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Review Article

Barriers to Care: A Study on Patient Inflow Challenges in Physical Therapy Services

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Abstract

Physical therapy is central to recovery, disability prevention, and quality of life enhancement. However, patient inflow into physical therapy services is restricted by multiple barriers that undermine access, adherence, and continuity of care. This narrative review aimed to synthesize evidence on barriers to patient inflow in physical therapy services, identify emerging challenges, and explore strategies to improve equitable access. A narrative review was conducted using five databases (PubMed, Scopus, Web of Science, CINAHL, Google Scholar) and grey literature from professional and policy organizations. Sources published between 2015 and 2025 were screened, and relevant articles and reports were included and synthesized narratively across structural, financial, geographical, cultural, organizational, and pandemic-related factors. Six major categories of barriers were identified. Workforce shortages and infrastructure deficits were most acute in low- and middle-income countries, while financial inequities such as high out-of-pocket costs and inadequate insurance were dominant in high-income regions. Geographical disparities, limited access, cultural misconceptions, low health literacy, and stigma reduced patient engagement. Organizational inefficiencies, including fragmented referral systems, further constrained inflow. The COVID-19 pandemic magnified these barriers but also accelerated adaptive strategies such as tele-rehabilitation, community-based programs, and direct access models. We concluded that these issues are crucial enough to be put in policy recommendations emphasizing the provision of financial protection, improved referrals, patient education, and incorporation of tele-rehabilitation as an intervention to build a timely resource to mitigate the global burden of disability.

Keywords: Physical therapy, patient inflow, barriers to care, accessibility, rehabilitation services, tele-rehabilitation.

1. Introduction

The significance of early and adequate physical therapy is to enhance functional independence, improve living conditions, and long-term rehabilitation in patients. As the demand for rehabilitation increases throughout the globe, many patients still face obstacles in their entry to such care. These obstacles may be in the form of slow initiation of the treatment process, weaker adherence to therapy sessions, and low health outcomes. The awareness of such complex

factors affecting patient inflow to physical therapy services should be promoted. It is essential to guide policy changes to enhance healthcare delivery and equitable access to rehabilitation (Schumacher et al. 2025).

Physical therapy is a core component of non-pharmacological and non-surgical management for musculoskeletal, neurological, and cardiopulmonary conditions (Fullen et al. 2023). However, the patient access is determined by a set of factors that are interrelated. The

unavailability of physical therapists is a structural barrier and a significant impediment, particularly in low and middle-income countries. Even in high-income settings, delays in service delivery may be regular in case of the long list of queues (Joyce et al. 2018). The financial constraints are another major barrier to care. Out-of-pocket costs, substandard insurance education, and socioeconomic factors may bar many patients from affording physical therapy. In addition, the rural residents disproportionately experience the effects of geographic distance to rehabilitation facilities, which is further exacerbated by transportation obstacles as inequalities amplify (Smith 2022). Patient-specific issues, such as the inability to develop awareness concerning the significance of physical therapy, cultural beliefs, and low health literacy, also contribute to inflow to services. Lack of knowledge concerning the necessity to treat physical therapy as an addition to care and not a need leads to late referral to the physician and poor uptake by the target population. Moreover, organizational issues (symbolized by disjointed referral systems, absence of inter-professional relationships, and bureaucracy) have also contributed to too much waiting time before starting therapy. These weaknesses were further exacerbated by the COVID-19 pandemic. Life in lockdown, isolation, and reshaped healthcare priorities had a dire influence on physical therapy service delivery, which aggravated existing obstacles. Tele-rehabilitation was developed as an option with a bright future, but inequalities in digital literacy and technological infrastructure made it difficult to use by everyone (Buabbas et al. 2022). Although several research groups have explored many of the above-mentioned factors, a careful synthesis showing how organizational, geographical, cultural, financial, and systemic factors work together in influencing the number of patients presented to the physical therapy services has not been explored in a comprehensive manner. It consequently follows

that a narrative review is a suitable tool to combine evidence from empirical studies, documents of the policy, as well as from organizational literature, to present a holistic perspective of these challenges. This review fills up the gaps in understanding access and offers suggestions and runways to build on equitable rehabilitation, in line with international charters such as WHO's Rehabilitation 2030: A Call for Action (Vaughn and Courran 2024).

