgical interventions
- Orthotic, protective, adaptive and supportive devices and supplies related to the functional and aesthetic requirements of performing arts
- Selection, sequencing, proper execution of tests and measures necessary for differential diagnoses
- Performing arts functional scales
- Preferred practice patterns used to treat physical therapy diagnoses
- On-site emergency response procedures unique to performing arts setting
- Signs/symptoms typically seen in performing artists that necessitate referral to physician/specialist (eg, eating disorder, substance abuse, psychological disorders)
- Ancillary professional responsibilities for case management, including knowledge of:
  - Other organizations devoted to performing arts healthcare
  - Alternative and complementary healthcare providers
  - Community and medical resources
  - Organizational structure of performing arts management and venues
  - Alternative pathways for provision and reimbursement of healthcare services
  - Applicable medical/legal/ethical issues

### **Clinical Reasoning and Critical Inquiry**

- Evidence-based theory and practice relative to therapeutic exercise and functional re-education
- Methods of analysis of research findings applicable physical therapy for performing artists
- Evidence-based theory and practice relative to manual therapy techniques
- Evidence-based theory and practice relative to modalities
- Research methods and design

## **B. Professional Competencies of Performing Arts Physical Therapists**

### **Professionalism**

- Consult with and/or educate peers, colleagues, other health care professionals, community agencies, legislative and/or regulatory organizations regarding issues of physical therapy practice pertaining to the performing arts
- Maintain adherence to APTA Code of Ethics
- Maintain active participation in professional organizations that address issues related to performer's health

### **Leadership**

- Manage staff and resources, including on and off-site services, for the performing artist while ensuring quality of services in those locations
- Plan, direct, organize and manage human, technical, environmental and financial resources effectively and efficiently

### **Systems-based Practice**

- Educate and collaborate with artist/management regarding the impact of organizational structure (eg, rehearsal schedule, lay-off periods, break periods) and practice/performance environment (eg, floor/surface, temperature) on health of performers
- Prescribe and conduct programs in prevention using individual and group training (eg, strengthening, stretching, posture, balance, endurance), ergonomic redesign, and education
- Plan, coordinate and administer pre-participation and ongoing screening activities for identification of lifestyle factors (eg, diet, smoking, substance abuse), performance/training place factors (eg, seating arrangements of orchestra, floor/surface conditions, temperature) and individual neuromusculoskeletal factors (eg, strength, power, endurance, flexibility) that may lead to increased risk for health problems or preclude performers participation

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### Education

- Educate other health care and performing arts professionals/administrators, and the public at large, as to the scope and role of physical therapists in the performing arts and the injury prevention needs of performers
- Contribute to the professional development of other physical therapists by teaching and mentoring

### Critical Inquiry

- Maintain current knowledge of performing arts physical therapy techniques, methods, and theories as well as current professional/medical-legal issues as they pertain to performing arts physical therapy through attendance at professional education venues and where current research is reviewed/reported
- Integrate current, scientifically valid research into performing arts physical therapy practice
- Identify research needs within the field of performing arts, evaluate outcomes data and assess new concepts and technologies
- Contribute to performing arts physical therapy body of knowledge by performing some form of clinical research (eg, case studies and clinical trials) and/or sharing observations through presentations or other related activities
- Apply scientific methods to read and critically review the professional literature

### C. Psychomotor Skills of Performing Arts Physical Therapists in the Patient/ Client Management Model

#### Emergency Care

- Determine the extent of injury and possible sequelae to appropriately determine whether the performer has the ability to continue participation without incurring additional injury.
- Recognize injuries and illnesses that require emergency medical intervention and provide emergency care, management, transport, and referral as appropriate.

