Primary Care Across the Care Continuum

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The model of geriatric primary care has undergone some dramatic changes over the last decade. Both nursing homes and assisted living facilities (ALFs) are developing into a framework where patients live out the rest of their days comfortably. Traditionally, neither environment was ideal, but the shift in services those facilities can now provide has shaped how a primary care provider (PCP) can also practice medicine comfortably with all the amenities of resources they may have utilized in a traditional office setting. If PCPs can envision this environment as a delivery method for quality primary care, unbound by the boxed-in walls they may have been accustomed to, then management of chronic care can be done in both a cost-effective way and also one in which the practice thrives. However, there may be some who believe primary care practices cannot make it in this environment; this chapter is dedicated to transcending that barrier.

Practices can, and do, thrive in a place where the services are brought to the patient rather than the patient going to get the services [1]. Labs, X-rays, ultrasound, barium swallows, and EKGs all are delivered in ALFs and nursing homes nowadays. These services have been extended to wound care, podiatry, psychological services, dentistry, and audiology to give a few additional examples. Now specialty services, such as neurology, psychiatry, and orthopedists, are being asked to join. In some cases, the setting makes it's even easier to deliver primary care medicine since everything comes to the patient rather than the patient going out to seek the service. In keeping that focus in mind and understanding the place where modern medicine and technology have taken us, thoughts have long been emerging about the best way to deliver that care.

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Fragmented Care

Fragmentation of the current delivery system of medicine in the United States is what initially created a costly and counterproductive environment. It's not surprising that families utilize an emergency department, or even a hospital, as a "one-stop shop" for the healthcare delivery system. Those environments allow a patient to get every test and every specialist, all housed in one environment, quickly, even though the cost is outrageous. However, since the product of this environment is high-paced, the care becomes fragmented, which compromises the patients personal safety. The safety net of the holistic care a primary care provider can provide, is simply overlooked just by the nature of the environment.

Various models have been developed to try to reduce fragmentation but have had difficulty implementing them. The GRACE model, discussed later in this chapter, is an example of a recently successful approach that combines care coordination with the expertise of a clinical geriatric provider [2]. Studies clearly show that single provider interventions are rarely successful in reducing readmissions [3]. A successful transition of care model has been shown to be effective if the services extend throughout the transition of care. Furthermore, well-known philosophical geriatric models have demonstrated in the real world the ability to reduce emergency department visits as well as hospitalizations to improve overall healthcare costs. In the earlier models, GeriMed of America and Senior Care of Colorado set the tone for more care-coordinated models such as Twin Cities Physicians and Rocky Mountain Senior Care. These newly developed models have, to some degree, been able to extend services along the continuum of care.

So why haven't organizations like this spread? One reason is those models described above have not had an effective payment model to support such efforts. Our existing healthcare system doesn't take a vested interest in incentivizing care coordination when multiple specialists are involved. Fee for service—the Medicare model—is a barrier to successful implementation of these types of care coordination programs. In fact, hospitals and private payers have made attempts to provide additional programs supporting continuity of care, only to find the care is still not completely coordinated because the teams involved in the patient's care poorly communicate with one another along those different environments. Additional barriers include the absence of evidence-based treatment decisions, lack of healthcare provider teams that are accountable for that particular patient, inaccurate medication reconciliation, delay in the transfer of medical records, lack of timely follow-up, duplicative testing and services, and substandard communication with patient's families [4].

Questions then arise: can states effectively handle the booming elderly population as they move along the spectrum of care? Will states find alternatives that combat those barriers described above? Will communities expand down the roads to include skilled nursing sectors or stick with assisted living communities only? Or, even more dramatic, will assisted living communities become what most would envision as a nursing home?

