



QUICK COVID-19 PRIMARY CARE SURVEY

SERIES 1 FIELDED MARCH 13-16, 2020

Close to half of primary care clinicians (46%) lack COVID-19 testing capacity and have little to no personal protective equipment (PPE). Staffing outages due to illness are already hitting clinicians (20%), nursing staff (17%) and front desk support (13%). On Friday, March 13, 2020, The Larry A. Green Center launched its first weekly Quick COVID-19 Primary Care Survey to assess the impact of COVID-19 on practices. An invitation to participate was distributed to 9,000 primary care clinicians across the country and remained open until March 16, 11:59pm PST (survey to be repeated weekly). Clinicians report a reduction in services (58%) and phone lines flooded with patient concerns (74%). They report new workflows, extensive phone triage, care coordination and redesigned work areas/systems to limit exposure. These are largely unpaid activities.

Sample – 534 clinician respondents from Family Medicine (n=377, 70%), Pediatrics (n=76, 14%), and Internal Medicine (n=58, 11%). 5% of respondents were from other disciplines, largely geriatrics and urgent care. Responses covered 48 states. Practice settings for respondents included 86 rural practices, 389 with >3 clinicians, and 280 with >50% of patients commercially insured.

Main Findings

- 46% of practices report no capacity for COVID-19 testing; 51% lack adequate personal protective equipment
- 52% of practices report COVID-19 having severe and near severe impact on their practice
- 58% have had to cancel well and chronic care visits to accommodate need; 17% lack enough available appointments

236 Respondents included open-ended comments.

85% of comments indicate lack of PPC and testing ability. For example:

- We have no face masks or respirators. They are on permanent back order. I have no way to protect myself or my staff from infection. We reached out to the hospital and they have none to spare. We have no gowns or eye protection and no rapid test. We have been sending everyone to ER. I need supplies yesterday
- It is appalling to me that we don't have broader testing capabilities. I had a patient two days ago who absolutely should have been tested. But because she hadn't traveled internationally, or had a known contact with COVID, we couldn't. She was flu negative. We know it's here in our area, and we aren't looking for it like we need to be. It's maddening.
- The state health department is telling residents that providers can choose to test through the commercial laboratories but we CANNOT GET SUPPLIES such as masks gowns or gloves to do this properly.

30% point to failed leadership, constantly changing guidelines, and failed coordination between agencies and institutions.

- Help. I'm medical director at 2 nursing homes... can't get my hospital or Public Health Dept to test febrile lower respiratory infection patients before sending them to my nursing homes. The nursing home staff have essentially NO PPE!!
- Enormous time and stress it takes to train, then re-train, then re-train, then re-train on the constantly changing protocols. Asking staff to make complex algorithmic decisions when they are themselves under stress and worried.
- Frustrated. Health dept telling everyone to see pcp for testing. We don't have tests.

31% reflect loss of employees, risk of financial collapse (from avoided face-to-face visits for which they are paid), and helplessness.

- I am a solo practitioner. I am afraid we will get sick, have to close, and I will lose my practice.
- I may have already been exposed and have no way to know if I am an asymptomatic carrier to others.
- Difficulty determining clinically which patients should be tested, running out of personal protective equipment, looming sense of doom that cases will spike suddenly and health care system will be overrun.
- Starting to have providers out so they can take care of kids out of school.
- We are paid strictly on RVU so we are going to have a dramatic financial risk. I have 1 N95 mask and no eye protection or gowns at all even before this thing has started. We can't test but it is clearly here. Please help us.

11% discuss health risks related to social inequities and a scarcity view creating risks in new areas.

- Telehealth for a technologically underserved population... a major problem.
- Parents aren't bringing children in for wellness visits. Babies are not being vaccinated - other illnesses still exist!!!
- Right now, worried well and acutely increased mental health issues are our biggest patient related problems.
- A single N95 being reused for days now. No guidance locally or otherwise. EMT volunteers are seniors with no protection
- We have decided to stop doing strep screens and influenza testing since they are aerosol generating procedures.

Primary care is the first contact for most entering the health care system. It sees over 50% of all US medical visits each year while receiving less than 7% of national health expenditures, and 0.2% of NIH funding. An over focus on known disease pathways and an under focus on clinician-patient relationships, acute care and wellness needs has left this critical national resource unstable. Urgent attention is needed to provide primary care with funding and resources sufficient to care for the health of the American population.

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QUICK COVID-19 PRIMARY CARE SURVEY

SERIES 2 FIELDED MARCH 20-23, 2020



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

Half of 533 primary care clinician respondents (54%) report the majority of their work effort is not reimbursable. Staffing outages due to illness/self-quarantine are twice as high in this week's survey among clinicians (46%), nursing staff (44%), and front desk support (29%). While a majority of clinicians are aware that telehealth visits are reimbursable by insurance (61%) and Medicaid (52%), a third of them (33%) do not know how these payments will happen. Majority use of telehealth, defined as $\geq 60\%$, remains limited for video-based care (6%), e-visits (2%), and use of patient portal/secure messaging (4%). A greater portion (17%) report majority use of phone-based visits.