### Examination

#### 1. History

- Obtain work/performance place and status data that includes, but is not limited to:
  - Current and prior work
  - Performance requirements/occupational demands (eg, training, touring, and performing demands)
  - Ergonomic considerations (eg, temperature, costumes, footwear, instrument type, flooring, constraints to motion)
  - Level of skill/experience of the performer
  - Utilization of adaptive devices (eg, taping, bracing, instrument modification)
- Obtain data regarding current condition(s)/chief complaint(s) by identifying areas of primary and secondary symptoms including:
  - Recognition of contributions from multiple sites
  - Quality and behavior of symptoms
  - Previous relevant history
  - Current therapeutic interventions
  - Goals of the performer, family, caregiver, and artistic staff for the therapeutic intervention
- Obtain data regarding functional status and activity level of daily living and performance-related tasks
- Obtain general health status via self-report, family report, or caregiver report that includes, but is not limited to:
  - Physical function
  - Psychological function
  - Psychosocial factors (eg, performance anxiety, performance organization politics and expectations, life stressors, body perception, and emotional response to current condition)
- Obtain data regarding social/health habits (past and current), including behavioral health risks (eg, smoking, substance use, eating patterns, risk factors related to sexually transmitted diseases) and fitness level

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- Obtain relevant data and recognize implications from other medical tests, records and clinical findings
  - Obtain medical/surgical history
  - Obtain growth and development history
  - Obtain data regarding medications currently and previously taken for chief complaint, and for other conditions
  - Obtain social history (eg, cultural beliefs and support systems)
  - Obtain general demographic information
  - Obtain data on living environment and community characteristics
  - Identify familial health risks (eg, history of cancer)
  - Interpret data from history in order to assist in planning physical therapy exam by:
    - Developing a working hypothesis of the physical therapy diagnosis that includes:
      - Nature and severity of problem(s)
      - Probable cause(s) of problem(s)
      - Anatomical structures involved
      - Stage of condition
      - Possible contraindications to physical therapy examination
    - Assessing «red flags» and determining need based upon whether patient demonstrates:
      - Neuromusculoskeletal problems responsive to physical therapy intervention
      - Condition(s) requiring referral to another health care provider
      - Identifying chief and secondary problems
      - Identifying relevant, consistent and accurate information
  - Plan a physical exam that:
    - Includes examination techniques with a high probability of reproducing the chief complaint and contributing to the development and refinement of the working hypothesis(es)
    - Is comprehensive but has the focus and detail appropriate to the working hypothesis, the patient's problems, and the performance context
    - Considers the nature, severity and irritability of the symptoms/problems
    - Prioritizes areas, movements and functional activities to be examined as well as examination procedures and examination sequence
2. Systems Review
- Perform systems review to identify the impaired or unimpaired status of the:
    - Cardiovascular/pulmonary system
    - Musculoskeletal system
    - Neuromotor system
    - Integumentary system
    - Communication ability
3. Test and Measures
- Conduct a physical examination that collects data as necessary in the following categories:
    - Ergonomics and body mechanics: assess environmental hazards, and health and safety risks, including but not limited to: training duration/intensity, recent changes in training/performance/rehearsal schedule, repertoire, temperature, costumes, footwear, instrument type, flooring, constraints to motion, and presence of actual, potential or repetitive trauma
    - Gait, locomotion and balance: assess balance during static and dynamic performance-specific activities
    - Work (job/school/play), community and leisure integration or reintegration (including IADL): assess performer's ability and readiness to return to performance-specific demands via functional tests