Given those over 65 years of age will increase to over 98 million older persons living in America by 2060 (Fig. 9.1) and those 85 are expected to increase to 19

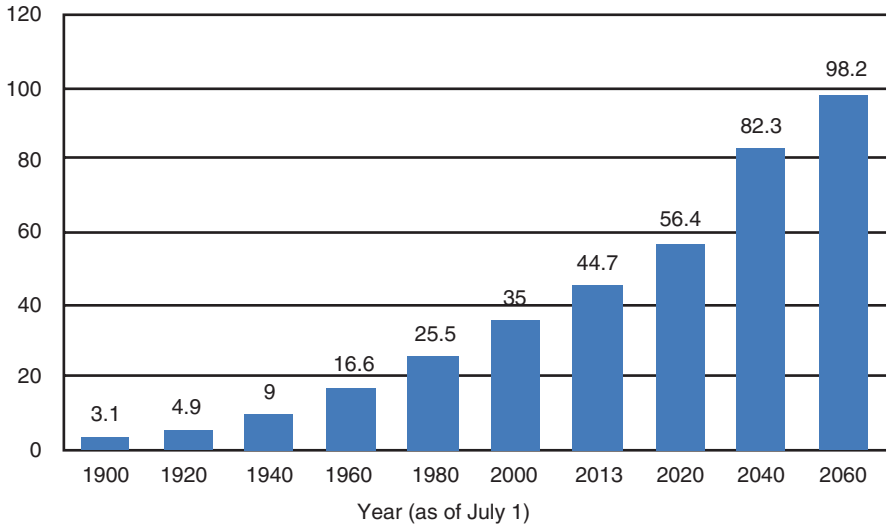

Fig. 9.1 US Department of Health and Human Services projections for adults aged 65 and older

million people by 2050 [5], there is going to be a huge shortage of providers. These are just a few of those questions that need to be answered to prepare for the influx of aging seniors to meet their needs.

One reason for concern is Medicare alone won't be able to cover healthcare needs for seniors given that influx. Those projections indicate that nearly one-fifth of the US adult population will be over 65 by approximately 2040. The traditional fee-for-service model will collapse under the weight of all those seniors.

Senior living communities that desire to stand apart have started to catch on to the idea and are now building "neighborhoods" that are servicing all types of care within that community. Newer housing developments for seniors are steering away from exclusively assisted living, independent living, or skilled nursing and instead working within a framework like that of continuing care retirement communities (CCRCs). These communities set aside space for a percentage of skilled nursing beds in relation to independent living, assisted living residences, and memory care. For the model to embrace continuity, at the helm, there is a physician with a handful of physician assistants and nurse practitioners delivering all of the hands-on care, alongside a designated care coordinator—oftentimes a social worker—who is coordinating the services those patients may need, e.g., labs, X-rays, dentistry, durable medical equipment, etc.

National organizations have also been instrumental in proposing several descriptions of what constitutes ideal transition of care service. The American Geriatrics Society has identified four best practices in transition of care: clinical care needs, policy needs, education needs, and research needs. In their report, they emphasize communication between the providers involved and unobstructed access to patient records containing problem lists, allergies, medications, advance directives, a baseline physical and cognitive assessment, and contact information for both

professional care providers and a point of family contact [6]. Models, such as that described above, have taken root in places like Minnesota. The Reducing Avoidable Readmissions Effectively (RARE) campaign was a collaboration of 86 hospitals in the state of Minnesota [7]. Ultimately, more than 7000 readmissions were prevented through this campaign.

In Minnesota, there was a focus on five key areas during the transition of care:

- Comprehensive discharge planning
- Medication management
- Patient and family engagement
- Transition of care support
- Transition of care communications

It is a system like this that Medicare and larger health insurers should embrace. However, it's also the framework of this system which PCPs can strive to work within and create a practice around.