Additional Main Findings

- 43% of clinicians report no capacity for COVID-19 testing; 55% lack vital supplies, including PPE.
- 49% of clinicians report severe impact due to COVID-19; last week only 21% reported severe impact
- 87% are limiting well and chronic care visits, up from 58% last week
- 28% of respondents have needed to use parking lots to assist with limiting exposure while treating patients

Telehealth Findings

- Use of telehealth for at least 60% of visits is limited for video visits (6%), e-visits (2%), patient portals (4%), and phone visits (17%).
- 60% of practices report no use of video visits, 70% no use of e-visits, and 34% are not using patient portals
- 83% report patients are accepting of telehealth visits; 49% intend to continue telehealth after COVID-19

235 respondents included open text comments.

- Half of most comments continue to refer to lack of personal protective equipment (PPE) and testing capacity
- Many comments concern potential practice closures related to lack of PPE and diminished reimbursable work
- Significant challenges due to rapid telehealth adoption, mental stress, and unsafe work environments
- Many have significant concerns regarding clinician and staff outages and heightened levels of stress

Lack of personal protection equipment (PPE) places front-line primary care clinicians at risk. Uncertainty regarding payment mechanisms able to adapt to accelerated use of virtual and telephone platforms have further increased the vulnerability of this critical workforce. Primary care acts as the first point of contact for most patients, but is dangerously under-resourced. Urgent attention is required for the following: COVID-19 testing and PPE supplies, telehealth capabilities, and funding levels appropriate to the mission of caring for the health of the American population.

Methods – On Friday March 20, The Larry A. Green Center, in partnership with the Primary Care Collaborative, launched Series 2 of the weekly Quick COVID-19 Primary Care Survey. An invitation to participate was distributed to 9,000 primary care clinicians across the country and remained open until March 23, 11:59pm PST.

Sample – 533 clinician respondents from Family Medicine (61%), Internal Medicine (16%), Geriatrics (12%), Pediatrics (8%), and general Primary Care (2%). One percent of respondents were from other disciplines. Responses covered 48 states plus Puerto Rico and the Virgin Islands. Practice settings for respondents included 17% rural, 72% larger than 3 clinicians, and 18% some type of community health center. Close to half of our sample (48%) had $>50\%$ of patients commercially insured. One third (33%) owned their own practice and another third (34%) were associated with an academic center.

"It is in the community; we know that our patients are coming into our clinic with it. The inability to test and identify mildly symptomatic patients is driving the spread of disease, & the lack of testing makes us all feel powerless." - Oregon

Example quotations:

Lack of resources – PPE, testing, technology

- Limited supply of PPE and tests is a major challenge. Decisions are being made based on availability of supplies rather than the best clinical judgment. – GA
- Lack of PPE and universal testing is affecting the stress level of team! – FL
- Not enough tests. Not enough protective equipment. Front line doctors are going to die because we are being sent out to fight something we cannot see, we cannot treat, & we cannot test for without the PPE necessary to protect ourselves. – VA
- We stopped doing patient visits last Monday due to lack of PPE. – OR
- I converted to all home visits but ran out of PPE within days as many of my patients have chronic coughs (eg COPD, CHF, etc) & don't meet current directives for testing. Someone donated a few gowns & masks (I can't otherwise obtain PPE) – PA
- 3 weeks into this and still unable to get PPE. Can't get a new thermometer if I need it; telehealth for my EHR is back logged – [there is a delay in getting] signed up. Using cell phone and Skype/zoom for some patients. – FL

Lack of information

- I have to use Facebook for information. Dissemination of information is disjointed and poorly managed. – WA
- No direction from state health agencies, changing instructions, no supplies to take samples to send out for testing, private testing labs taking 5-6 days for results, unable to care for elderly in person or telehealth, since they don't have access to smart phones or internet. – CA