2. Methodology

2.1 Study Design

This study was conducted as a narrative review with the objective of synthesizing and critically analyzing the literature related to barriers to care and patient inflow challenges in physical therapy services. A narrative review approach was chosen because it allows for broad and flexible integration of heterogeneous evidence, including empirical studies, policy reports, and organizational documents. This review was undertaken following systematic steps of conducting a literature search, screening, extracting, synthesizing, and reflexive appraisal to enhance rigor (Ferrari 2015).

2.2 Literature Search Strategy

Five large databases were searched, namely, PubMed, Scopus, Web of Science, CINAHL, and Google Scholar. Free-text keywords were also used with the combination of Boolean operators and controlled vocabulary (e.g., MeSH terms in PubMed), such as physical therapy OR physiotherapy, barriers to care OR access to care OR patient inflow, and rehabilitation services OR service utilization OR referral patterns. The search was limited to peer-reviewed and policy journals in English that were published between 2015 and 2025 as a way of balancing between contemporary and trendy. Grey literature, including reports from the World Health Organization (WHO), the World Confederation for Physical Therapy (WCPT), and selected national health agencies, was reviewed to

incorporate policy-level insights (Siddaway, Wood, and Hedges 2019).

2.3 Inclusion and Exclusion Criteria

Studies addressing barriers to access in physical therapy or broader rehabilitation services, literature discussing patient inflow challenges such as waiting times, referral delays, or inequities in utilization, peer-reviewed journal articles, official policy documents, or professional organizational reports, studies focusing on structural, socioeconomic, geographical, cultural, or organizational determinants of access, and publications in English between 2015 and 2025 were included. Studies focusing solely on clinical outcomes of therapy without reference to access or service delivery, and non-scholarly opinion pieces lacking conceptual or empirical depth, non-English publications, were excluded

2.4 Screening and Selection

Search results were exported to a reference management tool, where duplicates were identified and removed. Titles and abstracts were screened for relevance against inclusion and exclusion criteria, followed by full-text review of eligible articles. The screening process was performed by two reviewers independently, with disagreements resolved through discussion. After applying the criteria, relevant studies and reports were included in the final synthesis (O'Dea et al. 2021).

2.5 Data Synthesis and Reflexivity

Consistent with narrative review methodology, the synthesis emphasized descriptive and interpretive integration rather than statistical pooling. Findings were compared and contrasted across different contexts, highlighting commonalities, divergences, and interrelationships among barriers. Reflexivity was maintained by acknowledging the potential for selection bias in literature inclusion and the subjectivity inherent in narrative interpretation. This limitation was mitigated by the use of multiple databases, the inclusion of grey literature, duplicate screening by two reviewers,

and transparent documentation of eligibility criteria (Siddaway, Wood, and Hedges 2019).

2.6 Ethical Considerations

As this review synthesized publicly available literature, ethical approval was not required. Academic integrity was maintained by appropriately citing all consulted sources and ensuring that interpretations remained faithful to the original contributions of the authors.

2.7 Data Extraction and Organization

A structured template was used to extract key details from eligible sources, including author(s), year, country/setting, study design, population group, identified barriers, and proposed solutions. Extracted data were organized into six overarching themes: (1) structural and workforce shortages, (2) financial and socioeconomic constraints, (3) geographical and transportation-related challenges, (4) cultural and patient-level factors, (5) organizational and referral system inefficiencies, and (6) adaptive solutions such as tele-rehabilitation (Ferrari 2015).

3 Results

This narrative review synthesized evidence from peer-reviewed studies, organizational reports, and policy documents published between 2015 and 2025. The analysis revealed that patient inflow into physical therapy services is hindered by multiple, interconnected barriers. These barriers can be broadly grouped into six categories: workforce and structural shortages, financial and socioeconomic barriers, geographical disparities, cultural and patient-level challenges, organizational inefficiencies, and adaptations such as tele-rehabilitation introduced during the COVID-19 pandemic. Importantly, these barriers rarely act in isolation but often overlap, compounding inequities in access and continuity of care.

