

Primary Care Physical Therapy: 2025 Consensus Definition

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Abbreviations: OCS = Board Certified Orthopedic Clinical Specialist; FAAOMPT = Fellow, American Academy of Orthopedic Manual Physical Therapists; SPT = Student Physical Therapist

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Methods for Definition Consensus

Over several decades, the American Physical Therapy Association (APTA) has been prompted with numerous motions in its House of Delegates to elaborate on the role of physical therapists in primary care.¹⁻² One of the most common inquiries presented to the 2022-2025 APTA Federal Primary Care Special Interest Group (PC-SIG) board members was “how is primary care physical therapy (PCPT) defined?”. As this area of practice is still developing in the United States, it was determined that a definition consensus document would prove to be an invaluable resource for the physical therapy community.

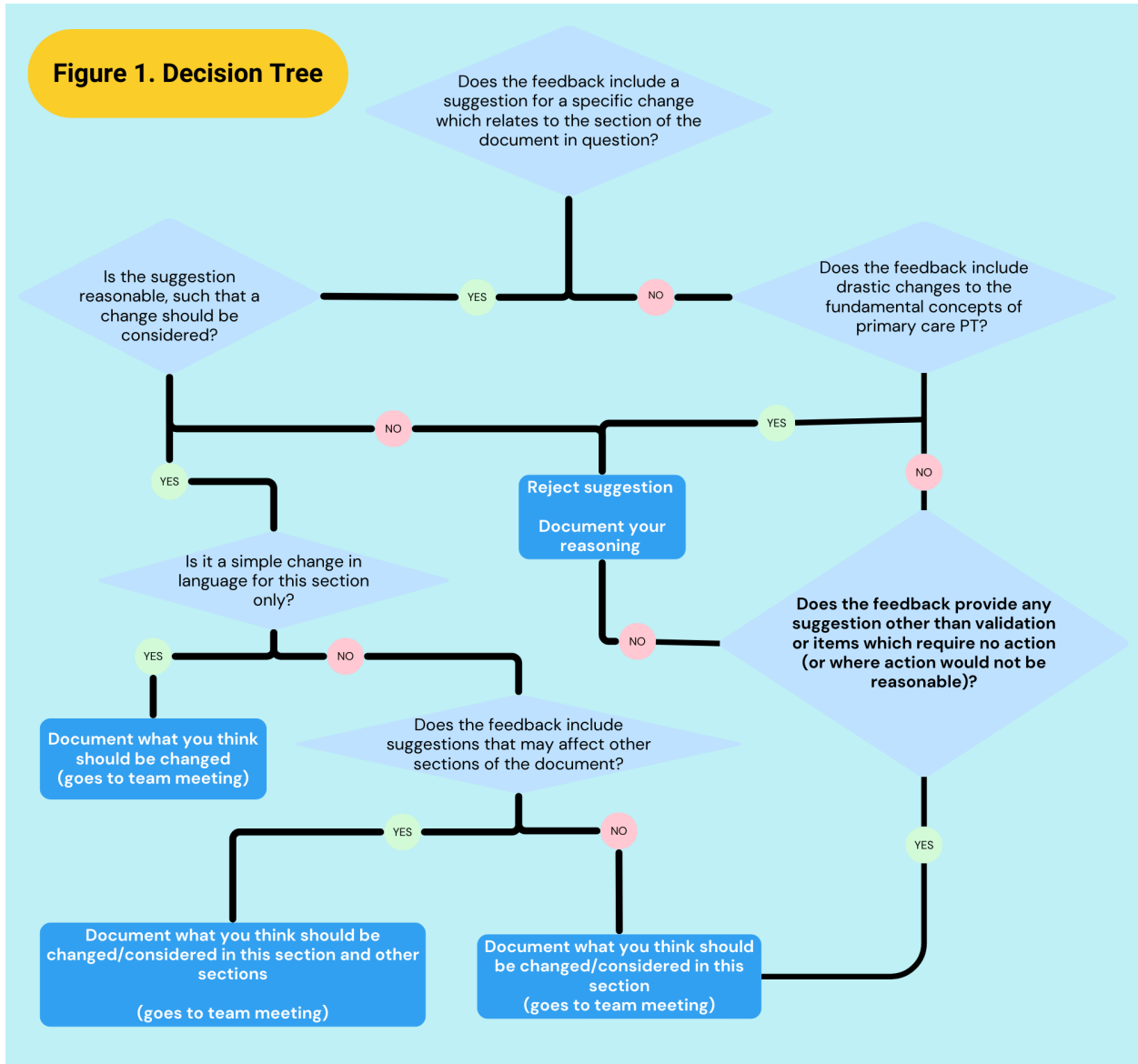
The first draft of this consensus document was originally established by members of the 2022-2025 PC-SIG Board, drawing from 1) American Board of Physical Therapy Specialists

petition for PCPT clinical specialization (in development at the time of writing), 2) literature reviews, 3) research initiatives and 4) input from clinical experts who have served in primary care roles in both the federal and private sectors.

The first draft was agreed upon by the PC-SIG Board on Sept 16, 2024. This draft was published on the APTA primary care webpage, and shared through numerous email campaigns and social media outlets. A 60-day public comment period from Sept 23 - Nov 22, 2024 was offered to all members of the physical therapy (PT) community. Public comment was garnered via an online survey where respondents could opt to provide feedback on specific areas of the consensus document. Other than non-identifiable demographic information, all sections of the survey were optional for response. Once the public comment period ended, the survey was closed. At that point, PC-SIG Board members volunteered to serve as reviewers of the feedback. In an effort to blind reviewers, one PC-SIG Board member who did not serve as a reviewer (KO) removed all personally identifiable information from the survey and assigned responses to specific questions to each reviewer in random order. In an effort to standardize the review process, each reviewer was provided basic guidance on the use of a decision tree (Figure 1). Reviewers could opt to 'reject' feedback points that were determined to be 'commentary only' or strayed heavily away from the original concepts. For other feedback points, reviewers were asked to document how they felt the concepts could be implemented and if they felt other areas of the document would need to be addressed. The reviewers documented reasoning for each decision made on every feedback point that was submitted in the survey. Based on the feedback provided, a revision draft was compiled by KO, which was then reviewed and accepted by PC-SIG board members.