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- Assistive and adaptive devices: assess effectiveness of assistive or adaptive devices or equipment used during performance activities (eg, instrument modifications)
- Pain and nociception
- Anthropometric characteristics— assessment of the following:
  - Edema
  - Body dimensions and composition
- Arousal attention and cognition: assess patient-determined effects of cooperation and motivation (depression or impaired motivation) on rehabilitation process
- Circulation (arterial, venous, lymph): assess circulatory condition (eg, vertebral artery examination, skin condition, thoracic outlet tests, and peripheral pulses)
- Aerobic capacity and endurance: assess aerobic capacity in relationship to performance requirements (eg, dyspnea perceived exertion, heart rate)
- Neural integrity - assessment of the following:
  - Response to palpatory provocation with special consideration of nerves at risk due to performance demands
  - Peripheral nervous system (eg, sensory and motor deficits corresponding to segmental level or individual nerve)
  - Disorders of the central nervous system (eg, abnormal reflexes, muscle hypertonicity, coordination deficits)
  - Sensory nerve distribution (eg, discrimination tests, thoracic outlet tests, pain, light touch, pressure)
  - Autonomic nervous system (eg, vasomotor instability, excessive or absent swelling, pupil constriction)
- Integumentary integrity - assessment of the following:
  - Soft tissue mobility
  - Changes in body contour that suggests underlying musculoskeletal dysfunction (eg, effusion)
  - Changes in skin quality and appearance associated with underlying musculoskeletal dysfunction (eg, adhesion formation, lesions, vascular insufficiency, temperature changes)
- Joint integrity and mobility – assessment of the following:
  - Ligamentous stability
  - Accessory motion
- Motor function (motor control and motor learning) – assessment of the following:
  - Ability to demonstrate the skillful and efficient assumption, maintenance, modification and control of performance-specific postures and movement patterns (considering patterns of co-contraction/stabilization/disassociation)
  - Abnormal patterns of muscle activity during active and performance-specific motion
  - Compensatory movements
- Muscle performance (including strength, power and endurance) - assessment of the following:
  - Orthotic, protective and supportive devices: effectiveness of orthotic, protective and supporting devices used during performance activities (eg, taping, bracing, footwear modifications)
  - Muscle strength, power, endurance during performance-specific functions
  - Muscle tension and atrophy
- Posture - assessment of the following:
  - Alignment of body segments during activities of daily living and during performance specific activities
  - Bony anomalies or structural asymmetries and assess relative positions of bony prominences in neutral and performance specific positions

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- Active Range of Motion (AROM) - assessment of the following:
    - Available AROM compared with expected range with respect to age, body type, physical condition and performance-specific requirements
    - Effects of weight-bearing, repeated, sustained or combined movements on AROM and symptom generation
    - Onset, quality and amount of motion of bony landmarks during AROM
    - Effects of altering position at an associated segment on available AROM (eg, the effect of cervical side-bending on active shoulder abduction)
    - Symptoms, crepitus or sounds associated with AROM and point of AROM in which they occur
  - Passive Range of Motion (PROM) - assessment of the following:
    - Available range of muscle flexibility by use of muscle length tests compared with performance-specific requirements (including single and multi-joint structures)
    - Available PROM compared with expected range with respect to age, body type, physical condition and performance-specific requirements
    - The nature of the limitation at the end of the available range (eg, end feel)
    - Effects of repeated, sustained or combined movements on PROM and symptom generation)
    - Symptoms, crepitus or sounds associated with PROM and point of PROM in which they occur
- Correlate history and physical examination findings to knowledge of specific epidemiologic injury characteristics in the performing arts
  - Establish clinical judgment regarding examination findings, including but not limited to:
    - Priority
    - Nature and severity of problem(s)
    - Location and type of involved structure(s)
    - Possible indications, cautions, or contraindications to physical therapy management
    - Pathologic sources of symptomatology
    - Psychosocial factors affecting management
  - Develop impairment list to guide physical therapy interventions to improve performer specific function
  - Correlate history and physical examination findings to identify contributory, noncontributory and inconsistent information
  - Differentiate a neuromusculoskeletal from a non-neuromusculoskeletal problem
  - Correct deficiencies in examination as appropriate

### Diagnosis

- Organize examination findings into clusters, syndromes, or categories to which physical therapy interventions will be directed and to determine prognosis

### Prognosis

- Determine the performer's ability to continue participation without further injury
- Determine need for continuance, modification, or discontinuance of training and/or performance
- Determine performance-specific criteria necessary to return to maximum possible participation in the art form (eg, 90 minutes of pointe work without modification)
- Determine treatment priorities through identification of performer's primary problem(s) which have the highest probability of responding to physical therapy intervention

### Evaluation

- Determine relevance of biomechanical demands of performance potentially related to the chief complaint (eg, plantar flexion range of motion as causative factor in posterior impingement)

