Journal of Primary Care & Community Health
Volume 12: 1–4

DOI: 10.1177/21501327211014093
journals.sagepub.com/home/jpc
SAGE

The Importance of Practice Facilitation in Primary Care When Pandemic Takes Hold: Relationships of Resilience

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Abstract

The COVID-19 pandemic is unprecedented in recent history as radically and forcefully changing healthcare delivery. Practice facilitators, who often use tools of improvement science, have long played a critical role in supporting routine primary care practice transformation when healthcare system and policy changes occur. However, current events have taken many healthcare systems to the brink of collapse. Our practice facilitation team, which has a long history of sustained primary care partnerships in rural under-resourced settings, is finding creative solutions to carry forward work in research and quality improvement, and the tools of improvement science are well-suited to address rapidly changing demands of primary care during such a crisis. We reflect here on practice facilitation through the pandemic—the value of applied improvement science, and the critical necessity of strong relationships, flexibility, and creativity to support ongoing primary care partnerships.

Keywords

COVID-19 pandemic, practice-based research, practice facilitation, quality improvement

Dates received 18 March 2021; revised 17 March 2021; accepted 9 April 2021.

The COVID-19 pandemic is transforming priorities, interactions, and how healthcare systems operate around the world. Our practice facilitation team has a long history of supporting frontline rural under-resourced primary care clinics as part of the Oregon Rural Practice-based Research Network (ORPRN).[1] The ORPRN network includes over 400 family medicine, internal medicine, and pediatric clinics across the state of Oregon, with the majority located rural and frontier regions. Clinic ownership is diverse and includes independent clinics, health/hospital system-owned clinics, federally qualified health centers (FQHCs), and tribal clinics. ORPRN's mission is to improve health outcomes and equity for all Oregonians through community-partnered dialogue, research, education, and coaching. Relationships based on trust, mutual understanding, and respect among all clinic members have served as the foundation of ORPRN's nearly 20-year history of research and quality improvement, all conducted with practice facilitation across the state.

Practice facilitators must develop strong relationships with the clinics they serve to be effective. They must be viewed as a trusted ally, caring about the clinic's well-being. To enhance this and best represent their region, practice facilitators often live and work in the same communities as the clinics they serve. The COVID-19 pandemic has dramatically changed these relationships; but these unusual times have highlighted the critical importance of strong systems for improvement as well as the value of practice facilitation to support strategic change.

When the COVID-19 pandemic hit, the ORPRN team was deeply engaged in a five-year study called "RAVE," the Rural Adolescent Vaccine Enterprise funded by the American Cancer Society. RAVE provides practice facilitation to 45 primary care clinics in rural Oregon with the goal of improving Human Papilloma Virus (HPV) vaccination.[2] At the study's inception, the average county-level HPV series completion rate among rural Oregon counties was

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just 28%,[3] far below the Healthy People 2020 goal of 80%.[4] By March 2020 the study intervention was well underway—we had completed 10 months of longitudinal practice facilitation and developed local community partnerships with 9 clinics (the first "wedge" in our stepped-wedge research design). The study design specifies that participating clinics be randomized to one of 5 intervention wedges starting every 6 months over a 3-year period. The intervention consists of 18 months of practice facilitation aimed at: (1) developing robust systems for clinical quality improvement and (2) supporting clinics in leading a local project to improve HPV vaccination. During the intervention, clinics meet monthly with a practice facilitator and hold weekly internal meetings to conduct rapid cycle small tests of change using The Model for Improvement.[5] Between monthly meetings, facilitators support clinics via email, telephone, and occasional drop-in visits. As a clinic-led intervention, each site chooses their own vaccination-related aim and each plan-do-study-act cycle with coaching from the practice facilitator. The study also provides funding for clinics to partner with a local community group to lead a local social marketing campaign.

The COVID-19 pandemic and its containment plan evolved quickly in Oregon. On March 8th 2020, a state of emergency was declared and later that week schools closed, gatherings were restricted, and restaurants were limited to take out and delivery. By March 23rd, Oregon had a statewide stay-at-home order, which included prohibiting any elective medical procedures and mandating school closures for the remainder year. Immediately, we heard from our clinic partners about decreases in both well and sick office visits. To support clinics, we reached out to discuss the impacts of COVID-19 on our study and the flexibility of our improvement work. These discussions helped us understand what was happening on the frontlines and guided our next steps. Our priority was to remain connected with clinics.

> *RAVE has taken a back seat for a few weeks while we are dealing with the current COVID pandemic. We are hoping to get going on it again in the near future. Providers and staff are working extra hard during this time. We do however need to cancel our upcoming meeting on 04/13. I am not quite prepared to set decide[sic] if we can do an online meeting in place or when we would be able to reschedule a future in person visit.*
>
> —Clinic A

> *Unfortunately, we have also scaled way back on RAVE. We are doing as much telehealth as possible, and limiting our in-person visits. With the schools closed and the covid19 issues going on our marketing ideas aren't going to work out. At this time I don't think we can do the monthly visits. We have a staff meeting today and I will discuss with them options on limited meetings or what our next steps are.*
>
> —Clinic B

By April, clinics started having decreased capacity to engage with the RAVE study as they responded to the pandemic. With most community organizations shuttered, partnerships for the RAVE-sponsored social marketing campaign evaporated. Clinic-level impacts of the pandemic were diverse. Some clinics experienced a rapid decrease in revenue that led to forced layoffs and furloughs; some transitioned completely or mostly to telehealth; and some limited populations eligible for care (eg, no in-person well visits for patients >1 year old). Throughout the early pandemic, clinics reported reduced clinic hours, increased telehealth, and overall decreases in patients seen—down by as much as 75% from their usual volume. Many clinics reorganized their physical spaces to minimize exposure risk and shuffled their internal teams by dramatically shifting workflows and responsibilities.