The revision draft along with a feedback form was shared publicly and also emailed to original survey responders that opted to leave contact information on February 1, 2025. Based on new feedback, a second revision was drafted and shared on February 8, 2025. The PC-SIG will hold a public meeting at APTA Combined Sections Meeting on February 14, 2025. At this meeting, the review process will be shared and attendees will be offered the opportunity to vote to 'accept' or 'reject' the final version of the consensus document.

Figure 1. Decision Tree



General Background of 'Primary Care'

There are numerous definitions of 'primary care'.³⁻⁶ Prior to defining primary care physical therapy, it is important to outline 3 major themes in which the general term 'primary care' has been defined and represented throughout literature - 1) Primary Care Attributes and Services, 2) Primary Care Providers and Teams, and 3) Primary Care Role in Healthcare System Organization.³⁻⁶

Attributes and Services

There are numerous definitions of primary care in the literature. While definitions vary slightly by organization or purpose, they share several key attributes associated with primary care delivery³⁻⁶. These attributes describe a model of care that supports *first-contact, integrated, accessible, ongoing, comprehensive, coordinated,*

person-focused, and community-aligned care with the goal of achieving improved health with higher quality care at lower costs.

Primary care providers (PCPs), as described later in the document, render both preventive and reactive health care services.⁷

Preventive care services include health promotion activities, routine screening, and disease risk reduction interventions.

- Health promotion activities are those which serve to promote and optimize health on an individual and population level.⁸ Such activities include, but are not limited to individual and community education in physical activity, nutrition, healthy sleep, avoidance of risky substances, mental stress reduction, and fostering healthy social connection.⁹ Additionally, primary care providers may also be involved in population health risk analysis and mitigation, such as analyzing regional alcohol use trends and promoting campaigns to reduce alcohol consumption accordingly.⁸
- Routine screening tests and measures serve to detect disease and assess health risk prior to symptom onset. Such services might include but are not limited to socioeconomic and behavioral health risk screening tools, routine vision and dental exams, mammograms, colonoscopies, bone density exams, routine blood screening, and cardiopulmonary fitness testing.¹⁰
- Disease risk reduction interventions include, but are not limited to immunizations or other types of prophylactics.¹⁰

Reactive care services are provided in response to a specific injury, illness, or symptom affecting health.⁷

Providers and Teams

Historically, primary health care has been rendered by a physician supported by nurses, medical assistants, technicians and administrators.¹¹ However, rapidly expanding scientific discovery, combined with the rising prevalence of complex chronic conditions, increasing administrative burden and inflated costs have necessitated a restructure in this model.¹¹⁻¹³ Numerous medical guidelines suggest that care delivery and outcomes are often improved when rendered by a team of professionals.¹⁴⁻¹⁷ Team-based care brings together “relevant expertise that can no longer be represented in one professional discipline”.¹¹ This model is especially effective in primary care settings, which serve to meet the large majority of individual healthcare needs.³⁻⁶ Further, a team-based approach at the first point of contact supports the goal of overall cost containment by reducing unnecessary specialist consultations and diagnostic tests, which lead to delays in care and higher rates of chronicity.^{11,18-20} This is especially important as the current landscape of primary care in the United States is plagued by heavy daily caseloads with reduced patient contact time, yielding lower rates of diagnostic confidence and increased reliance on specialty care.^{11,20} Thus, PCP models and clinical disciplines have evolved.

Primary care providers (PCPs) are clinicians who deliver ongoing health services which cover a broad spectrum of common health needs, both preventive and reactive. PCPs may be individuals or teams of the following clinician types: physicians, physician associates, nurse practitioners, dentists, midwives, optometrists, physical and occupational therapists, chiropractors, clinical pharmacists, dieticians, behavioral health providers, and other clinician types.^{3-6, 9}

Role in Healthcare System Organization

Healthcare systems are often organized into hierarchical levels of care such that individuals with healthcare needs progress to higher levels of care only if necessary. This serves to enhance workflow, reduce unnecessary healthcare waste and contain cost.²¹ These levels of care can be described as primary, secondary, tertiary and emergency care, where primary care serves as the first point of entry for individuals with non-emergent healthcare needs.²¹

Primary care providers often consult with secondary and tertiary care teams to provide specialized management of individuals with specific medical conditions or surgical/procedural needs.

Case Example: A 35-year-old patient presents to their primary care provider with vague knee pain and a radiograph is obtained, showing an undifferentiated bony anomaly. The PCP might first consult with a general orthopedic surgeon (secondary care - a specialty) and if more specialized investigation is warranted, care might continue with an orthopedic oncologist (tertiary care - a focused specialty within a specialty).

Secondary and tertiary care providers typically provide care for a limited period until that specific condition resolves or is independently managed. However, secondary care providers can also provide ongoing specialty care for certain chronic conditions.

Primary care can also be differentiated from emergency care, which serves to manage individuals with emergent conditions which require immediate medical attention in an emergency department setting.

Primary Care Physical Therapy

The general conceptual framework of 'primary care' as previously described served as the foundation for defining primary care physical therapy.

