Reporting from the front lines: Revenue under fire, staffing cut and, yes, stolen toilet paper

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As the coronavirus shuts down vast swaths of the American economy and the nation grapples with an unfolding national emergency, health care providers on the front lines are seeing severe repercussions to their day-to-day business operations, their financial livelihood and the ways they interact with patients.

These firsthand stories from medical practice providers show the severity of the COVID-19 impact, the solutions providers are coming up with and a growing consensus that things are never going back to the way they once were.

From a neurology practice in Florida to a university heath system in Alabama, take an intimate look — directly from providers' perspectives — at how life has changed for frontline medical groups in the struggle against the pandemic.

COVID-19 perspectives #1: Jeffrey Gelblum, M.D., neurologist, First Choice Neurology, Miami, Fla.

At this time, Miami Dade is in shelter-in-place mode. So basically we're as close to lockdown as you can get — closed except for urgent cases, tight as a drum, no traffic. But neuro doesn't stop, although the world seems to.

As a result we have quickly segued into telehealth. It's now 90% of our day in and day out practice.

I average 20 patients a day of which 16 are follow-up telehealth encounters. But I still need to lay hands on some patients. The waiting room is a wide-open space now. We took all the chairs out. Patients never see another person [besides staff]. If the patient has a fever, cough, any of that, we obviously make sure [on the phone] that's not the case before they come to the office.

I miss the hands-on interaction, of course, but telehealth opens up this whole new perspective. You see a whole other dimension of the human being that you call your patient. And from a therapeutic angle, when you see them in the office and then see them at home, you get a fuller picture of what's going on with them. I was never in the house call era, that was before my time. But I like this level of intimacy.

There are some situations for which telehealth doesn't work. If someone's coming in with a nerve-root problem, foot or wrist drop, peripheral injury, walking issues, etc., then telehealth is not ideal. Those are the 10% of our patient who may still come in, but we try to scatter their appointments.

Honestly it was very funny — I had an older patient, in her 70s, sitting in her kitchen, doing telehealth with us. She has a seizure disorder, well-controlled fortunately. We're chatting and she says, "Isn't it nice to have you sitting here with me in my kitchen." Not to be too glib about it, but it is nice to see patients in their home environment. Sometimes they'll give me a tour.

I think this is not just a blip — I think it's going to be a logarithmic curve [for telehealth]. Many patients who've never drunk from this well will say, "Why sit in traffic to take a kid or a grandmother to the doctor? Why hassle when I can sit at home?" From a practice management perspective, this uses fewer resources than a routine [in-office] follow up.

COVID-19 perspectives #2: Nicholas Jones, M.D., plastic and reconstructive surgeon with Lexington Plastic Surgeons in Atlanta, Ga.

In Georgia, they haven't shut down ASCs, so last week we were able to do a few cases. But we've cut back staff. Usually we have 18-20 people. Now it's bare bones. An office manager, a tech for the procedures, one nurse maybe who helps set up. But the others — schedulers, billing, consultants, nurses — they're gone.

We've seen about a 70% drop in patient traffic. A lot of our patients are from out of town, so logistically they can't get here, and their appointments are postponed. For larger operations, we've cancelled not for performance reasons, but because

of the potential for complications. God forbid they have to go to the hospital now.

We're going to hold off, and only see patients who are follow-ups, or those with emergent issues. New patients we'll handle with virtual consults and telemedicine. We had a telehealth component, but before we didn't use it much.

People want cosmetic surgery. A lot of them want to use this time off from work to do it but we can't do it. But if they want it in the future, we're telling them to do a virtual consult now. They can book surgery, get a date, and get a good price. We're offering specials, basically.

[A] thing I've learned is, in order to protect your business you really have to have an emergency fund. And you have to run the business as efficiently as you can. We have too many employees. We could have gotten the same amount of work done with half, and now we have to do that. And put more of your revenue into savings.

Also, stockpile supplies. Right now gloves are in shortage, and some vendors have delays with deliveries. Take Keller funnels, which we use for breast augmentation — they're on back order! It makes no sense — but I think the problem may be that they're produced in China.

Basically, you have to know your supply chain.

I do wound care as an aside — I go to a nursing home one day a week. It's not going to cover all my expenses. I just started doing it with this company about a month ago. I was planning to leave this group and start a solo practice, and I knew I wouldn't have the same income to start and I needed another revenue stream. I didn't really even want to do it at first but it's given me a another perspective and I'm providing a much needed service. It's not what I thought I would be doing, but elderly patients, bed-bound and stuck in a nursing home, need care too! I'm glad I'm doing it.

