QUICK COVID-19 PRIMARY CARE SURVEY

SERIES 17 FIELDED JULY 24 – 27, 2020

Four plus months into the pandemic, lack of substantial policy response by public or private sector leaders and a persistent dire "new normal" pose a credible threat to potential collapse of US primary care and of independent practice. Four in 5 surveyed clinicians report practice strain is worse than in March, the first month of the pandemic, with 50% saying that they are just getting used to the poor conditions. Although telehealth has proven a useful care tool during the pandemic, lack of sufficient support has resulted in a downturn in use and a choke point for patient access.

Policy Implications – Failure to act has already caused a contraction of the US primary care system with justifiable concern that it will retrench further. At the national level, primary care leaders and their supporters need to present a united voice to persuade public policymakers and health plan executives to act or US primary care will collapse.

~450 clinicians described primary care's abnormal "new normal." 90% of responses fell into the following categories:

- 26% – A physically and emotionally damaging work environment – unrelenting pressure from constant and daily exposure to serious illness, PPE that is either lacking or must be worn all the time, and physical distancing from both patients and co-workers while bearing witness to great emotional COVID-19 related hardship and stress
- 20% – Balancing in-person visits with telehealth visits, new workflows and physically isolated team members
- 19% – Critically understaffed – furloughed staff means lack of adequate support for increased in-person volume, clinicians doing nursing and clerical duties; higher staff absences due to simple or COVID-19 illness and childcare
- 19% – Forced financial loss – limits to the number of patients that can be seen because of physical distancing needs and reduced staff; longer hours to meet operational needs; reduced payments; increased costs of care
- 7% – "Never feeling any sense of control" resulting from continuously changing regulations, billing requirements, COVID-19 protocols, shifting staffing levels, and an unpredictable funding environment

16% of clinicians report financial improvements, while 1 in 5 remain uncertain about their viability 4 weeks out

- 20% of clinicians had salaries skipped or deferred over the last 4 weeks; 24% report recent layoffs/furloughs
- 10% had employees quit because the work environment is unsafe; 25% have open positions that they cannot fill
- 44% report face-to-face patient volume continues to be 30-50% lower than pre-pandemic levels

Telehealth could help meet rising population health burden; use of telehealth has reduced in face of limited support

- 46% report patients not scheduling in-person preventive/chronic care visits; 27% conditions seem worse
- 80% say patient mental health burden is heavier than usual – a concern for which most find telehealth beneficial
- 13% had digital health billing denied
- 21% have been informed by private insurers that telehealth payments will be pulled back in the next 4 weeks
- < 17% are relying heavily on virtual visits and 58% are conducting the majority of patient visits in-person

Clinicians wanted to know if their colleagues support the opening of schools… so we asked the question

- **27% said yes**, school should open; **7% were not sure** what the answer might be.
- **66% said no**, schools should not open, with half of those saying schools could open if area COVID-19 rates were below threshold and the school was able to maintain CDC recommended distancing. Many were concerned about vulnerabilities among those with learning disabilities, those who might face abuse, or younger children.

Methods – This survey fielded by The Larry A. Green Center, in partnership with the Primary Care Collaborative. The survey invitation was fielded July 24-27, 2020 with thousands of primary care clinicians across the country.

Sample – 523 respondents from 47 states and Guam. Family Medicine (73%), Pediatrics (5%), Internal Medicine (15%), Geriatrics (3%), and 4% other. Settings included 23% rural, 15% community health centers, 9% in schools/offices, and 28% in designated patient-centered primary care homes. 34% had 1-3 clinicians; 29% had 4-9 clinicians; 37% had 10+ clinicians. 32% self-owned, 13% independent and large group, 40% owned by a health system, and 5% were government owned. 8% were convenience settings and 5% were membership-based.

"In the '80s, I helped run an AIDS hospice… I have provided care in "hot" (active) war zones on three continents. I have provided medical care and humanitarian observation within the prisons of the three most powerful empires of our era. Never before have I felt so helpless…" – Colorado

We asked clinicians, "Can you briefly describe your new normal?" Common among the 447 comments – these sentiments