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- Predict the optimal level of improvement in performance-specific function and the amount of time needed to reach that level
- Develop a plan of care, which includes:
  - Establishment of list of specific interventions
  - Frequency and duration of interventions
  - Anticipated goals
  - Expected outcomes
  - Discharge plan

### Intervention

- Coordination, communication and documentation
  - Collaborate and coordinate with performance organization regarding performers care, expected functional outcomes and timeline for return to performance
  - Collaborate with appropriate artistic support staff and/or family regarding modifications of art form/lifestyle activities necessary to maintain/improve health of the performer
  - Refer to other professionals or resources when necessary
  - Coordinate with third party payer regarding performer's case management
- Patient-related instruction:
  - Actively engage cooperation of the patient and associated artistic staff by using appropriate methods, style and level of communication
  - Directly address issues of compliance with performer given tendencies of noncompliance/excessive compliance in performing arts culture
  - Discuss examination findings, diagnosis, and prognosis and outline expected outcomes with patient
  - Outline responsibility of patient in order to achieve established goals
  - Educate patient in home care treatment
  - Discuss/negotiate acceptable treatment goals, plan, and responsibilities
  - Educate the performer and appropriate artistic support staff/family regarding requirements of optimal performance (eg, dietary guidelines, substance abuse, sleep deprivations, smoking)
  - Provide program of follow-up care
- Procedural interventions - select and apply the following as needed:
  - Functional training for performance, including:
    - Simulated environments and tasks, task adaptation, task training, work conditioning and work hardening
    - Injury prevention education relative to performance environment (eg, schedule intensity, training duration, repertoire, temperature, costumes, footwear, instrument type, flooring/surface, constraints to motion, presence of actual, potential or repetitive trauma)
  - Therapeutic exercise: performance-specific considerations to the implementation and progression of the following interventions:
    - Aerobic capacity/endurance training
    - Balance, coordination and agility training
    - Body mechanics and postural stabilization
    - Flexibility exercises
    - Gait and locomotion training
    - Neuromotor training
    - Relaxation training
    - Strength, power, and muscular endurance training
  - Manual therapy techniques (eg, manual traction, connective tissue massage, therapeutic massage, mobilization/manipulation, passive range of motion)
  - External dressings, supports, braces, protective taping/devices and cushions (with consideration to aesthetic requirements)
  - Integumentary repair and protection techniques (eg, application of dressings and topical agents, and education regarding skin care relative to performance demands, such as blisters, corns, abrasions)
  - Physical agents and mechanical modalities
  - Electrotherapeutic modalities

### Reexamination

- Recognize when performer has received optimal benefit from physical therapy

- Analyze significance of changes in patient status as it relates to the treatment plan (eg, relationship between anticipated result intervention and actual result, cause of change, adequacy of change, factors that limit progress)
- Anticipate performer's needs and prepare for discharge
- Modify plan of care as needed (eg, alter interventions, tests used, referral necessary)
- Assess response to intervention
- Modify goals as needed (eg, evaluate whether goals are realistic, modify relative to new tests and measures)

### Outcomes Assessment

- Characterize or quantify the impact of physical therapy interventions on the following domains: pathology, impairments, function (eg, ADL, performance-specific), disability (eg, family, community, performance roles), risk reduction/prevention, health/wellness/fitness, performing arts organizational resources, patient/client satisfaction
- Perform outcomes data collection for assessment of meaningful clinical change and for use in statistical reports

## VI. Practice Settings

The clinical curriculum of all accredited fellowship programs must include a variety of practice settings, as noted below. A fellow-in-training should experience a minimum of 5% of their time in each setting, as required by the *ABPTRFE Quality Standards for Clinical Physical Therapist Residency and Fellowship Programs*.

If a fellowship program is unable to provide each participant with an opportunity to engage in patient care activities within these settings, the program must provide additional learning opportunities (eg, observation, didactic, journal club, research) related to patient care within these settings for the minimum required hours noted above.