Other methodologies have also shown success. The Mathematica Policy report incorporated elements of care to reduce hospitalization. They concluded successful programs were more likely to provide the following six elements of care [8]:

- Face-to-face care coordinator contact with patients
- Face-to-face care coordinator contact with physicians
- Evidence-based patient education
- Management of care setting transitions
- Facilitation of communications across providers
- Medication management

The GRACE model, as described earlier, aspires to the following seven attributes [9]:

- NP/social work team assigned by physician and practice site
- Focus on geriatric conditions and medication management to complement primary care
- Provided recommendations for care and resources for implementation and follow-up
- Incorporated proven care transition strategies
- Provided home-based and proactive care management
- Integrated with community resources and social services
- Developed relationships through longitudinal care

What's important about the model isn't the number of items on the list, it's the concept of how to manage care throughout that continuum. Looking at how each neighborhood looks, and understanding it well, helps shape the way that primary care practice looks.

How Neighborhoods Differ

Independent Living Facilities

The setting itself is *currently* considered a completely independent setting, but it may be shifting giving the competitive nature of these communities. Currently, independent living facilities, at the very least, have included a service coordinator such as a social worker to navigate the dynamics of social services available to the aging population. The primary focus of these service coordinators is to identify those supportive services—housekeeping, transportation, meals, and socialization—and to create the "link" to service needs of the older adult. In some settings there are even nurses on staff during typical business hours to answer simple questions and provide health education, monitoring of basic vital signs like blood pressures, and coordination with the residents' physicians.

Assisted Living Facilities (ALF)

Assisted living facilities (ALFs) have literally proliferated with an estimated 1.4 million elderly adults currently residing in ALFs across the country [10]. To some extent, ALFs offer some potential advantages to PCPs in that geriatric adults are more collectively accessible. Developers too have marketed this residential option to the elderly as a place to go when they can't live independently in their own home. In 1999, research was done to evaluate the community at large in an ALF. At that time, the study evaluated ALFs that had 11 or more beds and that either self-identified as an assisted living provider or offered at least a basic level of service, including 24-h staff oversight, housekeeping, at least two meals a day, and personal assistance to include at least two of the following—managing medications, bathing, or dressing [11]. At that time, four out of five of the residents in these facilities were totally independent in all activities of daily living (ADLs), 13% needed help with one or two ADLs, and 8% needed help with three or more ADLs. It is obvious to see these findings indicate the assisted living population is significantly less impaired than the nursing home population. Additionally, only 44% of those ALFs had policies that would admit patients who needed assistance with transfers, and 47% would admit people with moderate cognitive impairment.

By 2002, that dynamic had already started to change. It was observed there was a shift, and even though ALF residents were still healthier than the nursing home population, they were older and required more services. Evidence suggested that ALFs were accepting less healthy people over time and that residents were also aging in place. The longitudinal analysis revealed an increase in the proportion of residents with significant functional disability [12]. Another additional dynamic was access to nursing services. In doing so, it significantly reduced the odds of individuals moving to a nursing home, and thereby ALFs could collect revenue that they would have otherwise lost. The conclusion is assisted living facilities had the potential to substitute for a nursing home.

By 2010, this dynamic has changed even more. More than half of ALF-admitted residents had considerable healthcare needs with roughly 40% of residents needing assistance with three of five basic ADLs. Additionally, they served more adults with dementia accounting for nearly 81% of residents in smaller-sized facilities and 63% of those in larger facilities [13].

Nursing Home Expansion into Assisted Living

Since that time, dropping occupancy rates and market competition have forced many traditional nursing homes to explore expansion into assisted living facilities. Some nursing home operators have transformed their building into makeshift ALFs, with nursing and service coordinators and an "in-house" team to support labs, X-rays, dentistry, podiatry, and even physician services across the spectrum of ALF to long-term care (LTC).

From a marketing standpoint, those facilities use terms like "aging in place" when in reality it's a tool for financial survival for these facilities. Although patients may never have intended to go to a nursing home, these individuals did have a sense of security of knowing that this higher level of care was right nearby.