3.1. Barriers at the Structural and System-Level Healthcare system functional deficiencies remain a leading contributor to patient inflow problems in physical therapy services. The lack

of qualified physical therapists is a long-standing problem on a global scale, especially in countries with low and middle-income levels, where the rate of rehabilitation specialists in relation to the population is low. Access to care is often delayed, even in well-resourced settings, due to access to long queues, shortened clinic hours, and a lack of adequate rehabilitation facilities. These inadequacies diminish the initiation of the therapy on time, which is important in the case of stroke or musculoskeletal injury, where an early intervention has a considerable impact on the outcome of the recovery. There are indications that substantial improvements will not occur without addressing structural bottlenecks (Harland and Blackledge 2017).

3.2 Financial Constraints, Socioeconomic Inequality

One of the most widespread barriers to accessing physical therapy is related to the lack of financial resources. The high out-of-pocket expenses, copayment, and low insurance coverage will often scare or retain patients. These problems are also exacerbated by socioeconomic disparities, where the low-income families are the most affected. There is evidence that patients in the disadvantaged population are more likely to discontinue physical therapy before completion due to a lack of money, which results in poor rehabilitation. Financial protection and insurance reform function as the basis of rehabilitation access sustainability (Petil Jr and Caballero 2025). The financial inequalities overlap with the geographical disadvantages, which makes the issue more harmful in the low-income rural population (Fryer et al. 2021).

3.3 Transportation and Geographical Barriers

The availability of a physical site in reach is significant in dictating access to rehabilitation. The disadvantaged rural and remote patients are faced with systemic disadvantages, including a lack of rehabilitation centers, extensive travel routes, and a poor transport system. These

inequities are increased by the nature of urban-centric rehabilitation facilities. Barriers to transportation also discourage continuity of care because regular attendance is discouraged. Notably, these geographic issues tend to intersect with the financial ones, thus exacerbating inequalities in patients in rural and low-income categories (Ofek, Khatib, and Joubran 2024).

3.4 Cultural Perceptions and Patient Awareness

The inflow to the physical therapy services also depends on cultural attitudes and patient awareness. Physical therapy is not valued as much in some societies as compared to surgical or pharmacological treatments, and therefore, the cases are not often referred to or used. Poor health literacy also drives the misconceptions, as some of the patients view physical therapy as only applicable to serious or chronically disabled. Such perceptions diminish chances of prompt inflow and adherence.

Several cultures consider physical therapy as supplementary and not necessary. Patient flow is further diminished by low levels of health literacy and misconceptions. One example of this is the conception that physical therapy is required only in severe or chronic conditions. The issue of stigma about disability in specific societies or rehabilitation deters patients that accessing services, which will further limit access.

3.5 Systems (Organizational and Referral Systems) Inefficiencies

The organizational barriers are also of great importance when it comes to patient inflow. Disjointed care, lack of interprofessional dialogue, and bureaucracy often make it difficult to initiate therapy. Patients usually face discrepancies between prescriptions and the physiotherapy slots, making them stay longer in the waiting lines. These inefficiencies and exceptions of coordination within the health systems and resource scarcity might also serve as the source of the delays. Therefore,

streamlining referral processes and direct access models can help to reduce delays (Hodyl et al. 2024). In other instances, the referrals may get lost in the disconnected systems, leaving patients to be deprived of the required rehabilitation altogether (Rowley, Ky, and Matthews 2024).

3.6 COVID-19 Implications on Physical Therapy Access

The COVID-19 pandemic aggravated existing access barriers and caused new disruptions. Physical therapy services, as far as face-to-face management, significantly broke down due to lockdowns and social distancing requirements, and resource redistribution. The next option was tele-rehabilitation, which offers continuation of care where possible. Nevertheless, its utilization was checked by online disparities, inadequate or negative technological literacy, and frail infrastructure in those parts that had resource limitations. Despite its potential, telehealth is not enough, especially without pursuing and investing in digital equity and enhanced system integration (Buabbas et al. 2022).

