INTRODUCTION

With over 6.3 million deaths, 557 million confirmed infections, and the continued appearance of new variants, the reach of the SARS-CoV-2 virus has been and continues to be massive [1, 2]. The severity of the pandemic has caused the need for a plethora of institutional adjustments. It has resulted in a high-pressure system for all aspects of healthcare, including general practitioner (GP) practices. GPs are frequently the first line of contact for patients with suspected infections, and like all other healthcare providers, they have had to overcome or work with numerous new treatment obstacles during the advent of the COVID-19 pandemic. Notably, clinical examinations have become limited and, in many cases, been replaced with teleconsultations [3]. While patient and physician safety is of utmost concern, these changing practices can lead to more patient safety incidents (PSIs), such as poor follow-up of pre-existing conditions, and late or missed diagnoses. Accordingly, during COVID-19, PSIs have become significant global causes of morbidity and mortality [4]. According to the Eurostat database, excess deaths caused by COVID-19 in Poland were one of the highest in Europe, reaching 69.1% in December 2021 [5]. Vulnerable patients, such as those who need frequent follow-ups or have difficulties accessing healthcare, are at higher risk for PSIs. An important number of patients enrolled in GP practices are vulnerable because of chronic illnesses, long-term disabilities, or low socio-economic status.

A recent review with evidence from past epidemics has shown that primary healthcare is crucial for managing infectious disease epidemics [6]. During COVID-19, GP practices felt the need for structural and organizational changes to be able to continue providing the quality care their communities require. How GP practices can adapt to pandemic settings depends on many factors, and guidelines created by individual practices and governments to do so can both contribute to achieving quality care, but also produce barriers to it.

At the end of 2020, an international consortium led by Ghent University in Belgium initiated the PRICOV-19 project in 37 European countries and Israel to explore how GP practices responded to the new challenges.
pandemic [7, 8]. The presented study focuses on how these factors, including those at the levels of individual GP practices and governmental/systemic levels, have contributed to safe and effective care for patients in Polish rural and urban practices. Accordingly, the aim was to assess the differences in adapting rural and urban GP practices to the COVID-19 pandemic in Poland in terms of structural changes, patient flow, infection prevention, information processing, as well as internal and external communication. Such data will inform both medical practitioners and policymakers on the aspects of healthcare systems and GP practices that are effective, and which need refinement, aiding in the continued fight against COVID-19 and serving to prepare for future pandemics.

MATERIALS AND METHOD

PRICOV-19 is a cross-sectional, questionnaire-based study in 38 countries. In each country, a coordinating centre was established; in Poland, the Department of Family Medicine at the Jagiellonian University Medical College in Kraków was responsible for managing PRICOV-19. The study was approved by the Research Ethics Committee at Ghent University Hospital (Project No.: BC-07617) and by the Bioethics Committee at Jagiellonian University (No. 1072.6120.302.2020). The study is described in detail elsewhere. A summary is presented below.

Study tool. The final version of the PRICOV-19 questionnaire was developed and validated by the research team from Ghent University. The first draft of the questionnaire was developed after a thorough literature review. Subsequently, the Delphi procedure was used, and a panel of five PHC experts and one methodological expert evaluated the validity of the items and the length of the questionnaire, formulated suggestions for changes, and recognized missing items. After the second version of the questionnaire was developed, three cognitive interviews were organized with two GPs and one non-GP. An online version of the questionnaire was made using the Research Electronic Data Capture (REDCap) platform and pre-tested first among ten participants (both GPs and non-GPs), and then piloted among 159 Belgian GP practices. Finally, the international consortium partners reviewed the questionnaire for acceptability in their country and cultural adaptation.

The final questionnaire consisted of 53 items divided into six sections: patient flow, infection prevention, information processing, communication with patients, collaboration, collegiality, self-care, and characteristics of participants and GP practices. The final English version of the questionnaire was forward and backward translated by two independent researchers and piloted by ten Polish GPs. The final Polish version was uploaded to the REDCap platform.

Participants. A convenience sample of 207 GP practices was recruited from 16 regions of Poland in proportion to the number of inhabitants of each region, the number of participating practices being predicted by the study protocol. Managers of the practices who could potentially participate in the study were approached by telephone and email. After their initial agreement, a separate invitation and informed consent form were sent to them via email. Two additional reminders were sent to non-respondents. Those who returned a signed informed consent form were included in the study and received the link to the questionnaire. In each practice, only one person (physician or another team member) was expected to answer the questionnaire on behalf of all practice team members. Data collection in Poland started in December 2020 and finished in August 2021.

