QUICK COVID-19 PRIMARY CARE SURVEY

SERIES 12 FIELDED MAY 29 – JUNE 1, 2020

The vast majority of primary care clinicians (>70%) report patients as their allies and valuing their care. In stark contrast, they identify strong lack of value for primary care among the Federal government (39%), private insurers (34%), hospitals (34%), health systems (31%), and government insurers (30%). Although payment systems continue to undervalue digital health options, clinicians' rapid adoption and use of digital health has started to reveal clear preferences. When infrastructure permits, many rate video visits over telephone calls and find virtual care is best suited for primary care based mental and behavioral health counseling and adult visits for patients with stable chronic conditions. Digital health appears least suited for assessments of injuries, non-stable chronic care, and well child visits.

At a time when primary care appears most needed, primary care clinicians are finding themselves least valued

- 72% of clinicians endorse "Yes, without a doubt!" when asked if primary care is valued by their patients
- 30-40% also felt valued by, in rank order: the public, public health, and employers
- 17% endorse "That's a hard no, loud and clear" when asked if primary care is valued by the Federal government

3 months into the rapid adoption of digital health, clinicians are realizing its greater strengths and weaknesses

- 17% now deliver care evenly among video, phone, and in-person modalities
- 32% rely on digital health platforms more than anything else during the pandemic
- >80% find video-care is best suited for visits that address stable chronic conditions, mental and behavioral health counseling, medication reconciliation, and worried well visits related to COVID-19
- Results were mixed regarding suitability of video for preventive care, acute illness, chronic pain, care transitions
- Both video and phone-based care were felt not well suited to well child care, evaluation of injuries or accidents, portions of preventive care visits, developmental assessments and acute illnesses

The harsh "new normal" of primary care shows few signs of easing

- 52% still lack personal protective equipment and 69% report severe or close to severe stress
- 11% report vaccine inventories that are expiring unused and therefore lost investment
- 79% continue to report limited well and chronic care visits, including 51% well child visits delayed by parents
- 6% of practices report they are (possibly temporarily) closed and 35% have furloughed staff
- 27% have skipped or deferred paying their clinicians, 21% have had their telehealth billing denied

Policy Implications – More than two months into the pandemic there are few signs that conditions are improving for primary care, leading many to question whether the health system and payers support their role as primary and first contact for the majority of the population. Public and private policymakers need to take immediate steps to support primary care through dedicated funds in the short term and a commitment to basic infrastructure reform for the long-term. Failure to do so may permanently impair the ability of primary care to recover and meet population health needs.

Methods – This survey fielded by The Larry A. Green Center, in partnership with the Primary Care Collaborative. The survey invitation was fielded May 29 to June 1, 2020 with thousands of primary care clinicians across the country.

Sample – 558 respondents from 47 states. Family Medicine (68%), Pediatrics (6%), Internal Medicine (17%), Geriatrics (5%), and 5% other. Settings included 24% rural, 14% community health centers, 11% in schools/offices. 35% had 1-3 clinicians; 26% had 4-9 clinicians. 33% self-owned, 13% independent and large group, 38% owned by a health system. 7% were convenience settings, 4% were membership-based. 4% were government owned.

"Primary care has been unappreciated, undervalued, and underfunded for over a decade. COVID has brought these issues even more quickly to the front and put us at our breaking point." – Oregon

"Office closing permanently July 30, 2020." – Indiana

"The marathon of COVID is starting to wear on people. It makes me so very sad to see it politicized; the one time we should be reminded of our common goals, our interconnectedness… It breaks my heart." – Virginia

225 respondents provided general open comments. Among these:

Many obstacles to primary care delivery during COVID-19 appear direct result of poor infrastructural support…