- It is new, it is not normal. Masks, fear, people being more cautious than needed and others with head in sand. Missouri
- More telehealth, lots of stress about patient numbers, angry/exhausted coworkers. New York
- Lower salary for more work, risk of serious illness every day, doing my staff's jobs because they are afraid to touch and be in the room with patients, spending my own money ($30k) on PPE for the entire clinic despite working for a huge hospital system, and having the federal govt specifically exclude me in COVID-19 workplace benefits (FFCRA). Pretty much a nightmare. Texas
- Horrible. Angry patients, extended work and new duties to accommodate testing - never feeling any sense of control. I feel like my life is expendable in terms of the overall company's financial health. Nevada
- Insecurity, exhaustion, moral outrage, despair, grief, rage, despondency. Seriously questioning whether to continue to stay and serve a society that doesn't seem to value me, my loved ones, or what we do. Currently working ~120hrs/wk providing unfunded care at my own personal expense to gravely ill persons... I have maxed out my own resources and reserves. Colorado
- Patients neglecting their health, patients experiencing financial issues and mental health burden. Iowa
- Increased patients and decreased staff. I now do clerical and nursing work in addition to my usual patient care. South Carolina
- No longer seeing patients for routine urgent care needs. It's all COVID. I am not sure where the other needs went? Arizona
- PPE that is expensive and often unattainable. Unable to get swabs for COVID in any sufficient quantity to meet demand for testing. Patients are angry at the situation and rightfully so. I am waiting 5-14 days for results on patients which is unacceptable when we are trying to get a handle on this pandemic. Arizona
- Some days are video, some in-person. We 'put out fires', manage patient problems that were deferred. More 'volunteer' care, patients with poor access, poorly/unpaid telephone and portal care. Video is over-sold - I can't examine people over poor-quality video. Pushed to schedule more patients to cover operating losses during COVID surge and system ramp-down. Michigan
- [Those] still getting sick are the essential workers - low income, often immigrants working in stores, restaurants, cleaning etc. DC
- Me – safe at home. My patients in poverty and disasterville. Social justice issues intersect medicine like never before. Texas
- Masks, PPE, decline in patient visits, 30% increase in time it takes to see a patient so longer hours. COVID-19 testing in the parking lot. Very poor return time on the tests and attempts to install in our office unsuccessful due to limited supply. Virginia
- A person at the door asking patients before they come in if they have a fever or were exposed to someone sick; asking geriatric patients to call before coming in and possibly not to come in if not urgent; waiting area is marked with tape to indicate which seats can be used; have an acrylic panel on the front desk [between staff and patients]; and we're all wearing masks. California
- Highly stressful. Loss of autonomy as admin changes procedures frequently. Reduced staffing (nurses/receptionists). Distancing means lower patient volume. Many new patients due to providers retired/left and people relocated from NYC to upstate. NY
- Trying to balance making up for lost patient care while still practicing safely and while helping families navigate school decisions, including my own. In other words, always stressed. North Carolina
- I'm only seeing 1/2 my normal patient load and am, as of last week, only using telemedicine unless a patient has an emergency. Also, new normal is insurance cutting reimbursement because if our using telemedicine. Mississippi
- Staff anxious that infected patients may get past doorway screening, exposing them to undiagnosed COVID positive patients. Hospitalized COVID+ patients doubled. Screening thousands of faculty/staff returning to campus, seeing many new symptomatic positive cases. We need more staff but have been restricted from hiring additional staff due to budgetary constraints. Alabama
- The loss of support from the payers, especially the ending of cost sharing waivers for telemedicine, has felt like abandonment by the payers, leaving us out here on the front lines to safely care for patients while they post record profits. Texas
- We have terminated one MA and cut the hours of others. We have outsourced our hospital care since both practice physicians are older than 65. Not bringing in 1st and 3rd year medical students for teaching purposes as previously done. Florida
- Seeing a mix of acute and chronic concerns, CMAs, RNs and LISWs chasing people on the phone to arrange care visits, real or virtual. Chronically low on PPE, testing supplies and referral resources. Iowa
- I feel like a brand new medical student where nothing comes easy. Even seemingly straightforward complaints, like ear pain or sore throat are difficult due to COVID as a possible additional diagnosis. Michigan
- It is getting worse: staff stress, patient stress, volume management, crazy increase in medical conditions. Colorado
- Our new role is to calm our patients, cut through confusing misinformation and try to manage their ongoing health issues. Texas
- We expect more stress as children will not be returning to school in the fall, and many of our staff have no back-up childcare options, so will not be able to work. They also may not have the best ability to home school. Alabama
- I have serious doubts about my own safety - and with each growing day I hate being a provider more and more. Nevada
- We will not survive financially if we cannot continue to bill for telemed. These make up 70% of our business currently. California
- Telemedicine payments have been a nightmare. Some insurers are paying $20-30 for 1/2 hr telephone visit. Massachusetts
- Staff sent home, determined by [volume], leaving us very short staffed. Spending freezes. Volume was down, but is now higher than it has been in a year. Practice disrupted by minor illnesses that used to not require time out. No rapid testing. Kansas
- Reduced salaries, reduced schedules, reduced vaccinations for kids, hiring freezes, supply chain issues even for non-PPE. Oregon
- Practice staff (providers, nurses, et al.) have quit because they need to attend to family issues, educating their kids, not enough other providers available to share the loads, being pulled by secondary appointments at other jobs, etc. Wisconsin