Vanishing margins: Leading a private practice through COVID

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Gwinnett Clinic's Jefferson location, one of 17 locations in the Atlanta, Georgia area.

On March 12, 2020, I received a call from the local health department about COVID-19 that thrust me and our medical practice into a new era. I am a primary care physician and owner/operator of Gwinnett Clinic (GC). GC is a community-based primary care practice with multi-specialty support founded in 1983. It operates 17 neighborhood primary care clinics in northeast metro Atlanta. These clinics surround a hub location that offers specialty care for primary care patients.

Like our peer practices, GC was not prepared for the pandemic. We were not designed to serve as a COVID-19 testing, vaccination, and treatment site. And, we were not set up to provide COVID-19 care in concert with routine primary care and walk-in services. Overnight, we began operating two businesses (COVID-19 care and primary care) with the budget of one. At the beginning, physician leadership was guided by a sense of civic duty and concern for our patients' lives.

By late March, it was clear that COVID-related safety considerations were hampering the group's ability to deliver routine care. The pandemic exposed how little the American health care system has invested in the primary care-public health dyad. The practice struggled to navigate sterilization procedures, ever-changing CDC recommendations, and the well-documented shortage of personal protective equipment (PPE). These challenges occupied every minute of the day when not taking care of patients. There was no organized system of information dissemination from the federal or state government, although we received valuable, albeit limited, support from the county health department.

There was no way to justify putting our practice's aging staff and physicians at risk without PPE, but at the same time, there was no way to justify abandoning our patients and community. Rather than compromise, we went to extraordinary lengths to protect both groups: staff and patients. We searched high and low to find PPE, and paid dearly for it.

By early April, we offered virtual care at all clinics. Before May, we corralled enough gear to test for COVID in parking lots while offering limited primary care inside the clinics. No staff or physician was forced to work, though almost everyone wanted to. We were proud of our efforts, but the resulting collateral damage was accelerated burnout for our physician leadership.

Overnight, despite the success of GC rapidly opening multiple COVID testing sites and operationalizing COVID-era primary care for our patients (in-person and virtual) emotions shifted. I transitioned from feeling optimistic and swelling with pride about our ability to meet the moment, to feeling fearful and exhausted. I was afraid that a faulty decision or simple mistake could violate the physician's solemn oath: Do No Harm.

The negative economic impact was significant by late April. Without taking out additional loans or utilizing savings, it would not be possible for most primary care practices to meet a guaranteed-salary payroll in the face of month-to-month double digit drops in revenue.

Already thin margins vanished. For the first time in my career, the viability of our practice came into question.

Fortunately, the practice received two lifelines: a Small Business Administration-backed Paycheck Protection Program (PPP) loan and, Health Resources & Services Administration (HRSA) Provider Relief Funds. It is difficult to overstate the importance of these funds arriving when they did. Without them, our practice's financial picture would have required dramatic cuts that would have reduced primary care access across the county. I felt relieved when we received the first PPP loan. In retrospect, the relief would be temporary.

We expected the pandemic to end within a few months, or at least to have developed a sustainable business plan to deliver care during a pandemic.

However, the roller coaster of clinical changes was only beginning. We were flying blind, and fast: monitoring financials daily, hiring and training new staff weekly, and updating practice protocols monthly. All of this was happening while I and other physician leaders continued to practice full time: online, in the parking lot, and inside the exam room. It was exhilarating and exhausting.

One of the most unanticipated but ultimately significant barriers to implementing our strategy to deliver both COVID care and primary care was school closures. The majority of our staff are parents with school-aged children. Our workforce shrank at the same time the demand for care exploded. We were inundated with testing demand. Patients were understandably frustrated and scared, just as our staff was understandably overwhelmed and afraid. Testing visits required double or triple the normal amount of time with pre-visit intake by phone or telemedicine, followed by in-person testing and subsequent phone calls for results several days later. Answering patient questions as they awaited test results was a daily challenge, particularly during periods when labs ran several days behind, up to two weeks at times. We were the first private practice in our network area to administer COVID vaccines. Our phone servers overloaded when the announcement was made public on our website. Immunization slots for an entire day would be claimed in seconds.

The financial pressure returned in cycles, every six months or so. As a new variant would surge, patients would seek only COVID care and stop coming for preventive visits, chronic disease management, or other sick care. We falsely anticipated that the federal government would compel commercial insurers to provide its contracted physicians with some financial support. We also expected special funding for private practices that tested and treated, like it did for large health systems and hospitals. Such funding never came.

During the summer of 2020, I joined the AΩA Fellow in Leadership program. It was oxygen for my professional life, which was intimately intertwined with my personal life. My cohort and mentors recognized the unique situation in which I found myself. Early in the program, they listened more than instructed. I needed to process what I was experiencing, and the AΩA virtual leadership series was my only opportunity. The AΩA community of practice provided me with counsel and support as I balanced helping lead my practice and patients through the pandemic with the personal demands of being a physician spouse and having a physician spouse. As the youngest of the Fellows that year, I leaned on my co-Fellows and faculty for wisdom during this period. I realized that the greatest trade-off that I made in choosing community primary care over academic medicine was giving up regular mentorship opportunities—a void that my AΩA Fellowship filled at the time I needed it most. The program also helped me crystallize the benefits of being in private practice, specifically the autonomy to do what I felt was my duty as a physician and community member, especially during the pandemic.

Over the course of the AΩA Fellow in Leadership year, I honed specific leadership skills: situational leadership, consensus building, and continuous learning. Through the Inward Journey, I began identifying my shortcomings as a leader. The pandemic had exposed those weaknesses, just as it had exposed those of our primary care infrastructure. The AΩA program gave me the tools to accept and address my failings. I learned about grace, and finding the courage to show it to myself and others.

For the remainder of the pandemic, during the most intense periods of stress and fear, that grace provided the kind of lasting relief that a loan never could.

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