> *Towards the middle of March we laid off about 60% of our staff. We closed our Urgent Care temporarily, we reduced our hours in the Family Practice by one day. The remaining staff really had to carry a heavy load during that time. Many of us who are crossed trained were working in numerous departments, having odd jobs here and there and just doing whatever was needing done.*
>
> —Clinic C

> *Your email has perfect timing, I was talking with the supervisors about RAVE this morning ☺ I agree that priorities have changed, and as of now it would be easier for us to keep RAVE on the backburner. They brought up a good point and let me know we are no longer doing well visits over age 12 months and so Gardasil is not really on our radar right now. Let's plan on touching base in May.*

> *I'm sorry for the late notice, but I've had a meeting (COVID-19) put on my schedule the same time as our meeting. As I'm sure you can imagine and empathize this taken our top priority as one of my clinics is the geriatrics dept, and they are front lines right now. That being said, we've had to shuffle staff around to accommodate the building's (6 other clinics) needs.*
>
> —Clinic D

Remarkably, despite these massive disruptions, clinics have remained committed to partnering on the RAVE study. In some situations, clinics have even found increased capacity for improvement work, driven by a slower pace of office visits and more visible demand for rapid change.

> *At the end of last week we received funds from [deleted to protect clinic anonymity] and were able to bring back all our staff as of Monday. We are excited to have everyone back and now that we are overstaffed for our patient load at this time, we are knocking out projects. These funds are set out for the next 8 weeks. What we still have some uncertainty about is if we will be able to continue to maintain our staff capacity after that*

time. There are still so many things changing daily with all of this, it is hard to get a clear projection as to how everything will play out.

—Clinic C

One quickly recognized issue included a rapid decrease in the rate of preventive visits among children with an associated decline in childhood vaccinations. These findings have been noted in other states as well[6] and the World Health Organization[7] estimates that more than 80 million children are missing vaccines as a result of the COVID-19 pandemic. To address this, clinics pivoted improvement work focused on improving HPV vaccination to help find safe ways to deliver vaccination and well care broadly. In many instances, entire systems of vaccine delivery had been transformed by the pandemic. For example, when vaccine champions and care coordinators were called into other roles, clinics had no one to "scrub" charts for needed vaccines before patient visits. Sometimes, usual provider continuity was disrupted when individuals were called to cover designated respiratory infection clinics and others were gone for long periods of quarantine and family leave.

During these rapidly changing demands, improvement science has been an ideal tool to facilitate needed innovation. Using rapid cycles of change, clinics developed systems for drive-up vaccinations paired with virtual well visits, they created new availability for vaccination services without an appointment, and they educated staff about addressing vaccine hesitancy and utilizing data linkages available through the Oregon ALERT Immunization Information System. The decisions of each clinic reflected the unique challenges and resources available within the community, and improvement science tools made rapid, systematic, and community-specific innovation possible.

Through these unparalleled times of change, primary care clinics have demonstrated remarkable resilience and adaptability. As a facilitation team, we too have identified guiding principles to help us support clinics: (1) Relationships are paramount—we do this work in solidarity; (2) Rapid change requires flexibility—the new normal is a moving target; and (3) Thinking creatively can uncover novel solutions.

While our *strong relationships* with clinics have always provided the foundation for successful improvement partnerships in our network, the pandemic made clear: (1) the critical necessity of this trust and (2) the logistical challenges of remotely maintaining supportive relationships. Our team has poured energy into finding connectedness from a distance while our clinical partners continue to take a leap of faith to press on with improvement work during uncertain times. Our mutual trust makes both of these possible.

Trust also allows us to *be flexible* when needed. Our practice facilitators recognize that "one size does not fit all," as they tailor the facilitation to where their clinics are. This means we sometimes take a lighter facilitation approach—reducing or splitting meeting times into more manageable chunks, checking in with smaller groups, and at times pausing the work entirely while clinics attended to necessary higher priorities and then re-engaging when the dust settles. Many times, instead of addressing change cycles specific to HPV vaccination, we supported clinics in change cycles focused on operations (eg, workflows, staffing, billing, etc.). These adaptations are necessary to improve preventive care and supported improvement work in these areas can go far in working toward the quadruple aim.

Being flexible has opened the door to *creative solutions* and finding shared goals. This has involved open and clinic-centered dialogue to understand rapidly shifting realities. For example, as schools and libraries closed and were no longer available to co-lead social marketing for HPV vaccination, some practices turned to local coffee shops to help get the word out to families.

The impacts of the COVID-19 pandemic are ongoing and many will be long-lasting. As with most aspects of healthcare currently, the day-to-day functions and realities of practice facilitation are evolving. As clinics rapidly adapt to shifting demands, the need for strong facilitation partners is clearer than ever. As a facilitation team, we view this opportunity with optimism, great responsibility and humility. To successfully continue supporting clinics during this pivotal time, we must emphasize relationships, flexibility, and creativity. With these shared values, we believe we can support systems to deliver the highest quality of care no matter what the future brings.

Acknowledgments

We sincerely appreciate all the clinics participating in the Rural Adolescent Vaccine Enterprise and share a special thank you to those who allowed us to share their stories for this reflection.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by a grant from the American Cancer Society (RSG-18-022-010)

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