Definition

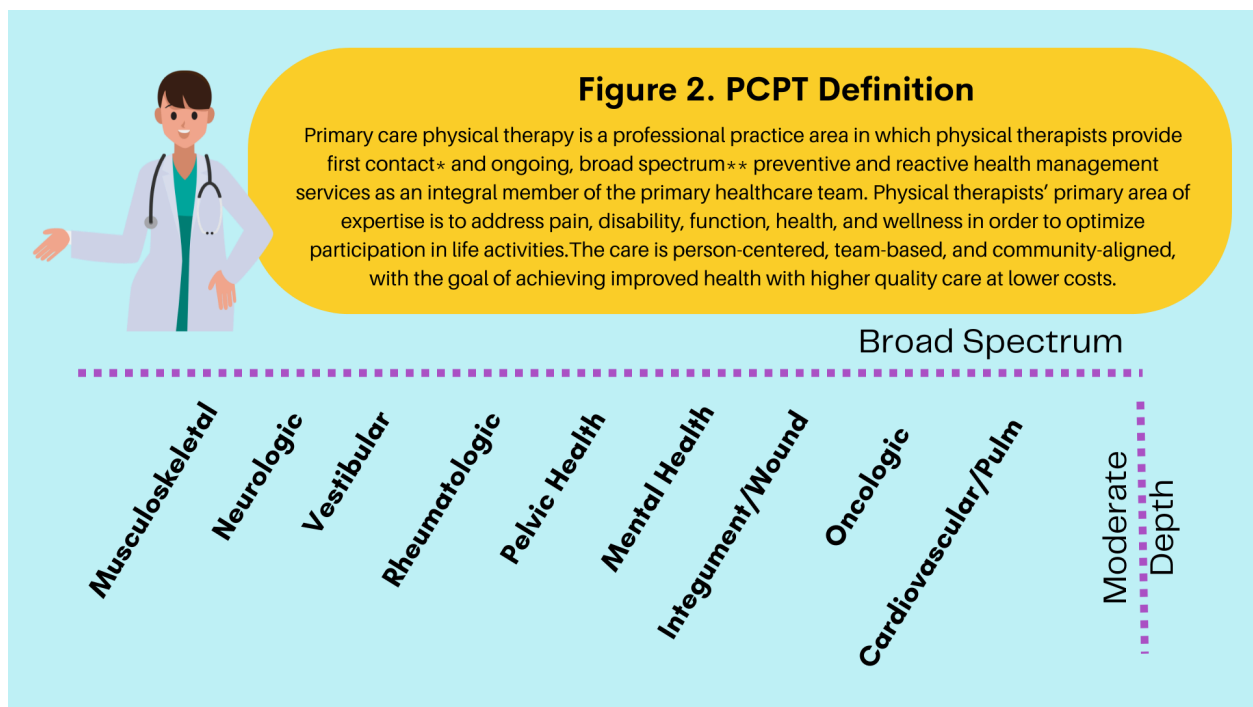
Primary care physical therapy is a professional practice area in which physical therapists provide first contact* and ongoing, broad spectrum** preventive and reactive health management services as an integral member of the primary healthcare team. Physical therapists' primary area of expertise is to address pain, disability, function, health, and wellness in order to optimize participation in life activities. The care is person-centered, team-based, and community-aligned, with the goal of achieving improved health with higher quality care at lower costs. (Figure 2)

*PCPT first contact care can be delivered both on an individual (PT only) or collaborative primary care team basis as a part of an index or first-time visit for a health need.

**Broad Spectrum, as demonstrated in Figure 2 means that the clinician has clinical competency to evaluate and manage cases across body systems.

Case Examples:

- 1) A 5 yr old female with autism with frequent UTIs and toileting concerns
- 2) A 32 yr old male with T6 spinal cord injury 2 years ago who is wheelchair dependent. New complaint of bilateral shoulder pain after joining adaptive basketball team
- 3) 78 yr old obese male with COPD with a complaint of imbalance and reduced walking stamina
- 4) 54 yr old female with stage 4 breast cancer with neck and upper back pain
- 5) 17 yr old male with acute onset chest and shoulder pain and inability to lift the arm after bench pressing at the gym 2 hours ago
- 6) 67 yr old male with hypertension with report of new onset shoulder and upper back pain
- 7) 8 yr old male with ADHD whose parents bring him in for 'atypical movements in sports'
- 8) A 34 yr old female with complaints of fatigue, intermittent tingling and weakness of the hands and feet, and widespread bilateral joint pain.



Goals

Integrating PCPT into a primary care team can accomplish several goals including, but not limited to:

1. Early access to physical therapists contributes to
 - Decreased healthcare costs ²⁸⁻³¹
 - Reduced imaging utilization ^{28, 29, 30-36}
 - Reduced unnecessary specialist referrals ^{28, 30, 36-39}
 - Increased patient satisfaction ^{40, 41}

- Improved adherence to opioid reduction standards by offering reasonable and effective alternatives for pain management ^{28, 31-32, 34-36, 43}
- 2. Reduced primary care provider (PCP) workload ⁴⁴
- 3. Improved access to PCPs ⁴⁴
- 4. Improved PCP satisfaction ⁴⁴⁻⁴⁶
- 5. Optimized whole health management for individuals with chronic non-communicable diseases or those at moderate to high risk for loss of function and activity participation. ²²⁻²⁷

Services

A PCPT may independently perform and/or contribute to both preventive and reactive health management services as a member of the primary care team. Such services may include but are not limited to:

- Screening, triage, evaluation, differential diagnosis within PT scope, physical therapy management, and referral coordination for individuals presenting with:
 - new or chronic neuromusculoskeletal or vestibular conditions
 - chronic non-communicable diseases such as diabetes, hypertension, obesity, cancer, lung disease and mental health conditions. This may include interventions such as exercise programming and monitoring for the purpose of improved mood, weight reduction or lowering blood pressure. ²²⁻²⁷

NOTE: Individuals with non-communicable diseases often require a host of interventions (pharmacologic, lifestyle, psychologic), necessitating co-management with other members of the primary care team and appropriate specialists as recommended by clinical practice guidelines.