Statistical analysis. The descriptive analyses of categorical variables are reported in percentages, and in means with standard deviations and medians with inter-quartile ranges for continuous variables. Differences between practices in urban and rural settings were assessed using chi-square and U-Mann Whitney, or t-test for independent groups (respectively for the type of data). For comparison of the measurements before and since the pandemic, the Wilcoxon test was performed. A P-value of < 0.05 was considered as the level of statistical significance. All analyses were completed using Statistica 13 software package (Statsoft Inc.).

RESULTS

Respondent characteristics. Even though 207 GP practices were recruited, not all questionnaires were filled out completely, and fewer answers to some questions were included in the analysis as a result. After data cleaning, 180 practices were included in the study, 51.1% from large (inner) cities, 14.4% from small cities, and 34.4% located in rural areas.

Practices from large and small cities cared for more patients than those located in rural areas, with the median number of patients per practice (Q1; Q3) being 5,500 (3,300; 8,500), 5,750 (2,750; 10,000), and 3,600 (2,500; 5,200), respectively (p = 0.0008). Also, 62.9% of practices in large cities provided medical training in family medicine, while only 26.9% of those in small towns and 35.5% in rural areas did so (p = 0.0003).

Practices varied significantly regarding the type of staff employed (Tab. 1). Three of four practices in large cities were involved in the post-graduate training of family physicians, while only half of those located in small cities or rural areas were. Community midwives were employed more frequently by practices in larger cities than in other locations. Practices from smaller cities more frequently employed receptionists and other administrative staff. More staff members worked in practices in larger cities than rural areas. A significantly higher number of GPs worked in practices in larger cities than in other locations (small cities or villages). The same difference was observed for the number of GP trainees (Tab. 2).

Structural changes. Respondents representing 122 (68.2%) practices stated that they experienced limitations related to the building or the infrastructure of the practice when providing high-quality and safe care since the onset of the COVID-19 pandemic. However, 120 (71.0%) respondents stated that the COVID-19 pandemic led their practices to consider adjusting their buildings or other infrastructure. Practices in larger cities reported these changes more frequently, but the differences were insignificant.

Patient flow. In 138 (78.4%) of the surveyed practices, patients making an appointment by phone were required to state a
Table 1. Type of allied personnel.

|                      | Total N (%) | Large (inner) city N (%) | Small city N (%) | Rural N (%) | p-value |
|----------------------|-------------|--------------------------|------------------|-------------|---------|
| GP trainee           | 117 (65.0)  | 69 (75.0)                | 14 (53.8)        | 34 (54.8)   | 0.0159  |
| Practice nurse       | 149 (82.8)  | 77 (83.7)                | 19 (73.1)        | 53 (85.5)   | 0.3518  |
| Community nurse      | 158 (87.8)  | 84 (91.3)                | 20 (76.9)        | 54 (87.1)   | 0.1389  |
| Community midwife    | 124 (68.9)  | 70 (76.1)                | 11 (42.3)        | 43 (69.4)   | 0.0045  |
| Practice manager     | 94 (52.2)   | 50 (54.3)                | 14 (53.8)        | 30 (48.4)   | 0.7559  |
| Receptionist/        | 119 (66.1)  | 64 (69.6)                | 21 (80.8)        | 34 (54.8)   | 0.0388  |
| administrator        |             |                          |                  |             |         |
| Cleaning employee    | 128 (71.1)  | 65 (70.7)                | 18 (69.2)        | 45 (72.6)   | 0.9421  |

Table 2. Number of staff members and medical doctors

|                      | Total     | Large (inner) city | Small city | Rural area | p-value |
|----------------------|-----------|--------------------|-----------|------------|---------|
| Mean (± SD); Me (Q1; Q3) |           |                    |           |            |         |
| Staff members        | 12.6 (± 8.1) | 14.0 (± 8.5)       | 12.7 (± 8.5) | 10.5 (± 6.9) | 0.0149  |
| GPs                  | 3.5 (± 2.5)   | 4.3 (± 2.9)        | 2.9 (± 2.2)  | 2.4 (± 1.3) | 0.0000  |
| GP trainees          | 1.8 (± 2.1)   | 2.4 (± 2.4)        | 1.2 (± 1.6)  | 1.0 (± 1.2) | 0.0001  |

Interviewed practices reported a risk of numerous incidents related to patient flow during the COVID-19 pandemic (range: 15–51%), and undertook measures to prevent them (range: 16–66%) (Fig. 2). No differences were observed between practices operating in different locations.

Opinions of the respondents about the frequency of safety measures introduced toward patients requiring transportation of home isolation are presented in Figure 3. In these aspects, the respondents did not vary in relation to the location of their practices.