COVID-19 perspectives #3: Benjamin Ticho, M.D., ophthalmologist with Ticho Eye Associates, Chicago Ridge, Ill.

A lot of routine things are getting put off: Cataract surgery, eyelid stuff, eye muscle surgery, some glaucoma. These are procedures we'd do in ASCs and hospitals. The ASCs and hospitals are shut down except to urgent and emergency cases.

I thought ASCs would stay open longer. They're not places where large gatherings happen, so I thought we could minimize the risk of infection without compromising the availability of machines [that hospitals need]. But from a political correctness standpoint, it doesn't look good if you keep doing elective surgeries when you're trying to send people home.

When patients are checking in here, they wait six feet apart. We've rearranged furniture because we have a smaller volume anyhow, and we've taped adjacent chairs so no one's sitting next to anyone else. We also do temp checks.

We have protective supplies because we're not using them in surgery [much], But we're having trouble keeping toilet paper in our building! Most of that supply is going to people's houses.

In office we do some blepharoplasties and eyelid procedures. But our business is 80% down in the past two weeks. No [business] insurance is covering that. We don't have a lot of great alternatives. We've started doing telemedicine but it's hard to get much volume. And there's not much you can do with it that's meaningful in ophthalmology.

This week will be the week that helps me decide. Chicago is a week or two behind New York — if we become New York, I'd say we're in for a longer haul and tougher decisions have to be made. I have to ask, how as a small practice can I survive? The big ones, the multispecialty groups, they have bigger resources. There's no one I can turn to and say, "please grant me the money to stay open a few months." And it's not clear how the federal program will work; if it trickles down to little old me, wonderful. But larger hands are going to grab larger amounts.

Small practices are already in a difficult position relative to multispecialty groups with economies of scale. One thing that'll be interesting — the trend of big practices buying smaller ones. Is that going to accelerate? Because practices like mine, I guess people will be able to buy them more cheaply. Or can we rebound? Is it a three-month lull? That I can live with. Three more months of practice tacked on at the end of my career? I can do that. But if I have to lay people off, that's tougher.

It's not that eye disease going away. This week I diagnosed a unsuspected retinal detachment, took foreign bodies out of a couple of corneas, treated multiple contact lens ulcers, sewed up an eyelid that was torn up in a sidewalk fall. Medicine is still happening. But the non-urgent stuff — you don't realize how much your practice depends on that till it goes away.

COVID-19 perspectives #4: Thalia Baker, associate vice president of primary care at UAB Medicine, University of Alabama at Birmingham.

My main hat is the primary care network, campus doctors, community-based providers. So we're the front lines.

We don't want patients going into clinics where they might be exposed. If it's post-op on a knee, do it over video or the phone. We won't want them to come in to see the orthopedic surgeon. But some people have to come in. For example, pregnant moms who have to be monitored; we have them isolated in an infant center.

We've never had a world where primary care is not full, but now people aren't coming in — not even to the urgent care.

We're at 30% of volume. Patients are afraid to come in and are being advised to isolate at home. ... Our primary care has gone from nearly 100% face to face to 92% virtual. It was like we turned on a dime because we had to.

Right now, our focus is on taking care of the patient — can't focus on reimbursement. However, everyone in health care is hemorrhaging money right now.

When they call they get a choice: We offer them video visits. If they can't or don't want to do that, then a phone visit. If they totally resist we can bring them in, but we have outdoor tents for treatment. Fortunately the weather's nice. We call it curbside service. They pull up in their cars and providers greet them in PPE [personal protective equipment]. We try everything we can think of to prevent exposure.

Way at the very beginning, four weeks back, our infectious disease people created a screening protocol that's implemented in our access center where they call. We run a 16-hour nurse triage. They do prescreen [for COVID] and if it appears warranted they get a 15-minute increment appointment for drive-through testing: come by car, under a tent in the parking lot, open air, and it works great. They get results in 24 hours.

I will tell you: This is a change that we're not going to go back from. It's not going to be 100% face-to-face anymore. It'll be a substantial change in a way we treat — and patients love it! They say "Why could I have not had his before?"

One big issue is that schools are out and colleges are closed. A lot of our providers find working from home more stressful, because they have the whole family there, and they've had some issues with kids coming home from college with the virus. So if they want to come in, we let them shut their door and do remote visits from their office.

Biggest challenge has been supplies. We've had a hard time getting them. At our drive-through test site we limit ourselves to 250 tests a day because if we don't, we won't have test kits for the [coming] peak. We are rationing to make sure it lasts the whole time. Same with drugs, too, especially the ones we use for the ventilator patients, those drugs are short. And of course on PPE everyone's struggling.

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