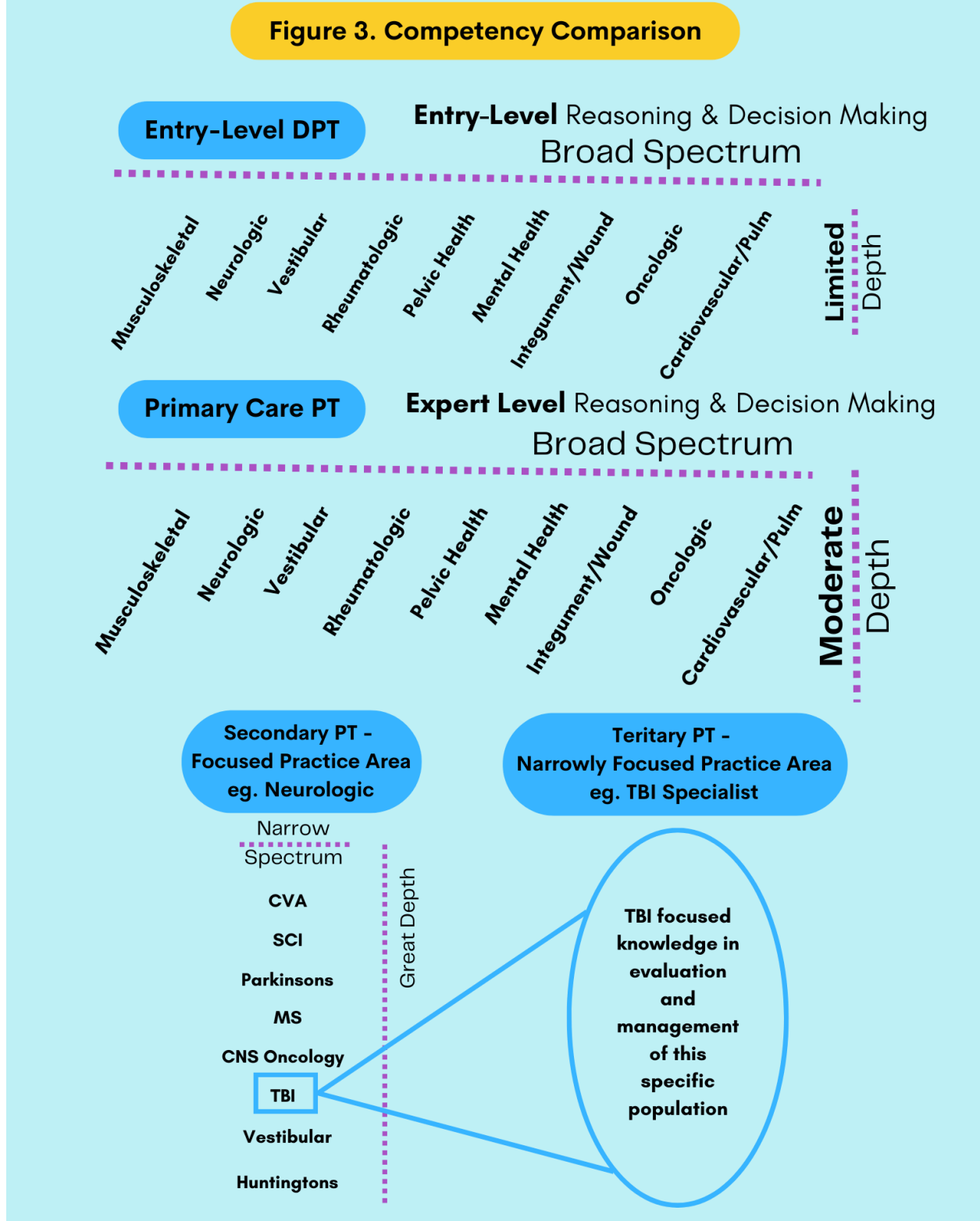
- Disability evaluations and physical limitation recommendations
- Work, school and sports physical evaluation and physical limitation recommendations
- Periodic physical fitness 'well' assessments
- Individual or community-based exercise and movement education programs
- Population health risk analysis and mitigation initiatives

Education, Competency, Clinical Privileges and Specialty

Education

Entry level education for doctors of physical therapy includes training in medical screening, differential diagnosis, management planning and health promotion in all physical therapy practice areas. While entry level physical therapists may serve in primary care roles, they may have limited depth of knowledge and expertise compared to a more experienced physical therapist (Figure 3). This is true of all areas of practice. Similarly, secondary and tertiary physical therapists may be more experienced in focused areas of practice (Figure 3). A more detailed explanation of the physical therapy levels of care is provided later in the document.

Figure 3. Competency Comparison



Competency

PCPTs must maintain the following core competencies, which may be obtained through formal or informal means of post-professional education:

- Expert level broad spectrum differential diagnosis, clinical reasoning and decision making skills
 - identifying the need and urgency required for additional specialist input
 - appropriately determining when to use diagnostic testing, such as imaging or labs
 - analyzing pharmacologic impact on symptoms and physical function
 - applying 'whole health' reasoning when determining plans of care; analyzing social determinants of health and lifestyle factors and their associated impact on prognosis and outcomes
- Strong interdisciplinary and patient communication skills, displaying confidence and competence
- Awareness of medical system capabilities and barriers as it relates to patient advocacy and care navigation
- Awareness of the PCPT role within the primary care team as a whole
- Population health analysis and risk mitigation skills - one such activity might include working with local health departments or government agencies to foster community access to safe exercise environments such as walking and biking paths, as well as community or occupational education programs which promote movement
- High level of work efficiency, promoting optimal cost savings in care delivery

Clinical Privileges

Prior to outlining the ideal clinical privileges for PCPT, it is important to provide background on scope of practice levels. There are 4 types of scope of practice levels which include 1) professional, 2) jurisdictional, 3) institutional and 4) personal. Professional scope of practice in the United States is outlined in the APTA's Guide to Physical Therapist Practice⁴⁷, which is all encompassing for all areas of physical therapist practice, regardless of jurisdictional, institutional or personal scope. However, individually licensed physical therapists must abide by their jurisdictional practice act, held by each jurisdictional regulatory authority that issues their license. Physical therapists must also abide by the rules for their clinician status as set forth by any healthcare institution in which they are affiliated. Finally, physical therapists have an ethical obligation to provide care within their personal scope, which includes areas of practice in which they have adequate training and experience to justify safe and effective care delivery. For example, a physical therapist that has never evaluated a patient with a recent spinal cord injury should defer care to or seek close mentorship by a physical therapist who is more experienced in this practice area.⁴⁷

Clinical privileges are variable. It is the responsibility of each individual clinician to understand the scope which applies to them. Further, advocacy efforts have been effective in scope and privilege expansion in recent years, specifically in the area of imaging privileges. Continued work in this area is crucial. With that stated, the authors feel strongly that a PCPT should maintain the following clinical privileges in order to be effective care managers:

- unrestricted direct access
- unrestricted ordering of diagnostic imaging modalities within scope
- use of diagnostic ultrasound
- ordering diagnostic labs within scope

- referring to specialists
- prescribing durable medical equipment
- recommend physical limitations for work, school, sport or other activities

NOTE: this is not a comprehensive list and should be adjusted based on unique circumstances and personal scope considerations.

