



QUICK COVID-19 PRIMARY CARE SURVEY

SERIES 11 FIELDLED MAY 22-26, 2020



Despite 38% of practices receiving some Federal financial support, the financial pressures remain acute. Close to half of respondents have had to layoff/furlough an average 30% of their staff and 28% deferred or skipped salary payments to clinicians. For those that reported more detailed financial information, 77% reported a negative net (revenue-expenses) in April 2020 as compared to 18% negative net in January 2020. Clinicians are clear that if they are adequately supported, they will provide the kind of comprehensive, coordinated, and relationship-centered care that patients are seeking from primary care.

38% have received federal or state support, preventing immediate closure but the platform remains unstable

- 14% were temporarily closed; 1% permanently closed; 56% have significant decrease in patient volume
- 17% had digital health billing denied and 4% had state-based cuts to Medicaid
- Among those reporting ability to sustain their practices now, almost all had received PPP or SBA funds
- Alternative methods for sustaining practices include: 5% additional credit line; 1% private equity; 7% personal savings; 2% personal loans; 3% grants
- 24% received no support of any kind

10% of clinicians report practice members choosing to leave due to harmful “new normal” in primary care

- 74% practices operating under severe or near severe stress
- 46% have no or severely limited access to testing; 59% continue to have no PPE
- 84% of clinicians have patients who struggle with digital platforms
- 27% of practices report no use of video visits, 53% no use of e-visits

If primary care were to receive the perfect financial solution, what would you promise in return? Most common responses were:

- Excellent care based on primary care foundations: continuity, coordination, comprehensiveness, access
- Personalized care, relationship based, integrated across platforms, equitable, compassionate, open to all
- Payment now would mean ability to stay open while providing a safe environment for work and care
- High quality, appropriate care, outcomes and evidence-based medicine
- A small number spoke about PCMH, quadruple aim, and continued ability use of digital health

Policy Implications – Per the survey, a small percentage of primary care practices are financially weathering the COVID-19 storm, with most of them receiving Federal support. However, the vast majority are not in that situation and need dedicated funding from the provider relief fund to make up for volume declines, lack of parity with telehealth/telephonic visits on the part of commercial payers, and other expenses they've incurred to respond to the pandemic. More than two months into this public health crisis, time is running out for the Administration to respond.

Methods – This survey fielded by The Larry A. Green Center, in partnership with the Primary Care Collaborative. The survey invitation was fielded May 22-26, 2020 with thousands of primary care clinicians across the country.

Sample – 506 respondents from 48 states. Family Medicine (65%), Pediatrics (6%), Internal Medicine (18%), Geriatrics (5%), and 5% other. Settings included 24% rural, 15% community health centers, 12% in schools/offices. 30% had 1-3 clinicians; 26% had 4-9 clinicians. 30% self-owned, 13% independent and large group, 41% owned by a health system. 8% were convenience settings, 4% were membership-based, 21% were designated PCPCH. 5% were government owned.

“Medicare has made tremendous concessions to maintain practices. Unfortunately, the experience with commercials has been less helpful.” – Virginia

“Cuts to staff are just now coming; we’ll have fewer available PCP’s when the second wave comes.” – Georgia

“Virtual care works when the physician and patient have a relationship. Eliminating insurance driven churn and building a strong foundation for long-term relationships is essential to bending the cost curve.” – Washington

262 respondents provided general open comments. Among these:

Telehealth

- Video is better than phone but most of our patients aren't able to use it. My home internet is useless so I am only available when I drive to my office. I would be able to serve my patients better if quality internet capacity was extended to rural areas. it takes a lot of bandwidth to load a secure electronic record, and more to do a video visit. Michigan
- Difficulties for elderly to obtain video visits – video visits often allow better assessments of 'Gestalt' and of specific pain syndromes. Lack of monitoring equipment at home (BP, pulse ox, scales) and lack of payment [make this hard]. New York
- Being able to provide virtual care has been crucial. Figuring out how to make this easier for patients and assuring they have continuity with us (instead of insurers offering outside telehealth companies) is key. Maryland
- Huge time-consuming change and cost to telemedicine conversion that is reimbursed at lower rate. Maryland
- There is significant fear about not only physical health but mental health and how to access care for either. Though many have been able to convert to telehealth, there are reasons for some this is not the right choice. New York
- My partners & I do have some worry given limitations for doing physical exams in tele-visits that liability will be increased. Wonder how we can be protected to do our jobs with less worry. Maryland
- Providers took pay cuts in an effort to stay open. The demand for telehealth is booming. Reimbursement starting to improve but has to be for the long haul until a vaccine is available. It is great that insurers are covering telephone calls. Pennsylvania
- Telehealth is a great avenue going forward to see patients and maintain financial viability if payments are on par. However, in a rural practice the lack of access to stable, affordable internet and phone service is a severe detriment. New York
- Telemedicine has opened up a lot of access to patients who would otherwise not have it. There will always be a need to see patients in the office, but ... we need to be able to have [telemedicine] available with full reimbursement. Ohio

50% of comments focus on financial barriers to sustainability, care delivery, and necessary connections with patients

- I've been working without pay since March 1. Maryland
- We are a tiny, independent clinic with a single clinician. This has devastated our practice. Texas
- As before the pandemic, we continue to give vital care to our patients without a vehicle for reimbursement. This was not a sustainable model for our practice even before the pandemic. The pandemic may kill my practice. Texas
- Fee-for-Service does not support healing relationships. We need to get away from transactional care. Oregon
- Our practice is down about 600K compared to last year at this time. Also our team staff is being lost - we have lost social worker, and losing BH psychologist and because of hiring freezes, it is unknown when we'll get these key roles back - if at all. Oregon
- We lost at least \$400 K in March and April. We have a large elderly, disabled, and low-income population. We are rural and do not have access to reliable broadband. I have been able to continue to provide care, mostly by phone. New Hampshire
- Delivery of medicine can be simplified by eliminating burdensome documentation. This wastes physician time, and [hurts] the physician patient relationship. This pandemic demonstrates the need to spend time with our patients, not paperwork. Texas
- I'm shocked by the lack of government and institutional support. I'm thinking of giving up clinical practice. New York
- Primary care gasping for air as it has been, poor thing. I almost want to say put it out of its FFS misery! Rhode Island
- Incredibly stressful. Debated career choice given the degree of personal risk and marginal payout for primary care practices but feeling a deep commitment to help our patients and community in dire times. Oregon
- We are doing almost exclusively COVID related work and our workload is very high. Our payor mix is really bad right now and the patients out of work have no money to pay us. Most of our work is not reimbursed at all right now. Nebraska
- May is going to be worse than April. My practice revenue is down 50% and I am using my personal fund to pay expenses. Kansas
- People rely on us for information. There is a lot of unreimbursed work, such as answering messages, simplifying COVID information, etc. All of this unpaid work is what helps support a public health response. Minnesota

84% of clinicians report patients delaying preventive and chronic care visits – clinicians fear the public health impact

- I have seen several patients suffer [as a result of not coming in] either due to loss of insurance or fear of COVID. California
- I have seen more morbidity and mortality in my community from social isolation than from COVID (mental health, poor control of chronic disease, preventable deaths by delaying/avoiding care). Virginia
- I think we are getting to a point where patients are coming back in this rural community but our office staff has not returned - putting extra strain on those who are at work - lots of short tempers. Missouri
- Huge decrease in volume. Deferred a lot of care that will no doubt lead to poor outcomes for chronic illness later. New York
- We are a "free clinic" that only sees people with no insurance of any kind. Except for the recent PPP, we are totally supported by private (non-governmental) sources. We are bracing for a large increase in people with no health insurance. California