Financial impact/concerns

- I am concerned about the health of my patients and don't want to bring them out but yet I am concerned that I will have to lay off my staff if I am unable to bring in enough revenue to cover expenses. – MA
- We are [trying] to do as much telehealth as possible to limit exposure with no idea how much or if we will get paid. Our 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 private practice. We have no PPE and no way to get any. – CO
- Clinic revenue way down, resident teaching significantly impacted – TX
- Extreme financial strain that will impact our survival and ability to care for ANY patients for ANY reason. Nothing new, but primary care needs more resources. – NC
- I am a solo family practice doctor running my own clinic. I am in a total panic about how I'm going to pay my staff who all rely on their paycheck to pay their bills and feed their children. I want to know that I can do telemedicine visits and get reimbursed by insurance and how to do that. I have tried accessing webinars that are Full and feel very scared. – OR
- Our biggest issue right now is cash flow. Visits have [plummeted] and we are trying to avoid laying off experienced staff. We are projecting that physician owners will have zero income this year at best and may have to put money back into the practice in order to keep it viable if social distancing continues for more than 2 months. We are actually in better shape than most practices in our area. – NY
- Significant financial impact - visits decreased by about 75% given we are limiting well visits and sick visits to Minimize exposure. We are now furloughing/laying off staff and cutting nursing staff hours by 50% and owners are likely going to go without pay in order to stay afloat. – MA

Global stresses

- Older adults present atypically and classic symptoms and signs are not seen. Elderly with COVID19 may present with delirium falls and fatigue and we should be testing for older adults for these symptoms as well. Classic symptoms may not be present. We need more testing and rapid turnover for tests. PPE are available only for patients presenting with typical respiratory symptoms. [We] are already exposed by the time we test our older adults – TX
- Our group managed to set up parking lot COVID-19 tests this week after learning we could get supplies from a commercial lab. We also started telehealth visits once the government pressed insurers to lessen restrictions. One of the area academic practices had required their clinicians to do business as usual even until this time. – PA
- Shortage of supplies; lower clinic volumes from clinical easing and patients canceling; telemedicine and telephone visits starting but not yet established; no idea if we will be paid for telephone or telemedicine visits but we are billing for them. We have started respiratory clinics. Only 12 cases in the state. The calm before the storm. Not actually calm at all but limited [cases] – WV
- Patients are cancelling checkups. Patients don't want to come in for sick visits. We are overstaffed but don't want to harm staff by laying off. Lack of guidance at every level is stressful. Lack of testing is horrifically stressful. – MA
- I have covid 19 and have been out of work for 1 wk – NJ

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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

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QUICK COVID-19 PRIMARY CARE SURVEY

SERIES 4 FIELDLED APRIL 3-6, 2020



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

Four weeks in, 4 out of 5 primary care practices continue to experience sustained high levels of stress. This new normal includes persistent lack of personal protective equipment (58%) and tests (>50%), and nearly half of practices have clinical care team members out sick/quarantined. At the same time, practices (54%) are reporting an increase in patient mental and emotional health needs, patient challenges with implementing virtual care platforms (72%), and persistent financial uncertainties, with close to 60% not sure the majority of care they are provided is reimbursable.

More Specific Main Findings

- 29% of clinicians report no capacity for COVID-19 testing and 39% have only limited capacity
- Outages due to illness/quarantine reported for clinicians (48%), nursing staff (50%), and front desk (34%)
- 58% lack PPE; an overlapping but separate group of 58% rely on used and homemade PPE
- 90% of practices are limiting well and chronic care visits
- 40% of practices are prioritizing redeploy of clinicians within the health system

Virtual Health (Telehealth) Findings

- Full scale use of virtual platforms is limited: 23% rely on majority use of video, 5% on e-visits, and 6% on patient portal, compared with 40% conducting majority visits by phone
- 30% of practices report no use of video visits, 60% no use of e-visits, and 32% are not using patient portals

Primary care practices prioritize (as high or moderate) work that is largely unpaid, underpaid or delayed

- 86% of practices prioritize virtual triage and refer of potential COVID-19 patients (63% as high)
- 76% of practices prioritize calling patients at home for check in and monitoring (37% as high)
 - This rate is 43% (high) for majority Medicaid patients; 44% (high) for community health practices
- 59% are not scheduling preventive care; 51% are not scheduling well child care although 2/3rds prioritize

Policy Recommendations -- Required is a transparent, coordinated national effort to assure rapid and equitable distribution of testing and PPE for frontline practices. Payers must urgently implement capitation/global payment to allow practices the ability to stay open, pay staff, and choose patient visit types based on need, and not on reimbursement levels. Virtual telehealth/telephonic visits under commercial/Medicaid plans should be reimbursed at the same rate as face-to-face visits to meet patient needs, keep people out of the hospital, and protect healthcare staff.

Methods – On Friday April 3, The Larry A. Green Center, in partnership with the Primary Care Collaborative, launched Series 4 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 April 6, 11:59pm PST.

Sample – 1024 clinician respondents from Family Medicine (71%), Pediatrics (11%), Internal Medicine (8%), and Geriatrics (6%). Four percent from other disciplines. Responses covered 49 states. Practice settings included 22% rural, 78% larger than 3 clinicians, 27% community health centers. One third were >50% Medicaid; 25% owned their practice; 20% were part of academic centers. 23% were majority fee for service; 7% majority capitated; 35% had no capitation.