It is important to note that the term ‘direct access’ is not equivalent to ‘primary care physical therapy’. Direct access, by law or statute, allows for a patient to access a physical therapist without physician referral. While direct access is an important clinical characteristic of PCPT, this term by itself does not encompass the role and competency of a PCPT.

Specialty

At the time of writing, a primary care physical therapy clinical specialty is in development. Advancement of the clinical specialty may yield greater opportunities for formal PCPT post-professional education and clinical training opportunities such as continuing education programs, residencies or fellowships.⁴⁷

Settings and Populations

PCPTs can provide services in a variety of settings including, but not limited to, primary care clinics, physical therapy clinics, work-sites (occupational health), community centers, sports teams and sporting facilities, wellness centers, schools, and homes. Ideally, the PCPT would be co-located in a primary care clinic space or have other reasonable direct communication means (secure virtual conference, phone, messaging) with other members of the primary care team. Virtual care in the primary care space has been rapidly expanding as an affordable alternative to traditional full time in-person care.⁴⁸ O’Bright et al (2024) provides an overview of current PCPT practice models as well as structural, cultural and financial considerations when developing programs.⁴⁹

PCPT can also be focused toward a specific lifespan population. Similar to how pediatricians are PCPs for children and adolescents and geriatricians are PCPs for older adults, PCPTs can provide focused care for pediatric or geriatric populations. Jacobson et al reported on a framework for this model in a pediatric practice setting.⁵⁰

Finally, PCPTs can utilize this model of care to practice in urban, suburban, rural and frontier regional classifications. Each classification introduces unique characteristics which influence the health factors of its populus, justifying the aforementioned population health competency skills. Access to shelter, food and clean water sources, transportation, financial resources, safe environments to participate in activities, as well as employment and education status influence health and must be considered. The PCPT must be well versed in assessing these variables and incorporating them into the prognosis and management strategy of individual patients and communities.²²⁻²⁷

Compared with physical therapists practicing in urban and suburban regions, physical therapists practicing in rural and frontier regions often have reduced access to resources and specialists. Thus, the broad spectrum competency of the PCPT model is even more important for physical therapists working in rural and frontier regions.

Role in Healthcare System Organization

As previously described, hierarchical levels of care serve to organize the healthcare system in order to reduce unnecessary use of specialty care services. When applying this concept to physical therapist practice, the PCPT would screen and triage individuals presenting to primary care and then navigate the next steps of care as indicated, ie. referral management. Ideally, this would increase the number of appropriate physical therapy referrals and improve access to care to specialized physical therapists. This also increases the opportunity for PCPTs to have valuable touch points with individuals with non-communicable conditions who are not traditionally referred to physical therapy, eg. diabetes, hypertension, obesity, depression, etc.

Similar to a secondary physician specialist, a secondary physical therapist provides specialized health management, on either a finite or ongoing basis. One example of a secondary physical therapist might be a neurologic physical therapy specialist. A tertiary physical therapist might be further specialized in a specific practice area. For example, a neurologic physical therapist that has specialized training in traumatic brain injury. (Figure 3)

Secondary PT Case Example: An orthopedic physical therapist might manage a patient after an ankle injury or low back pain episode until they meet their physical and functional goals (secondary care, limited period).

Tertiary PT Case Example: An oncology lymphedema therapist might manage a patient with cancer and lower extremity lymphedema on an ongoing basis due its chronic nature, but might refer that same patient to a PCPT if they had a new onset of shoulder pain. (tertiary care, ongoing)

It is important to note that secondary and tertiary therapists may also refer to one another or to other medical specialists, as access allows.

Access to Care Pathways

There are numerous options for patients to access PCPT. Depending on the timing and setting, this may involve the PCPT as the first point of contact for patients presenting with conditions which cause pain and/or impact function or activity participation, ie. 'direct triage/direct access', or it may involve a collaborative visit where another healthcare professional in the primary care setting consults with a co-located and/or virtual PCPT, ie. 'the warm hand-off'. In the 'direct triage' scenario, a patient with a condition causing pain or impacting function or activity participation is directly triaged to the PCPT. This is most commonly achieved through a primary care call center or online decision tree which serves to distinguish the most appropriate provider to address the presenting condition. In the 'warm hand-off' scenario, a patient may be visiting their medical PCP for a routine visit, such as a blood pressure follow-up visit or annual wellness exam. During this visit, the PCP might identify that the patient has a condition that would benefit from a consultation with the PCPT. In this model, the PCPT is available for consultation at the point of service within the primary care clinic, either physically or virtually.⁴⁹

Both scenarios can be accomplished in traditional primary care clinics, physical therapy clinics, occupational health sites, sports health centers and other clinical care sites as previously described. Hybrid partnership between these clinical care sites is also

a viable option. There is a high level of flexibility with this model such that it can be adjusted based on clinic needs, patient needs, staff availability, and other variables. O'Bright et al (2024) provides detailed information and roadmaps for these pathways for PCPT.⁴⁹

PCPT Full-Time Team Member vs. PCPT Rotating Consultant

The levels of integration within primary care vary between organizations based on the goals of the program. A PCPT full-time team member is an established clinician within the primary care team. They would typically evaluate and manage their patients within the primary care clinic. In this model, the full-time PCPT may limit their patient management to cases which are expected to improve or resolve within a more abbreviated time frame and/or with less frequent visits over time as compared to a traditional physical therapy setting where patients are often seen at least weekly. However, in a rural or frontier setting, the full-time PCPT may serve as both.