Infection prevention. In most practices, all consultation rooms contained equipment and materials useful for preventing infection, including disposable gloves (99.4%), a sink and surface disinfectant (both 98.9%), paper to cover the examination table (98.3%), disposable medical coats (93.9%), and a waste bin that could be opened hands-free (91%). Practices were least often equipped with a tap operated via elbow or motion detector (48.3%). All the above items were present in 44.4% of the reviewed practices, and no differences related to practice location were found.
The COVID-19 pandemic has changed the application of several infection prevention measures (Fig. 4). The percentage of the practices in which none of the staff members wore nail polish rose from 8.3% (before the pandemic) to 23.9%. In addition, the percentage of practices where none of the employees wore a ring or a bracelet increased from 6.7% to 31.3% during the pandemic. Both above changes were significant in all locations (p<0.05).

The percentage of practices declaring that they always use a detailed cleaning protocol (e.g., what to clean, frequency, method) rose from 55.1% to 71.7% (p=0.0001) during the COVID-19 pandemic and was significant in large cities (from 46.2% to 68.5%; p=0.0003), but not in small towns or rural areas. In addition, respondents declared that these were always present in each consultation room before the pandemic in 84.9% of offices and 92.7% after the pandemic (p=0.0299). A similar change was observed for the use of hand sanitizers for home visits (65.6% – 88.9%) and waiting rooms (29.6% – 91%); the changes were significant in all locations (p<0.05).

A separate medical bag was always provided for home visits to patients with suspected infections in 22.9% of the practices before the pandemic, and 57% after its spread (p< 0.01 for all the locations).

The reviewed practices introduced numerous procedures for transferring documents to COVID-19-suspected patients during the pandemic. These include pickup at the practice, delivery by regular post, e-mail, or secured online system available always or regularly in 65.7%, 9.1%, 34.5%, and 14.7% of practices, respectively. No differences were observed between rural and urban areas.

Participation in the COVID-19 vaccination programme was considered by 63.7% of practices located in large cities, 61.5% of those in small towns, and 90.3% in rural areas (p=0.0006).

Information processing. During the pandemic, the problem of shortage of time to read the new guidelines and relevant and reliable literature concerned a greater number of practices (56.2%) than before the pandemic (49.4%) (p=0.0019) (Fig. 5). Before the pandemic, insufficient time to update practitioner medical knowledge was reported slightly less frequently in facilities located in rural areas (42.6%) than in small (48%) and large cities (54.4%) (p=0.0873). This percentage increased to 55.7% in villages (p=0.0041); there was no difference in other locations.

The frequency of meetings to discuss tasks increased significantly during the pandemic (p=0.0000) (Fig. 6). A significant change in this aspect was noticed in large cities (p=0.0004) and villages (p=0.0000). Before the pandemic, no significant differences in the frequency of practice meetings were observed depending on their location; because of pandemic changes, a higher frequency of meetings was reported more often in rural areas than in large cities.

Communication with patients. Only 106 respondents answered the question about updates to their practice website. One-third (34%) of the declared changes to website information were carried out less frequently than once a month, 17% approximately once a month, and 20.8% once a week. The respondents from two practices confirmed the daily renewal of website content. Over two-thirds (69.8%) of facilities had a patient leaflet with information on COVID-19. The patient communication policy did not differ due to the practice location.

Collaboration, collegiality, and self-care. When staff members left the practice, the files (administrative and medical) that required follow-up were always transferred to another colleague in 39.8% of practices, usually transferred in 35.4%, sometimes transferred in 9.9%, rarely transferred in 8.1%, and never transferred in 6.8%. The frequency of the transfers did not differ by the location of the practice.

If an incident about quality of care occurred in practice, it was discussed regularly during online team meetings (either with the whole team present or only with the healthcare professionals) in 31.4% of practices, or always in 19.8% of them. The topic was never addressed in 23.3% of practices, rarely in 11.0%, and sometimes in 14.5%. There were no differences found due to location.

DISCUSSION

Summary of main findings. The COVID-19 pandemic has had a significant impact on primary healthcare in Poland. More than two-thirds of participating GPs felt the need to introduce changes to the structure of their practice. There were also significant restrictions to the flow of patients. In over three-quarters of the practices, additional security procedures were introduced related to telephone registration,
and only in a quarter of the participating practices patients could consult without a prior appointment. Almost always, GPs aided support staff in case of doubts related to patient registration.

The use of video consultation quadrupled during the pandemic but remained relatively low. Teleconsultation has become almost universal. Most physicians used guidelines and other forms of information support when using these media; the activities of practices located in different localities did not differ significantly in this respect. However, it is worth noting that doctors in rural areas were significantly more likely to engage in active care for deprived patient groups.

Respondents identified risks related to possible delays in care for various groups of patients, the most common of which could occur in up to half of the practices. The most common preventive measures included active care for chronically ill patients. Almost all practices were involved in the transportation arrangement of infected patients, and two-thirds declared consistent interest in home isolation conditions. GP practices declared good sanitary equipment for infection prevention. The pandemic also significantly increased the frequency of declared infection prevention measures in practices at all locations. Almost twice as many respondents from rural areas declared their interest in participating in the COVID-19 immunization programme, compared to urban practices.