The Evolved Continuing Care Retirement Communities (CCRC)

The concept of a continuing care retirement communities was initially established in the mid-1970s to address the demands and preferences of middle- to high-income individuals for a continuum of care that attempts to exemplify the "aging in place" concept. Findings from a series of regional workshops that invoked the thoughts of stakeholders suggested that many had mixed views about the role of independent apartments in helping their elderly tenants remain in the community and delay or avoid transfers to nursing homes [14]. Consequently, developers built a campus that included independent living settings (apartments and cottages), facilities similar to subacute care as precursors to assisted living when people couldn't go back to their independent environment, and nursing homes which might also include memory care if it was needed. And even though individuals could still transition from one setting to another, those who bought in, signed and purchased a life-care contract, understood they would be fully taken care of in the event of debilitating illness or disability. Forty-five years later, CCRCs still exist, and even though the signed contracts or the "buy-in dynamics" may have changed, many continue to provide this concept of aging in place.

This model more explicitly recognized ALFs as a residential and care setting designed to meet the needs of individuals who needed nursing and social services. For some residents, assisted living was the last stop along the continuum as hospice services were being provided in this setting. Consequently, what has followed has been an evolution of what the CCRC, or more specifically, what the ALF has become. It appears to be evolving into the "new nursing home" as has been demonstrated by Kindred who has sold all their "traditional" nursing homes in favor of focusing on their home health and hospice segments where revenue margins are better [15].

Given this perspective, the typical "primary care" model has shifted with it. A physician-led provider team of geriatric-trained physician assistants and nurse practitioners can literally bring the office to the patient. These teams have arrangements with service coordinators or property managers and have the ability to make house calls to chronically disabled older adults who have multiple chronic conditions, especially for those who find it difficult or impossible to go to a doctor's office or a clinic. The teams provide intensive chronic disease management (often using electronic health records, health information exchanges, and in part telemedicine) just as in a traditional clinic setting. These providers are reimbursed currently on a fee-for-service basis, but coordination with a service coordinator can provide that link to essentially turn an independent housing clinician into a comprehensive health- and long-term care model.

The Latest Model

Now integrated hospital and healthcare systems want to join in offering a "package" as part of their repertoire of services. Organizations such as IPC The Hospitalist Company have attempted to follow their patients along the continuum—or develop their own versions of facilities that span the continuum of care. This health system itself is attempting to manage the transitions between hospital and skilled nursing facilities and reach across the gap of coordinating care in assisted living to make efforts to avoid costly nursing home placement. It is important to note, however, comprehensive hospital, health, and long-term care systems that achieve administrative integration do not always achieve good service integration. The key word needs to be care management. Otherwise, assisted livings become just another production center of revenue and don't really achieve continuity of care nor do they achieve meaningful savings in the healthcare system.

How the Model Fits in the Current System

There is strong concern that our current system will not be able to supply an adequate amount of clinicians to meet the ever-increasing chronic care needs of the aging population. Countries that focus on cost containment also focus on having primary care as a centerpiece of their healthcare delivery system [16].

In 2008, the National Committee for Quality Assurance provided a road map to define the framework of what that primary care model might look like to improve patient outcomes. They even went so far as to define these homes as medical homes. The definition included a model of care that bolsters the clinician-patient relationship and replaces episodic care with coordinated care. Each patient developed a relationship with a primary care clinician and a team of PAs or NPs who collectively took responsibility for patient care along with the patients' healthcare needs and arrange for appropriate care with other qualified clinicians. This model was really intended to provide a more personalized touch that was both coordinated and efficient [17]. This model itself was also endorsed by the American Medical Association and 18 specialty healthcare organizations [18].

There are seven joint principles this model aspires to follow:

Personal physician: Each patient and their families have a relationship with a physician-led team who are all trained to provide continuous and comprehensive care. The intent being that patient-centered care is built on that foundation of a patient-provider relationship.

Physician-directed medical care: The physician leads a team of individuals that collectively take responsibility for ongoing patient care. The intent is meant to encourage physicians to adopt a team approach to care.