The PCPT 'rotating consultant' may have a full-time role in a physical therapy clinic, yet serves as a consultant to the primary care clinic on a rotating basis, perhaps with several other physical therapists. The set-up and workflow of the operation is flexible and unique to the clinical needs and goals.⁴⁹

Financial Considerations

There are numerous options for payment. While some PCPT services would meet criteria for 97-series CPT charges billed to third party payers, others might not. In some integrated settings, there is the option of billing 'incident-to' the PCP, especially when a PCPT is rendering brief consults where a full PT evaluation charge might not be justified. Similarly, some clinics have reported 'lending' a PT to primary care at no cost to the patient (ie. PTs don't bill for services rendered in primary care). In this model, it has been reported that the PT clinics experience improved referral conversion rates from primary care, thus increasing downstream revenue¹⁸. However, without direct revenue from the PCPT service, these models have been questioned as they pose a threat to financial sustainability.

Collaborative Care Model (CoCM) codes are worth investigating for PCPT. This type of code was originally introduced when behavioral health specialists began integration into primary care teams. This type of CPT code allows for recognition of the time of multiple clinicians. At the time of writing, it is not well understood how these codes have been implemented over time. Future research should aim to explore this area.⁵¹⁻⁵²

Finally, it is important to note that the traditional insurance payment model is becoming less favorable. Direct to employer models, self-pay, and member models such as direct primary care, are becoming more popular amongst healthcare consumers and employers as they offer more affordable and often better quality alternatives to traditional insurance-based care.^{19, 53-55} Because health benefits are often tied to employment, direct to employer healthcare in particular is an avenue that healthcare professionals should explore^{19, 56-58}.

Future Versions

Hold this section until final consensus vote.

References:

1. PHYSICAL THERAPISTS AS PRIMARY CARE AND ENTRY-POINT PROVIDERS HOD P06-18-28-22
2. HOD P07-24-05-07 [Amended: HOD P06-18-28-22; HOD P06-1407-11; HOD P06-02-23-45; HOD 06-95-18-09; HOD 06-85-33-61; Initial: HOD 06-81-09-25; Formerly Titled: Physical Therapists as Primary Care and Entry-Point Providers; Entry Point into Health Care] [Position] https://www.apta.org/siteassets/pdfs/policies/ptservicesinprimarycare_hodp07-24-05-07.pdf - I dont know how to cite this.
https://www.apta.org/siteassets/pdfs/policies/ptservicesinprimarycare_hodp07-24-05-07.pdf
3. Defining Primary Care: An Interim Report (IOM, 1994b)
4. Institute of Medicine (US) Committee on the Future of Primary Care; Donaldson MS, Yordy KD, Lohr KN, et al., editors. Primary Care: America's Health in a New Era. Washington (DC): National Academies Press (US); 1996. 2, Defining Primary Care. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK232631/>
5. Primary Care. American Academy of Family Physicians. AAFP.org. Accessed January 7, 2025. <https://www.aafp.org/about/policies/all/primary-care.html>
6. Primary Care. World Health Organization. <https://www.who.int/>. Accessed January 31, 2025.
<https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/primary-care>
7. Waldman SA, Terzic A. Health Care Evolves From Reactive to Proactive. Clin Pharmacol Ther. 2019 Jan;105(1):10-13. doi: 10.1002/cpt.1295. PMID: 30597564; PMCID: PMC6314203.
8. Nutbeam D, Muscat DM. Health Promotion Glossary 2021. Health Promot Int. 2021 Dec 23;36(6):1578-1598. doi: 10.1093/heapro/daaa157. Erratum in: Health Promot Int. 2021 Dec 23;36(6):1811. doi: 10.1093/heapro/daab067. PMID: 33822939.
9. Lippman D, Stump M, Veazey E, Guimarães ST, Rosenfeld R, Kelly JH, Ornish D, Katz DL. Foundations of Lifestyle Medicine and its Evolution. Mayo Clin Proc Innov Qual Outcomes. 2024 Jan 20;8(1):97-111. doi: 10.1016/j.mayocpiqo.2023.11.004. PMID: 38304165; PMCID: PMC10831813.
10. Givler DN, Givler A. Health Screening. [Updated 2023 Feb 19]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK436014/>
11. Fiscella K, McDaniel SH. The complexity, diversity, and science of primary care teams. Am Psychol. 2018 May-Jun;73(4):451-467. doi: 10.1037/amp0000244. PMID: 29792460.
12. Peters AL. The Changing Definition of a Primary Care Provider. Ann Intern Med. 2018 Dec 18;169(12):875-876. doi: 10.7326/M18-2941. Epub 2018 Nov 20. PMID: 30458467.
13. Willens D, Cripps R, Wilson A, Wolff K, Rothman R. Intradisciplinary team care of diabetic patients by primary care physicians, advanced practice nurses and clinical pharmacists. Clinical Diabetes. 2011;29:60-68.
14. American Diabetes Association. 4. Lifestyle management: standards of medical care in diabetes—2018. Diabetes Care. 2018;41: S38-S50. [PMID: 29222375] doi:10.2337/dc18-S004