3.7 Emerging Strategies to Improve Access

Several strategies are suggested for getting out of these challenges. Having direct access to physiotherapists, i.e., being able to consult them without a physician referral, resulted in shorter waiting times and higher satisfaction. Community-based outreach and mobile rehabilitation units are the expanded services to the underserved populations. Tele-rehabilitation with good infrastructure and patient education would provide access to further levels. However, there is still a lack of evidence on the effectiveness and sustainability of these innovations over time, which presents a necessity to stringently evaluate the effectiveness of these technologies before organization-wide use (Song, An, and Kim 2024).

3.8 Synthesis

All in all, interconnected systemic, financial, geographical, cultural, and organizational

barriers determine patient inflow to physical therapy services. These challenges were further magnified by the COVID-19 pandemic, though adaptive innovations such as tele-rehabilitation, community-based rehabilitation, and direct access have shown promise. Importantly, the barriers are not isolated but interact in ways that compound inequities, particularly for rural and low-income populations. This underscores the need for integrated, multi-level strategies that simultaneously address workforce shortages, financial inequities, cultural perceptions, and system inefficiencies to ensure equitable rehabilitation access worldwide.

4 Discussion

This narrative review finds that the problem of patient inflow in the field of physical therapy is very complex. Our review suggests that the structural, financial, geographical, cultural, and organizational obstacles to access to physical therapy are interdependent and limit access to rehabilitation within a defined period, and are a threat to the health outcomes. These outcomes support the existing body of research indicating the urgent necessity of comprehensive change that would allow fair access to physical therapy on a global scale.

Labor and organizational deficiencies are underscored by insufficient physical therapists around the globe, which is a major setback in the provision of services in a timely manner. The shortage of workforce is among the challenges that have been described by the WHO as one of the most important challenges to having universal access to rehabilitation services. There is an imbalance in the distribution of rehabilitation professionals, especially in urban and rural areas, where inequalities are worsened. The key measures to minimize these structural constraints should include increasing the capacity of training, advancing retention policies, and capabilities for equitable distribution of service providers. The absence of solutions to these workforce shortages will allow

continuing delay in patient inflow, which will only decrease the possibilities to intervene early and provide a positive healing outcome (Stone et al. 2018).

Financial and socioeconomic inequality is a major obstacle to patient inflow. Existing literature demonstrates that patients with low-income status experience disproportionate discrimination because of high out-of-pocket expenses, restricted insurance rates, and internalizing competing economies. These differences are aligned with other larger data that report socioeconomic conditions as predicting compliance with rehabilitation and outcome. The solution to these inequalities could be increasing the insurance benefits, subsidies that might be paid for the services of rehabilitation and physical therapy in universal health coverage plans. Finally, financial inequalities disincentivize initiation and even persistence of treatment, and they directly limit the flow of patients (Hodyl et al. 2024).

Inequality in certain geographical areas is hampering patient inflow. Ineffective transport infrastructure and general concentration of facilities in the urban centers always disadvantage the rural and remote population. This disparity is indicative of the global disparities in health care delivery, with rural populations often experiencing a lack of services and increased indirect care expenditures. The interventions that have demonstrated potential to bridge this gap are mobile rehabilitation units and community-based rehabilitation (CBR) programs that bring services nearer to the patients. Nonetheless, on the one hand, geographical differences will continue to be a significant factor that determines a limited inflow of patients until these strategies are scaled (Braaten et al. 2021).

Perceptions of the culture and health literacy contribute immensely to patient inflow. Stereotyping of physical therapy and certain stigmas frequently make patients unwilling to consult a physical therapist. Poor health literacy

also minimizes compliance and participation. It can be improved by sensitization of the merits of choosing physical therapy as a primary intervention instead of an add-on therapy, by educational campaigns, and better physician-therapist partnership through referrals. It is important to address such barriers of cultural and awareness negativity in order to promote positive attitudes towards patients and enhance inflow (Levin-Zamir et al. 2017).

