



QUICK COVID-19 PRIMARY CARE SURVEY

SERIES 3 FIELDED MARCH 27-30, 2020



This is the third weekly national survey of frontline primary care clinicians' experience with COVID-19.

Nearly 8 in 10 primary care clinicians report their practices are under high levels of strain. Seven in 10 clinicians lack access to personal protection equipment (PPE) and staffing outages related to illness or self-quarantine continue to be high among clinicians (49%), nursing staff (42%) and front desk support (31%). Practices are stretched thin with 57% reporting less than half of what they are doing is reimbursable. Lack of staff, equipment, and financial strains are real with 61 percent reporting uncertainty about their ability to remain open after 4 weeks.

Additional Main Findings

- 70% of clinicians report insufficient COVID-19 testing capacity (32% have none; 38% have limited ability)
- 65% lack PPE and an additional 14% are short of supplies necessary to treat patients
- 90% are limiting well and chronic care visits
- 19% are no longer doing any routine care (including well, chronic care, and non-COVID acute visits)
- Only 34% report they have cash on hand to last 4 week; 13% don't have that and 52% were unsure.

Telehealth Findings – implementation of telehealth as major source of care remains limited

- Majority (>50%) use of telehealth is limited: for video (21%), e-visits (8%), patient portals (11%).
- However, 55% report using phone for the majority of patient visits.
- 39% of practices report no use of video visits, 49% no use of e-visits, and 24% are not using patient portals

Access and Sustainability Findings

- 5% report their practice is temporarily closed; another 5% are certain of closing within the next month
- 13% report they have temporarily closed to in-person visits; 11% will do so within the next 4 weeks
- 61% are uncertain if they will be open 4 weeks from now related to potential impact of staff illness (49%), lack of PPE (44%), and low volume reimbursable work (35%)
- 19% are unsure if they will need to permanently close within the next 4 works.

Methods – On Friday March 27, The Larry A. Green Center, in partnership with the Primary Care Collaborative, launched Series 3 of the weekly Quick COVID-19 Primary Care Survey. An invitation to participate was distributed to thousands of primary care clinicians across the country and remained open until March 30, 11:59pm PST.

Sample – 713 clinician respondents from Family Medicine (59%), Internal Medicine (12%), Geriatrics (13%), Pediatrics (5%), and 11% primary care-based pharmacists and behavioral health. Two percent of respondents were from other disciplines. Responses covered all 50 states plus American Samoa. Practice settings for respondents included 23% rural, 79% larger than 3 clinicians, and 29% some type of community health center. Close to half of our sample (47%) had >50% of patients commercially insured. 22% owned their own practice and another third (33%) were associated with an academic center.

Policy Implications – Medicare and private health plans must continue to adapt finance structures to protect patients and clinicians. These solutions include adequate payment for telehealth/telephonic visits (short term), and adequate prospective payments for primary care. Many practices need immediate financial help to keep their doors open; if they are shuttered, much more than COVID-19 care will be lost. This is a policy emergency that needs immediate attention.

“We have no PPE and no tests. How can we care for our patients without the proper tools. The message we are getting is that healthcare workers lives don't matter, we are dispensable.” - Maine

Open text comments were received from 252 clinicians

Financial stress

- When 50% of private practice PCPs go out of business, how will we EVER control health care costs? The answer we won't. Private practice PCPs are going to die without help. – Michigan
- We furloughed a large percentage of our organization due to lost revenue. – Connecticut
- Business has dropped off immensely and we are giving away a lot of free care but are trying to remedy that with technology. I am very worried about cash flow for our small rural hospital and clinic. – Missouri
- I am stepping out of clinic to work inpatient and avoid exposure to in person pts. We could not get enough patients to use telehealth to fill my schedule so I have offered to reduce my salary by 5/6ths and my NPs will see the patients. – Tennessee
- There is an increasing likelihood that my practice will financially fail over the next 4 weeks. I am in a solo practice but part of a larger group. We are being told to lay off employees. I am overrun with prescription refills and prior auths for medications and normal calls (all of which is uncompensated). Things may change in the next week, but I fear at a time when I will be most needed, my practice will no longer be around. – Virginia

Telehealth

- Encountering a huge issue with the Payers who are currently refusing to pay for Telehealth visits by our APP's if the visit is conducted from the APP's home instead of the office. – Virginia
- Patients most vulnerable don't have telemedicine access – Alaska
- The lack of clarity about telephone and virtual visit reimbursement is creating a lot of challenges, you're risking loss of the "frontline" in the state's response to the COVID 19 pandemic in this state. – Oregon
- We are setting up telehealth as quickly as possible with no idea how much or if we will get paid. – Missouri
- Older patients not able to do video visits mostly telephone visits minimally reimbursable - Medicare wellness not covered on video visits! – Maryland
- 8 employees. Laid off 5. Overhead still goes on. Telehealth is promoted by many others especially in employed or corporate medicine but it won't pay the bills in independent practice. – Michigan

PPE and testing

- I have been using the same mask for a week. My nursing staff are sharing 1 mask depending on how close their contact is with patients. This is unacceptable, but we either close or continue to expose ourselves to illness. Few hospices willing to accept patients w/COVID-some due to lack of PPE. – Texas
- 2 positive in our facility, 1st one two weeks ago resulted in the quarantine of 57 people b/c of course Positive only discovered days after being transferred to a bigger facility. – Missouri
- It is criminal to have healthcare workers risking their lives due to reluctance of the federal government to take charge of mandating production of PPE and patient support items (eg ventilators). – New Hampshire
- We are only handling emergencies over the phone- we cannot get sufficient PPE so we can't go to the office. The state is taking what little we have for the hospital. – New Jersey
- Test capacity ramping up in the labs but running out of specimen collection kits. Frightened at the prospect of running out of hospital beds, and trying to care for seriously ill patients in outpatient settings. – California
- The lack of PPE to protect the heroic and committed staff is criminal and dangerous for our colleagues, and the patients.. The lack of vents and people trained to use them is both criminal and dangerous for patients. – New York

Hopeful moments

- I've been completely humbled by the resilience and adaptability of everyone in the organization. – Virginia
- We have had awesome system response - set up triage line with 1500 patient calls per day, switched to virtual visits within one week, etc. – Colorado
- The vast majority of my patients are in a PMPM payment scheme, either through my BC/BS affiliate or Medicare CPC +. This, of course, has been a god-send. We are able to care for the vast majority of patients via telephone or the EPIC portal. My answers would be totally different if I was on fee for service. – Hawaii
- Rapid change in clinic processes, organization, cohorting of providers, parking lot tent set-up, time and space separation of sick and well visits, onboarding with video visits in <1 week system-wide. Amazing rate of change. – Oregon
- We have a strong partnership with our critical access hospital and are ready to take care of critically ill patients (not our norm) if needed. I feel comfort that we are "in this together." – Kansas
- Hospital operations team working collaboratively with primary care leaders, ED; designed parking lot testing centers, clinician pools for callbacks, patient education, expanded hospital care teams. – Pennsylvania