Practice teams had less time to regularly review guidelines or medical literature during the pandemic, but the frequency of staff meetings increased significantly, especially in large cities and rural settings. However, practice websites were rarely updated with more recent information for patients, and inward communication between practice staff members was relatively low, regardless of location.

**Comparison with other publications.** The use of survey- and interview-based studies to assess the state of GP practices was common during the COVID-19 pandemic. Grossman et al. (2020) conducted a web-based survey among 169 Israeli paediatricians in May 2020 to assess the frequency of teleconsultations in their practices [9]. Daily use of video conferences and pictures increased from 1% and 15% before the first COVID-19 lockdown, to 12% and 40% during the first lockdown, respectively [9]. Likewise, the current study showed an increase in the frequency of video consultations, reaching a maximum of 30%. A French study observed a similar increase of video consultations (30.7%) among GPs working at multi-professional group practices [10]. In other nations, the observed rise of video teleconsultations was even more meaningful. A 2022 study by Groenewegen et al. assessed the PRICOV-19 questionnaire data of 155 Dutch GP practices [11]; the authors found that teleconsultations increased greatly during the COVID-19 pandemic, particularly video consultations (rising from 6% to 65% of practices in pre- vs. post-pandemic levels).

Gomez et al. (2021) described the results of the qualitative study among GPs and physicians undergoing training in Southern California, finding that teleconsultations improved access to care through increased convenience, increased time for counselling patients, opportunities for improved medication reconciliations, and the capability to visualise patient domestic environments and meet patient families [12]. However, the authors noted increased difficulties in conducting physical examinations, and that the loss of touch and personal connections diminished the perceived strength of the patient-physician relationship. Also, Verhoeven et al. (2020) noted a decisive shift towards teleconsultations and triage for COVID-19- and non-COVID-19-related situations, with clinical decision-making focused on triage and respiratory assessment, and a postponement of most chronic care as a consequence [13]. Moreover, another review published in 2020 confirmed that telehealth plays a key role in COVID-19 primary care operations, offering effective clinical service delivery in the wake of the pandemic [14].

The current study shows that the frequency of staff meetings in both large cities and rural settings increased significantly during the pandemic. This development is critical; team meetings have proven to be essential for providing support, setting common goals, reflecting on performance, and enabling effective team functioning [15]. Regular and well-facilitated team meetings in primary care settings can provide a forum for several functions and are especially important during a crisis like a pandemic [16, 17, 18].

The results of the current study also showed the improvement of applying several infection prevention measures due to the pandemic. For example, significantly fewer employees in all the surveyed locations wore nail polish, rings, or bracelets during the pandemic. This behaviour is in line with the World Health Organisation’s recommendations in which appropriate hand hygiene is listed in priorities in the prevention of healthcare-associated infection caused by COVID-19 [19, 20].

In a study that assessed the impact of the COVID-19 pandemic on health service delivery and frontline workers in Malawi, south-east Africa, key barriers to implementing COVID-19 prevention measures included periodic shortages of basic resources (e.g., soap, hand sanitizer, water, masks, and staff); this was not the case in the current study [21]. Nevertheless, the same as in that study, there were no significant differences between rural and urban facilities regarding either the availability and use of preventative measures, or the uptake of routine services.

In the current study, the percentage of practices declaring that they always used a detailed cleaning protocol rose during the COVID-19 pandemic. The tendency of health care workers to make positive changes in hand hygiene and other infection prevention and control (IPC) measures due to the COVID-19 pandemic, was confirmed in another study conducted in China in 2020 [22]. Previously, it was shown that outbreak risk had an effective and long-term impact on the practice of infection prevention and control measures as healthcare worker behaviours are ameliorated [23, 24].

A recently published study (2022) showed that rural GP practices in New Zealand had a different response to the COVID-19 pandemic than urban practices [25]. The authors claimed that this observation demonstrated the strengths and resilience of rural practices. One of the possible reasons for this observation may be the demographic differences between the rural and urban general practice workforce of New Zealand, a factor that may play a role in the Polish PRICOV-19 results.

Some differences in the current study showed that a rural model of care might be more adaptive to new situations compared to the urban one. For example, significantly more respondents from rural areas reported involvement in giving information or explanations to the fragile groups (illiterate patients, those with low health literacy, or migrants). Rural
GP practices were significantly more likely to engage in active care for deprived groups of patients. Rural institutions also declared greater readiness to participate in the COVID-19 vaccination programme than those located in cities. Despite the many struggles caused by the COVID-19 pandemic, the crisis has offered an important opportunity for improvement in primary care systems, both in rural and urban locations.

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