The inefficiencies in the functioning of organizations that may limit the influx of patients are also emphasized in the review. Fragmented referral systems, lack of interprofessional communication, and bureaucracies are important to address. Complications of multidisciplinary care could be effective in reducing waiting time and ensuring that rehabilitation begins as soon as a referral is made. Direct access models — where physical therapists are directly accessed without the need to go through the physician and are made to consult with patients have illustrated better service efficiency and have minimized service bottlenecks.

The COVID-19 pandemic was both a disruption and an accelerator. Although lockdowns and infection control practices drastically limited the possibility of using an in-person way of service, the crisis boosted the implementation of tele-rehabilitation as a new solution. Tele-rehabilitation showed possible continuity of care, but also showed some digital inequities, especially in low-resource insurance. Enhancing the digital infrastructure and training both patients and providers would be useful in making tele-rehabilitation more visible outside of the pandemic environment. However, until these digital disparities are resolved, tele-rehabilitation will have a limited effect on patient inflow issues (Boldrini et al. 2020).

5 Policy and Practice Implications

Practical interventions are needed to address the issue of patient inflow in physical therapy

clinics. At the policy level, rehabilitation can be viewed as a blanket health cover. It is necessary to develop access at the service delivery tiers by expanding the workforce, community-based models, and enhanced referrals. At the patient level, these aspects can be enhanced by patient education campaigns and culturally competent interventions. Finally, at the technological level, there are tele-rehabilitation and computer-based technologies, which have scalable innovations that can be modified to be applied to conventional care once the infrastructure gaps are addressed (Tenforde et al. 2017).

6 Conclusion

This narrative review highlights that the issues of inflow of patients in physical therapy services are conditioned by a complex interaction of structural, financial, geographical, cultural, and organizational factors. The problems of workforce shortage and low service infrastructure are at the core of the issue, especially in the low- and middle-income countries, and even in high-income areas, where there still exist extensive waiting lines. Financial disparities, such as excessive out-of-pocket expenses and lack of insurance, unduly impinge on vulnerable populations and lead to discontinuation of treatment. Accessibility of the rural populations is further restricted by geographical disadvantages, cultural misunderstandings, lack of health literacy, and organizational inefficiencies, leading to systemic bottlenecks. The COVID-19 pandemic not only increased these barriers but also increased the pace of innovations like tele-rehabilitation and community-based models. To curb these hurdles, it is necessary to introduce interdisciplinary policy changes, growth in the number of workers, monetary assistance, and culturally sensitive policies to boost patient inflow and guarantee that physical therapy plays its crucial part in ensuring equitable and sustainable healthcare.

7 Recommendations

We recommend that the rural workforce of physical therapists should be increased, and there should be more focus on rural training and retention. This can be achieved by offering incentives, as well as by investing in rural rehabilitation centers and mobile units. Physical therapy should be included in universal health coverage to minimize out-of-pocket expenditures, provide financial security, and address socioeconomic disparities. Referral processes should be systematic and automated, and direct access strategies should be implemented to enhance interprofessional interactions and reduce delays. Tele-rehabilitation efforts should be intensified as an additional type of care, backed by strong digital infrastructure, training of providers, and attempts at achieving digital equity. We further stress that culturally sensitive education, especially on community health, should be introduced to create awareness, mitigate misperception, and make physical therapy a part and parcel of healthcare. We also recommend supporting context-specific research and evaluation of innovative models such as community-based rehabilitation, mobile clinics, and tele-rehabilitation to guide sustainable, evidence-based reforms.

Conflict of Interest

The authors declare that they have no conflicts of interest to disclose.

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Study Approval

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Consent Forms

NA.

Authors Contributions

Conceptualization and experimental work by Fateh Muhammad, Rab Nawaz Khan, analysis and interpretation by Majid Abbas, Usama Ali, Original Draft by Fateh Muhammad and Nouman Khan, Review & Editing by Fateh Muhammad and Benish Shahzadi.

Data Availability

The authors have all the data.

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