Whole-person care: The physician team is responsible for providing all the patient's healthcare needs and for arranging care with other qualified specialists if needed. The intent is again meant to encourage a team approach to care for a patient's acute, chronic, and preventive care needs.

Care is coordinated and integrated: Coordination occurs within the healthcare system but within the patient's community. The intent again is to foster a collaborative process where physical, occupational, and speech therapy and additional community-based services (i.e., pharmacists, podiatry, labs, imaging, dentistry, psychology) are providing a team approach to care.

Quality and safety: The model supports patient-supported disease management, but the information is shared through performance reporting, clinical decision support from clinicians, patient education, online communication, and ongoing quality improvement.

Enhanced access: Care is available not just during the workday but expanded hours of 24/7 access to the provider team using innovative techniques to communicate between patients, provider, and practice staff. The goal here is to constantly have access—whether it be in person and by telephone, secure email, or real-time video conferencing. Additionally, the care team gets secure text communication about the nature of a patient's concern and then decides when appropriate follow-up should take place.

Payment: To promote a sustainable model, reimbursement should be **rewarded** or given to those expanding services beyond just an actual patient encounter. The enhanced access demands and is deserving of a system that demonstrates value above the status quo, such as improved health outcomes and significant decreases in hospitalizations.

Bringing It to Fruition

By adopting those joint principles, primary care will be redefined, and those willing to embrace it will likely be rewarded. To facilitate that model though and create the multidisciplinary team as is described above, there is a need to include a physician who feels comfortable leading a team of PAs and NPs. And while the model certainly includes a physician seeing patients, it does not mean the patient needs to be

seen for every acute, subacute, or chronic illness by the physician. In fact, the drivers of much of that care are led by a physician assistant or a nurse practitioner who is skilled in geriatric medicine. The physician is then called upon to carry out routine visits as mandated by law or limited to those situations where an additional knowledge base or skill set of the physician is required.

This multidisciplinary team must also include a nurse or well-trained medical assistant that runs the primary care practice. Much like an office-based setting, where office staff help facilitate labs, X-rays, and subspecialty visits, this person can do the same from a physical location. That physical location could be an office or it could be a person's home; this is the dynamic nature of this type of primary care model. Each primary care practice identifies the internal team to lead that medical home model whether that medical home be a nursing home, an assisted living facility, or an independent living setting. Ideally, a registered nurse or licensed practical nurse could coordinate all of this. However, a good medical assistant can also go a long way in providing quality care.

Advantages and Challenges

Being a primary care provider in these settings requires constant communication with the facility, a good relationship with nursing and non-nursing staff, and some real creativity. A patient's couch or bed, rather than an exam table, may be where a full assessment occurs. Improvisation is a prerequisite of this setting. All the while, productivity is the mainstay of success. Given most of the patients are housed in one environment though, this can be done very efficiently.

One challenge is being accustomed to mobile services as was discussed earlier. Blood draws, ultrasounds, EKGs, or X-rays will have delayed turnaround times. Providers need to rely more on their clinical skills while waiting for such tests to come back. Providers need to be patient with a variety of durable medical equipment (DME) companies so that equipment can be procured for their patients. Wound care, podiatric services, and audiology can be done onsite in many cases. And home health services—PT, OT, and ST—should and can all be done in this setting. Hospice care is also an integral part of this process and becomes an invaluable part of the medical care people receive.

As the practice grows, time efficiency and medication-related issues present two major obstacles. Documenting monthly medication lists can be time-consuming, and finding patients can sometimes be challenging as well. Additionally, a provider may have several facilities to travel to in 1 day. Therefore, "windshield time" needs to be accounted for. Furthermore, each facility is different. Some ALF facilities have licensed caregivers administering medications, and others do not. Some permit nurses to receive verbal orders, while others require a handwritten and signed order. Providers need to know the nuances between facilities and morph around the needs of the buildings and not require the buildings morph around their needs.