15. Wagner EH, Flinter M, Hsu C, Crompton D, Austin BT, Etz R, et al. Effective team-based primary care: observations from innovative practices. *BMC Fam Pract.* 2017;18(1):13. <https://doi.org/10.1186/s12875-017-0590-8>.
16. Cooper LB, Hernandez AF. Assessing the quality and comparative effectiveness of team-based care for heart failure: who, what, Current Cardiology Reports (2022) 24:217–223 221 1 3 where, when, and how. *Heart Fail Clin.* 2015;11(3):499–506. <https://doi.org/10.1016/j.hfc.2015.03.011>.
17. Nishimura RA, Otto CM, Bonow RO, Carabello BA, Erwin JP 3rd, Fleisher LA, et al. 2017 AHA/ACC Focused Update of the 2014 AHA/ACC guideline for the management of patients with valvular heart disease: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *J Am Coll Cardiol.* 2017;70(2):252–89. <https://doi.org/10.1016/j.jacc.2017.03.011>.
18. Bodenheimer T, Kucksdorf J, Torn A, Jerzak J. Integrating physical therapists into primary care within a large health care system. *J Am Board Fam Med.* 2021;34(4):866-870.
19. Basu S, Zhang T, Gilmore A, Datta E, Kim EY. Utilization and cost of an employer-sponsored comprehensive primary care delivery model. *JAMA Netw Open.* 2020;3(4):e203803.
20. Bodenheimer, Thomas, and Hoangmai H. Pham. "Primary Care: Current Problems and Proposed Solutions." *Health affairs* 29.5 (2010): 799-805. *ProQuest.* Web. 27 Jan. 2025.
21. Todd, John Walford and Scarborough, Harold. "medicine". *Encyclopedia Britannica*, 21 Dec. 2024, <https://www.britannica.com/science/medicine>. Accessed 24 January 2025.
22. Líška D, Stráska B, Pupiš M. Physical Therapy as an Adjuvant Treatment for the Prevention and Treatment of Cancer. *Klin Onkol.* 2020 Spring;33(2):101-106. English. doi: 10.14735/amko2020101. PMID: 32303130.
23. Hsu KJ, Liao CD, Tsai MW, Chen CN. Effects of Exercise and Nutritional Intervention on Body Composition, Metabolic Health, and Physical Performance in Adults with Sarcopenic Obesity: A Meta-Analysis. *Nutrients.* 2019 Sep 9;11(9):2163. doi: 10.3390/nu11092163. PMID: 31505890; PMCID: PMC6770949.
24. Zhang F, Zhong Y, Qin Z, Li X, Wang W. Effect of muscle training on dyspnea in patients with chronic obstructive pulmonary disease: A meta-analysis of randomized controlled trials. *Medicine (Baltimore).* 2021 Mar 5;100(9):e24930. doi: 10.1097/MD.00000000000024930. PMID: 33655957; PMCID: PMC7939163.
25. Wattanapisit A, Ng CJ, Angkurawaranon C, Wattanapisit S, Chaovalit S, Stoutenberg M. Summary and application of the WHO 2020 physical activity guidelines for patients with essential hypertension in primary care. *Heliyon.* 2022 Oct 25;8(10):e11259. doi: 10.1016/j.heliyon.2022.e11259. PMID: 36325139; PMCID: PMC9618974.
26. Knapen J, Vancampfort D, Moriën Y, Marchal Y. Exercise therapy improves both mental and physical health in patients with major depression. *Disabil Rehabil.* 2015;37(16):1490-5. doi: 10.3109/09638288.2014.972579. Epub 2014 Oct 24. PMID: 25342564.
27. Heywood SE, Connaughton J, Kinsella R, Black S, Bicchi N, Setchell J. Physical Therapy and Mental Health: A Scoping Review. *Phys Ther.* 2022 Nov 6;102(11):pzac102. doi: 10.1093/ptj/pzac102. PMID: 35926073.

28. Bise CG, Schneider M, Freburger J, et al. First Provider Seen for an Acute Episode of Low Back Pain Influences Subsequent Health Care Utilization. *Phys Ther.* 2023;103(9). doi:10.1093/ptj/pzad067
29. Denninger TR, Cook CE, Chapman CG, McHenry T, Thigpen CA. The Influence of Patient Choice of First Provider on Costs and Outcomes: Analysis From a Physical Therapy Patient Registry. *J Orthop Sports Phys Ther.* 2018;48(2):63-71. doi:10.2519/jospt.2018.7423
30. Szymanek E, Jones M, Shutt-Hoblet C, Halle R. Implementation of Direct Access Physical Therapy Within the Military Medical System. *Mil Med.* 2022;187(5-6):e649-e654. doi:10.1093/milmed/usab245
31. Young JL, Snodgrass SJ, Cleland JA, Rhon DI. Timing of physical therapy for individuals with patellofemoral pain and the influence on healthcare use, costs and recurrence rates: an observational study. *BMC Health Serv Res.* 2021;21(1):751. doi:10.1186/s12913-021-06768-8
32. Crowell MS, Mason JS, McGinniss JH. Musculoskeletal Imaging for Low Back Pain in Direct Access Physical Therapy Compared to Primary Care: An Observational Study. *Int J Sports Phys Ther.* 2022;17(2):237-246. doi:10.26603/001c.31720
33. Fenton JJ, Fang SY, Ray M, et al. Longitudinal Care Patterns and Utilization Among Patients With New-Onset Neck Pain by Initial Provider Specialty. *Spine (Phila Pa 1976).* 2023;48(20):1409-1418. doi:10.1097/BRS.0000000000004781
34. Frogner BK, Harwood K, Andrilla CHA, Schwartz M, Pines JM. Physical Therapy as the First Point of Care to Treat Low Back Pain: An Instrumental Variables Approach to Estimate Impact on Opioid Prescription, Health Care Utilization, and Costs. *Health Serv Res.* 2018;53(6):4629-4646. doi:10.1111/1475-6773.12984
35. Halfpap J, Riebel L, Tognoni A, Coller M, Sheu RG, Rosenthal MD. Improving Access and Decreasing Healthcare Utilization for Patients With Acute Spine Pain: Five-Year Results of a Direct Access Clinic. *Mil Med.* Published online 2022. doi:10.1093/milmed/usac064
36. Mabry LM, Notestine JP, Moore JH, Bleakley CM, Taylor JB. Safety Events and Privilege Utilization Rates in Advanced Practice Physical Therapy Compared to Traditional Primary Care: An Observational Study. *Mil Med.* 2020;185(1-2):e290-e297. doi:10.1093/milmed/usz176
37. Bornhöft L, Larsson ME, Thorn J. Physiotherapy in Primary Care Triage - the effects on utilization of medical services at primary health care clinics by patients and sub-groups of patients with musculoskeletal disorders: a case-control study. *Physiother Theory Pract.* 2015;31(1):45-52. doi:10.3109/09593985.2014.932035
38. Downie F, McRitchie C, Monteith W, Turner H. Physiotherapist as an alternative to a GP for musculoskeletal conditions: a 2-year service evaluation of UK primary care data. *Br J Gen Pract.* 2019;69(682):e314-e320. doi:10.3399/bjgp19X702245
39. Goodwin RW, Hendrick PA. Physiotherapy as a first point of contact in general practice: a solution to a growing problem? *Prim Health Care Res Dev.* 2016;17(5):489-502. doi:10.1017/S1463423616000189
40. Kiljańska M, Soszyński P, Motyl A, Walewska-Zielecka B. Impacts of a Re-designed Care Path for Back Pain Directing Patients to Physiotherapists: A Pre-Post Intervention Study. *J Occup Environ Med.* 2021;63(5):e276-e282. doi:10.1097/JOM.0000000000002178