"We are burning through cash like crazy. Laid off 200 workers to date - all support staff. One physician on a ventilator with COVID." – New York

"Physicians are not protected in this climate. We are being redeployed, pay is cut, and we are not covered by the Families First Coronavirus Act, which is infuriating." – Washington

419 respondents included open text comments. Among these:

43% revealed tremendous financial strains threatening practice closures. Example quotations...

- We're holding out for a stimulus loan to stay open. If we don't get it we'll likely close our practice. Every day we go into work wondering if [if we'll have a job] the next day. The red tape to get aid may be the reason we have to shut down. Arizona
- Insurance reimbursement is not what "they" are telling us. Claims are denied for telemed. Arizona
- Extremely difficult to balance caring for patients and not risking exposure. Severe drop in all visits has become a financial disaster and may put a 25-year practice of 22 physicians and 100 staff out of business. Florida
- My revenue is down by 80% because my health system is not allowing us to bring in any non-urgent visits such as wellnesses, well child checks, or physicals. My health system is ALSO not allowing us to bring in ANY patients with any respiratory symptoms whatsoever. It is a very depressing time for me right now because I continue to have lots of administrative, unpaid work. Indiana
- Patients are very anxious and need guidance and reassurance. They still have other illnesses that need to be addressed. We should be paid and supported during this time so we can care for our patients. Maryland
- In pediatrics, the financial concerns of decreased volume of sick and well is overwhelming. New York
- We are considering closing. It's not financially viable; we're afraid of getting infected or [infecting] family members. New York

56% share high levels of stress related to difficulty with virtual health, ill-fitting policies and lack of PPE

- The crisis highlights the uselessness of the 3-day qualifying [hospital] stay; the absence of insight at CMS re older people's ability to access telehealth technology, and their ability to double the workforce by eliminating E&M coding. Florida
- Patients most vulnerable do not have capabilities for virtual visits. We contact them via phone - not getting reimbursed. Iowa
- Clinical pharmacists affiliated with a medical clinic should be included for reimbursement for telehealth visits. Illinois
- Despite state mandate for full coverage of telephone visits at the same rate as office visits, insurer computer systems are not equipped to pay for telephone visits; for 3 weeks 98% of our visits have been phone and we've not been paid. Massachusetts
- Because of COVID, 75% of our providers were told yesterday they are out on furlough for the next 8 weeks just to keep the community clinic alive to survive this. Minnesota
- The financial stress is overwhelming as we attempt to keep our 39 employees employed, apply for loans to keep us afloat, get the necessary PPE to protect our staff and physicians and oh yes, do what I am trained to do, take care of patients in the face of an entirely new set of parameters to avoid a life threatening illness. Other than that, just another week at the office. Missouri
- We are hamstrung by changing documentation/billing each day. It's hard enough to take care of patients ... can't we get away from a new code/documentation/coverage strategy for every innovative of care for every different type of insurance? Oregon
- We do not have enough/adequate PPE - reusing, utilizing donated Tyvek painter suits since we can't get gowns, & covering reused masks with homemade ones. It is impossible to do our jobs... I am currently ill with COVID-19. Washington
- GET US SUPPLIES!!! – Rhode Island; Help. Just help us. – Louisiana

Growing concerns about unmonitored chronic conditions, reduced preventive care, and other non-treatment issues

- I work at a rural community outreach clinic. ED's are turning away pts that need to be seen for pneumonia if no underlying med conditions. They are so focused on potentially severely sick COVID-19 pts, they are forgetting to treat other conditions. Idaho
- Our ability to manage our complex older patients is complicated by limitations on available urgent care resources, difficulty in scheduling any needed testing, lockdowns in assisted living, and their limited ability to participate in telehealth. Michigan
- Babies need their immunizations but parents are afraid to come in; I am worried kids will get sick from vaccine-preventable diseases. Second concern: how will we handle the huge backlog of care needed once this crisis abates? North Carolina
- We closed the practice for the last 2 weeks due to 3 employees sick on the same day. No PPE. New Jersey
- We need more testing. Criteria remain markedly limited. We also need better information about sensitivity of the tests which I suspect are lower than we think. Need clear communication about whether evolving PPE recommendations are based on real science/"the right thing to do" or based on resource scarcity. Hard to trust recommendations with statements like "cough is not an aerosolizing event" as in my hospital. Washington

Food for thought

- I am amazed at the ability of our large healthcare system to transform overnight. Flexibility on the part of both patients and providers has been key. Our ability to work together and realize that it's not going to be perfect but it's good enough for now has really helped. DC
- Direct Primary Care and small practice has been great for adapting to changes. Cash flow is more stable than FFS and as a small office we could make changes easily to improve patient care. Maine
- With patience and keeping focused on doing as much good as we can, we will get through this -- and maybe become humbled again into why we are doctors. Pennsylvania

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