Where to Start

It needs to be stressed that although a practice needs an MD at the helm for oversight, and perhaps for those difficult cases, the initials following the providers' names, such as MD, DO, NP, and PA, matter little to most older patients [19]. Older adults want to know someone cares for them and has their best interest in mind. The advanced practice provider should be comfortable understanding when more specialist engagement is needed.

To create an effective practice, all providers need to feel supported. Allow them adequate time to evaluate and treat older complicated adults. Practices not allowing sufficient time for initial or follow-up visits will find themselves with frustrated providers which can lead to attrition and dissatisfied patients or families.

A team approach is also necessary in settings like assisted living facilities and skilled nursing facilities. Providers should have relationships with nursing, social work, pharmacy, and therapy. This sounds difficult, but something as simple as saying hello to any of these professionals goes a long way in setting the tone of approachability. The team approach is also perceived as having continuity centered around it. Providers who are enthusiastic about their work will naturally build a mini-practice within the buildings they frequent and build that practice from within. Naturally, too, their familiarity with those patients goes a long way in being able to be more productive.

Compensation Strategies for Providers

Practices can be successful and provide good geriatric care if their providers see 13 to 15 patient visits in an 8-h day. This time reflects a typical visit, extended visits (whether it be a new patient history/physical or complicated follow-up visit), and windshield time. In any practice, whether it be Medicare-managed care or traditional fee for service, a practice cannot expect a provider to render quality geriatric care if the bar is set too high. Stick within that "sweet spot" of 13 to 15 patients, and providers will likely stick around rather than leave the practice. There are also those providers who see considerably less than that volume of patients but who build the volume of patients and facilities within the practice. They are appropriately called "builders" rather than "producers," and they too hold their weight in the practice. Keeping this in mind allows a practice grows at a steady pace.

There are mechanisms to ensure attractive compensation. They include salary, productivity bonuses in the form of payment and vacation, and considering how part-time providers can balance the ebbs and flows of a practice. A competitive salary allows a provider to focus on quality of geriatric services without pressuring them to focus solely on the quantity of visits. Incentives, based on volume, can also be instrumental for those providers that desire to work harder and add to that competitive salary. Finally, the use of part-time employees with a prorated salary or productivity-only salary will allow a float to cover those providers who are out on

vacation or whose facilities have a high number of patients during periods of time, e.g., more influenza cases in the winter months versus the summer or more elective surgeries in the summer months. The risks associated with that discussed above include a provider that may not be as productive as he or she should be to build the practice. It needs to be emphasized that some providers produce numbers under the expectation, while others produce volume over it. Successful practices find the right balance between salary and volume expectations.

One mechanism to account for this is a relative value unit (RVU) plan. Practices can design RVUs that reflect the time needed for various visits. For example, if a geriatric provider spent longer time with patients and families and it takes them one hour to complete this task, they get three RVUs for spending that time with a complex patient and family. On the other hand, a provider's colleague who is seeing three follow-up visits in one hour would get the same three RVUs. Therefore, each geriatric provider is not being penalized for the time needed to provide good geriatric care. RVUs make compensation fair regardless of how much time a provider devotes to geriatric services. However, it can be time-consuming for those in the accounting and human resource departments, and they need to calculate this weekly.

The Concept of Continuity of Care

In the leading paragraphs of this chapter, the importance of continuity of care was discussed. It is a selling point with ALFs and skilled nursing facilities (SNF) alike when they hear how a practice can drive volume into their buildings. It is not uncommon that patients take ill in their ALFs and end up hospitalized. A good geriatrician will serve the patient by trying to get them back home. To do so though means there may need to be a conduit—such as a skilled nursing facility—in the interim to get them back home. That continuity speaks volumes to the ALFs—knowing they're going to get their patient back—but it also improves overall care and makes the patient feel like they are literally being cared for by their "doctor" along that journey. For managed care, a 3-day hospitalization can oftentimes be bypassed; it equates to cost savings by not having that expensive hospital stay. Extending that geriatric arm is priceless and will ensure a practices success given it's managed correctly. To do that, a practice manager needs to maximize a geographic grouping of visits to make it convenient. For example, an advanced practicing provider should keep windshield time to a minimum and group facilities around one another.