41. Mallett R, Bakker E, Burton M. Is physiotherapy self-referral with telephone triage viable, cost-effective and beneficial to musculoskeletal outpatients in a primary care setting? *Musculoskeletal Care*. 2014;12(4):251-260. doi:10.1002/msc.1075
42. Horn ME, George SZ, Fritz JM. Influence of Initial Provider on Health Care Utilization in Patients Seeking Care for Neck Pain. *Mayo Clin Proc Innov Qual Outcomes*. 2017;1(3):226-233. doi:10.1016/j.mayocpiqo.2017.09.001
43. Kazis LE, Ameli O, Rothendler J, et al. Observational retrospective study of the association of initial healthcare provider for new-onset low back pain with early and long-term opioid use. *BMJ Open*. 2019;9(9):e028633-. doi:10.1136/bmjopen-2018-028633
44. Elrashidi MY, Mohammed K, Bora PR, Haydour Q, Farah W, DeJesus R, Murad MH, Ebbert JO. Co-located specialty care within primary care practice settings: A systematic review and meta-analysis. *Healthc (Amst)*. 2018 Mar;6(1):52-66. doi: 10.1016/j.hjdsi.2017.09.001. Epub 2017 Sep 23. PMID: 28958470.
45. Gadd S, Cox N, Slager S, Pinnock E, Mitchell M, Turner K. Assessing the impact of a payor-funded embedded clinical pharmacist on patient and provider satisfaction in a private primary care practice. *Am J Health Syst Pharm*. 2023 Jun 7;80(12):742-749. doi: 10.1093/ajhp/zxad045. PMID: 36860171.
46. Nicolotti LM, Koehler AN, Caballero Quinones E, Ballard PJ, Daniel SS. Medical provider satisfaction with integrated care in a pediatric gastroenterology clinic. *Fam Syst Health*. 2023 Jun;41(2):207-213. doi: 10.1037/fsh0000736. Epub 2022 Oct 13. PMID: 36227305.
47. ABPTS/ABPTRFE Primary Care Petition Subject Matter Expert Work Group Consensus. 2023.
48. Authors; Lachance CC, Severn M, Kim J. Evidence Base for Virtual Primary Care: CADTH Health Technology Review [Internet]. Ottawa (ON): Canadian Agency for Drugs and Technologies in Health; 2023 May. Report No.: HC0062. PMID: 37643253.
49. Katie O'Bright, Seth Peterson, Physical Therapists in Primary Care in the United States: An Overview of Current Practice Models and Implementation Strategies, *Physical Therapy*, 2024;., pzae123, <https://doi.org/10.1093/ptj/pzae123>
50. Jacobson, Ryan & Dobler, Rebecca. (2024). Embedding Physical Therapy in the Pediatric Primary Care Setting: Qualitative Analysis of Pediatricians' Insights on Potential Collaborative Roles and Benefits. *Pediatric Reports*. 16. 854-871. 10.3390/pediatric16040073.
51. Carlo AD, Corage Baden A, McCarty RL, Ratzliff ADH. Early Health System Experiences with Collaborative Care (CoCM) Billing Codes: a Qualitative Study of Leadership and Support Staff. *J Gen Intern Med*. 2019 Oct;34(10):2150-2158. doi: 10.1007/s11606-019-05195-0. Epub 2019 Jul 31. PMID: 31367872; PMCID: PMC6816741.
52. Lombardi BM, Greeno C, de Saxe Zerden L. Examining the use of psychiatric collaborative care and behavioral health integration codes at federally qualified health centers: A mixed-methods study. *Fam Syst Health*. 2023

Dec;41(4):527-536. doi: 10.1037/fsh0000827. Epub 2023 Sep 28. PMID: 37768626.

53. Mechley AR. Direct Primary Care: A Successful Financial Model for the Clinical Practice of Lifestyle Medicine. *Am J Lifestyle Med.* 2021 Apr 15;15(5):557-562. doi: 10.1177/15598276211006624. PMID: 34646107; PMCID: PMC8504342.
54. Brekke G, Onge JS, Kimminau K, Ellis S. Direct primary care: Family physician perceptions of a growing model. *Popul Med.* 2021 Aug;3:21. doi: 10.18332/popmed/140087. Epub 2021 Aug 2. PMID: 34651142; PMCID: PMC8513742.
55. Eskew P. Direct primary care membership medicine. *W V Med J.* 2014 Mar-Apr;110(2):8-11. PMID: 24902461.
56. Goldberg SE, Fragala MS, Wohlgemuth JG. Self-Insured Employer Health Benefits Strategy Established a Negative Cost Trend While Improving Performance. *Popul Health Manag.* 2019 Dec;22(6):547-554. doi: 10.1089/pop.2018.0184. Epub 2019 Mar 22. PMID: 30907688; PMCID: PMC6885757.
57. White ND, Lenz TL, Skrabal MZ, Skradski JJ, Lipari L. Long-Term Outcomes of a Cardiovascular and Diabetes Risk-Reduction Program Initiated by a Self-Insured Employer. *Am Health Drug Benefits.* 2018 Jun;11(4):177-183. PMID: 30464786; PMCID: PMC6207306.
58. Prall J, Ross M. The management of work-related musculoskeletal injuries in an occupational health setting: the role of the physical therapist. *J Exerc Rehabil.* 2019 Apr 26;15(2):193-199. doi: 10.12965/jer.1836636.318. PMID: 31111000; PMCID: PMC6509454.