- We have unlimited supplies to obtain and send out samples, our limitations are in having available staffing. It would not be cost effective to hire staff for a service with minimal reimbursement. California
- I am dismayed by the lack of prompt response from private insurers to give parity for phone and video or any prospective payment, not a loan, which would help the survival of independent practice, a demographic that will increase cost of care by 10% at least if it dissolves. Texas
- Testing is complicated, inaccessible and annoying. Two patients with missed bacterial pneumonia by myself and urgent care recently because so focused on COVID. Colorado
- We can order antibody test. We're interested in doing testing but we don't have the PPE yet! Nevada
- Primary care remains in a world of hurt and those of us who were lucky enough to survive the initial onslaught will not survive the next wave. Airplane flyovers and cheering patients is great, but we need payment reform which allows us to do our work and stay financially viable. Virginia
- PPE for house calls is challenging. However, our house call patients are comparable to patients in our local SNF/LTC, but experiencing approximately 10% of the mortality, so it's worth it! DC
- The fact that all planning and support for COVID testing was centered around ERs shows how pitifully thought of and supported family medicine is in the U.S. Texas

… and the challenges are compounding

- Demand for telehealth is increasing yet administrative staff is down due to fears about COVID or childcare issues. More paperwork for providers to complete which is time consuming. I feel busier now than I was in the past with less salary now. I feel burned out. All of us providers have underlying health conditions. I wear the same gown all week since supplies limited. I use same face shield since March. Test sites taking too long to test patients and everyone coming back negative yet many who I believe have the virus. Many employers who demand all employees be tested after 1 person is found to be positive. My office would like to do wellness on telehealth but need private insurers to pay. Nervous about next wave of infections. Pennsylvania
- We are still drowning. PPP funds will run out soon. SBA still has processed our EIDL loan application. While patient volumes are beginning to pick up a bit, it's hard to see how we can manage to stay open for more than a few months. Pediatrics has been left out of much help and is largely an afterthought. Mental health issues are rising rapidly among our patients, and we are being asked to handle them with limited resources and very poor payment for doing it. Texas
- After 3 months, ramp-down and redeployment, closure of our primary care site, and transition from 10% to 100% virtual care, lip service from organizational leadership about our value as primary care clinicians who could deploy anywhere….we are back to the same position as an afterthought to our leadership….only now at reduced salaries, reduced staff, and with the mission to 'ramp up quickly' to restore the organization's bottom line. The fundamental weakness of the American approach to health care as a business is very clear to me at this moment. Michigan
- All of my patients are under duress which is causing worsened conditions as well as new onset illnesses. I spend my day counseling everyone as well as trying to help their pain and suffering. Texas
- I'm dismayed by no real plan for widespread testing/tracing; things are opening up but there does not seem to be a plan other than telling people to 'social distance', which many people ignore. I fear we'll end up back where we were in March. California

Patchwork solutions to systemic problems helped initially but the solutions are beginning to fray

- We have kept our patients from utilizing inundated Emergency Rooms and Urgent Care Facilities for non-urgent problems. We have managed COVID-19 by phone and video and e- portal and only referred when necessary. Without primary care management, the hospitals in the NY hot zones would have been even more overwhelmed during the apex. New York
- I did not receive the pay checks loan. Applied day 1. I will feel the loss over the next several months. Did not stop taking care of pts needs, had to spend black market money for PPE when I could find it. My medical supplier canceled PPE orders because I had not ordered in the 3 months prior to COVID. Arizona
- Administrative decisions seem to be arbitrary at best, punitive at worst. Crowing about our "agility" in adopting telemedicine. But aren't comfortable going out to have bloodwork or imaging. What about the brittle diabetics and the uncontrolled hypertensives? The pressure is intolerable. I've started taking an antidepressant. New York
- Video adds only marginal benefit in spite of my answers to the above which include a lot of video plus telephone. I think that there is an emerging complex balance between when video is "essential" and "nice to have" … Also, insisting on video is a HUGE equity barrier for financial, linguistic, age related and other reasons! Massachusetts
- The ability to delay care that can be delayed is getting thin. Adapting the office so that it can provide safe in-person care is a growing need. Rhode Island