Most importantly, the geriatric provider must know how to capture their work. This applies more to a nursing home than an assisted living. It is difficult for a provider to bill on time in an ALF (it's all based on a face-to-face visit), whereas in a SNF, total floor time can be captured, and billing is reflective of all that floor time. It is imperative providers know and understand those nuances. Providers who know how to capture their work through good use of E/M and time-based billing will help a practice immensely.

And though practices will find nursing homes/SNFs to be more financially rewarding for a practice, since seeing a higher patient's volume is likely, it will create additional work for the practice. Three are worth noting:

- The volume of calls from nursing homes is exponentially higher than that of an assisted living. Since concerns can and will arise at any hour of the night, providers will need to take that call.
- The patient acuity is higher. Many of the patients as early as 5 years ago aren't nearly as sick as the patient in 2017. Shorter hospital stays contribute to that. More importantly, providers need to feel comfortable with that higher level of acuity.
- The third issue involves regulations in nursing homes. From the history and physical in subacute care to the mandated monthly visit in long-term care. Each state is different in what they require, but both timely physician and advanced practitioner follow-up can be stressful to a practice.

These constraints are lessened in a practice that only focuses on assisted living.

Expanding into the Home

Residential home visits can be very risky for any practice. The scheduling of appointments, the windshield time for providers, and the unexpected events all cost time and money for the practice. It can be done though when focus is placed on independent living settings such as senior housing or cooperatives where the population is only geriatric and concentrated. This allows for effective geographic grouping such as a nursing home or assisted living facilities. Another challenge is how to fairly compensate a person who decides only to take on home visits. Initially, practices should steer away from this model of care unless they predominantly go into senior housing centers.

Recruiting and Retention Strategies

Successful practices have considered the financial and emotional costs of replacing unfulfilled providers. Recruitment, training, delays in provider efficiency when they start, staff morale, and patient relationships are the mortar that hold the bricks of the practice together. An office manager who continuously keeps in touch with all their providers, to understand their concerns, can improve provider satisfaction.

A High-Touch/High-Tech Experience

A good geriatric practice weighs the benefits of high tech and high touch. To be able to view faxed orders or prescriptions, review labs or progress notes, and check imaging studies such as X-rays, is important; to do it all from your phone is the high

tech part of it. The use of devices for real-time video conversations with staff, families, and patients is the world that we have evolved into; medicine must evolve with it. For example, CPT codes now exist—and can be billed and paid in the state of Minnesota—for video conferencing and/or assessments.

Most importantly, all of this needs to be done in real time so that at any time, any provider, anywhere in the world, has access to those records. Ultimately, to span across the barrier of a wall within a practice, it's recommended that health exchange of information also be a part of this high-tech experience. It will make the practice stand apart from their competitors.

While young providers may have that skill set, older providers may struggle. But it works both ways. Older providers may offer insight in their experience and confidence to make complex decisions where those "techy" tools may not be as effective. It is a balance, but technology and a sense of touch can be very effective. Practices that incorporate high tech with high touch tend to more successful.

What's Next

The trends in America suggest older adults will be left without an adequate supply of primary care providers. Consequently, more care of older adults will fall upon non-fellowship-trained family practitioners, internists, and advanced practice providers [19]. However, given the right environment, creative solutions do exist for quality care. Advances in medical technology and mobile health services can enable a team of providers to fully deliver primary care service at the convenience of patients and families. The vast difference is they are not bound by the traditional brick and mortar older practitioners were accustomed to. These evolving practices can be highly reimbursable, with essentially low overhead expenditure, which is ideal for changing the language of primary care.

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