The minimum required practice settings for performing arts fellowship programs are:

- Outpatient facility
- Athletic event coverage/Performing Arts Venue

## VII. Patient Populations

The clinical curriculum of all accredited fellowship programs must include a variety of patient populations, specific to sex and age group as listed below, for a minimum of 5% of the program hours required by the *ABPTRFE Quality Standards for Clinical Physical Therapist Residency and Fellowship Programs*.

If a fellowship program is unable to provide each fellow-in-training with an opportunity to engage in patient care activities within these populations, the program must provide additional learning opportunities (eg, observation, didactic, journal club, research) related to patient care within these populations for the minimum required hours noted above.

The minimum required patient populations for performing arts fellowship programs are:

Age:

- Pediatrics (0-21 years of age)
- Adults (22-59 years of age)
- Geriatrics (60 years of age to end of life)

Sex:

- Female
- Male

## VIII. Medical Health Conditions

The clinical curriculum of all accredited fellowship programs must include a variety of medical conditions associated with the program's area of practice (see below list).

If a fellowship program is unable to provide each fellow-in-training with an opportunity to engage in patient care activities within these populations, the program must provide additional learning opportunities (eg, observation, didactic, journal club, research) related to patient care within these conditions.

# AMERICAN BOARD OF PHYSICAL THERAPY RESIDENCY AND FELLOWSHIP EDUCATION

## Description of Fellowship Practice Performing Arts

The following template must be used when logging fellow-in-training–patient encounters as part of the fellowship curriculum. Patients evaluated, treated, or managed by the fellow-in-training as part of the fellow-in-training’s education throughout the course

of the fellowship program should be included within the template. The patient’s medical condition is only counted during the first patient encounter. Patient encounters beyond the initial visit should not be included in the frequency count.

<b>Name of Fellow:</b>	
<b>Medical Conditions Performing Arts</b>	<b>Number of Patients Evaluated, Treated, or Managed by the Fellow-In-Training as Part of the Program’s Curriculum</b>
<b>INTEGUMENTARY SYSTEM</b>	
Abrasions	
Lacerations	
Vesicles	
<b>NERVOUS SYSTEM</b>	
Concussion	
Neural impingements (eg, thoracic outlet syndrome, carpal tunnel, Guyon’s canal entrapment, peroneal nerve entrapment, tarsal tunnel syndrome)	
Radiculopathies - cervical	
Radiculopathies - lumbosacral	
<b>MUSCULOSKELETAL SYSTEM</b>	
Acute/emergency injury	
Ankle impingement syndromes	
Ankle/Foot Instability (eg, subluxation/dislocation, ligamentous)	
Ankle / Foot Fracture	
Ankle / Foot Tendinopathies	
Arthropathy of spinal facet joint (eg, Facet dysfunction)	
Derangement of knee (eg, Tibiofemoral joint dysfunction)	
Derangement of ankle (eg, Tibiofibular joint dysfunction)	
Other disorders of ankle/foot (eg, MTP joint dysfunction)	
Knee Fracture	
Knee Ligamentous Injuries	
Knee Tendinopathies	
Mensical Pathology	
Patellofemoral Dysfunction	

# AMERICAN BOARD OF PHYSICAL THERAPY RESIDENCY AND FELLOWSHIP EDUCATION

## Description of Fellowship Practice Performing Arts

Hamstring injury	
Hip impingement	
Hip labral tear	
Sacroiliac Dysfunction (eg, arthropathy, instability)	
Snapping hip syndrome (coxa saltans, iliopsoastendinitis)	
Cervicogenic headaches	
Lumbar Spondylosis/Spondylolisthesis	
Rib dysfunction	
Sprain (cervical/thoracic/lumbar)	
Shoulder impingement	
Shoulder tendinopathies	
Other disorders of the shoulder complex (eg, scapulohumeral dysfunction)	
Epicondylitis	
DeQuervain's	
Wrist/Hand Instability (eg, subluxation/dislocation, sprain)	
Hypermobility of joint (eg, benign joint hypermobility syndrome)	
Fractures (eg, stress reactions/fractures) *do not log knee or foot/ankle fractures here	
Musculoskeletal pain, strain, or sprain	
Osteoarthritis	
<b>OTHER</b>	