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Improving Access to Primary Care

Environmental Scan

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Key Messages

- A limited literature search was conducted to identify interventions to improve access to primary health care in Canada.
- Identified programs included components such as better scheduling, incentives for family doctors to work after-hours or provide more cancer screening, encouraging doctors to see the same patient throughout the course of their care, and involving other types of care providers or aides in accessing care.

Context

Primary care is the first point of contact for a patient's health and well-being.[1] This care is mainly provided by family physicians and other general health practitioners, who diagnosis and treat illness.[2] Challenges of primary health care include inadequate continuity of care, poor health promotion, poor access in remote and rural areas, low access in urban areas that do not have after-hours options, and strenuous working conditions of health care providers.[2]

The purpose of this report is to provide a list and summary of program level and community-based primary care interventions that aim to improve access to primary care in Canada.

Research Question

What health system–level models and practices exist in Canada that can improve access to primary care (particularly in rural and remote settings)?

Methods

This report is not a systematic review and does not involve critical appraisal or include a summary of study findings. Rather, it presents an annotated list of citations and summary of the key components of programs and community-based interventions related improving access to primary care in Canada. This report is not intended to provide recommendations for or against a particular intervention.

Literature Search Methods

A limited literature search was conducted by an information specialist on key resources including MEDLINE and Embase through the Ovid platform, CINAHL through EBSCOHost, the Cochrane Database of Systematic Reviews, the International HTA Database, the websites of Canadian health technology agencies, as well as a focused internet search. The search strategy comprised both controlled vocabulary, such as the National Library of Medicine's MeSH (Medical Subject Headings), and keywords. The main search concepts were primary care and access, models, or practices. Retrieval was limited to publications from or

mentioning Canada or Canadian regions and cities. The search was completed on May 24, 2022, and limited to English-language documents published since January 1, 2012.

Selection Criteria and Summary Methods

One reviewer screened literature search results (titles and abstracts) and full texts of potentially relevant publications according to the inclusion criteria presented in Table 1. Primary studies and systematic reviews of primary studies were considered for inclusion if they presented results for interventions implemented in Canada to increase access to primary health care.

Table 1: Selection Criteria

Criteria	Description
Population	People trying to access primary health care in Canada
Intervention	Program/initiative level interventions, community-based primary care interventions
Comparator	Usual access to primary health care or no comparator group
Outcomes	Reduction in unnecessary emergency department visits, patient reported outcomes, reduction in hospitalization, improved patient and provider experience, continuity of care, improved access to care for underserved populations, time savings for patients, cost savings for patients, time savings for providers, cost savings for health systems (value), shorter wait times for services, respect and cultural safety, improving culturally safe care
Study designs	Primary studies or systematic reviews of primary studies

Exclusion Criteria

Articles were excluded if they did not meet the selection criteria outlined in Table 1, they were duplicate publications, or were published before 2017. Studies were also excluded if they did not mention an intervention or change in care, were descriptive, did not report results for Canada specifically, were not focused on increasing access, were about consultations with specialists, or included logic analysis. Additional references of potential interest that did not meet the inclusion criteria are provided in Appendix 1.

Overall Summary

This report identified 34 articles that reported on interventions conducted in Canada to improve access to primary care. Interventions were conducted in several provinces and territories in Canada including Alberta, [12] British Columbia, [30, 22] New Brunswick,[15] Newfoundland and Labrador,[18] Northwest Territories,[22] Nova Scotia, [6,10,20] Ontario, [7,13,14,17,19,23-25,32,35] Quebec, [3-5,8,11,16,27,29,33,34] and Saskatchewan.[26,28] Five studies[9,15,21,22,36] were conducted across multiple jurisdictions in Canada and 1 study[31] did not specify region within Canada. No studies were conducted in Yukon, Nunavut, or Prince Edward Island

For those articles about interventions for specific populations, these populations included:

- young families

- pregnant people
- pediatric patients
- people described as “vulnerable”
- immigrants, refugees, or asylum seekers
- farmers
- Indigenous peoples
- populations experiencing poverty, homelessness, or trauma
- people living with diabetes
- older adults
- people living in rural areas
- transgender and gender-nonconforming people
- people with income in the lowest quintile
- people with severe and persistent mental illness
- people with a chronic disease
- people who did not finish high school
- people experiencing addictions
- people discharged from hospitals
- people with limited access to primary care.

Practices identified included:

- advanced access models
- open-access scheduling
- incentives for rostering patients and offering after-hours care
- providing equity-oriented care
- including nurse practitioners or physician assistants in care
- better tracking and maintenance of patient appointment schedules
- centralized waiting lists and prioritization
- offering navigation help for patients to attend appointments
- provider networks
- digital tools and virtual care
- serving high-risk or underserved populations
- rural clinics.

Annotated Reference List

Thirty-four articles[3-36] were included in the current report; qualitative studies are summarized briefly in Table 2; reviews, including scoping, rapid, systematic, and realist, are reported in Table 3; longitudinal studies are summarized in Table 4; and other study types are summarized in Table 5. Further details can be found by consulting the individual article citations.

Table 2: Annotated Reference List Details — Qualitative Studies

Criteria	Description
Saragosa et al. (2022)[32]	
Study design	Rapid review and qualitative interviews; 3 articles were based in Canada and were relevant to this report
Practice or model studied	Primary care initiatives in non-traditional settings: • counselling, health care, case management, dental care, harm reduction led by Indigenous staff • immediate health needs addressed by case manager, interdisciplinary care, nurse, primary care, physician, psychiatrists, peer supports • nurses, care coordinator, personal support worker
Type of primary care practice	Primary health care
Setting	Non-traditional health care settings (including urban and remote settings): • community health centre • satellite centres • home visits • assertive outreach • shelter-based clinic • inner-city housing
Canadian province or territory where the intervention was used	Ontario
Age of population in study	NR
Groups included for whom health equity is a priority issue	Individuals experiencing homelessness: • urban Indigenous • recent discharge from hospital
Outcomes of effectiveness	Harm reduction and inclusivity teachings, access to health promotion and community building, Indigenous leadership, continuity of care, timely service, system navigation, engagement, client perceptions/satisfaction, goal achievement
Study conclusions	"Process evaluation found that the program bridged teachings of inclusivity and harm reduction; strengths included Indigenous leadership and access to health promoting activities and community building (p. 29)." "Self-reported service location and peer escorts key to continuity of care; case managers were valued; timely service provision, interpersonal skills promoted engagement and system navigation (p. 29)." "Client satisfaction associated with goal achievement; greater perceived goal achievement (p. 29)."
Intervention reach to patients	NR
Ngo Bikoko Piemeu et al. (2021)[27]	
Study design	Qualitative study (interviews)

Criteria	Description
Practice or model studied	Navigation intervention for people in Montérégie, Quebec, referred to as "socially vulnerable": • phoned patients to help them communicate with physicians or to offer pragmatic assistance • helped with preparing for physician appointment • helped with appointments with medical specialist or home care • provided information about primary care (services, open hours, address, how to look for information)
Type of primary care practice	Primary health care services
Setting	NR
Canadian province or territory where the intervention was used	Quebec
Age of population in study	Patients aged 23 to 78 years
Groups included for whom health equity is a priority issue	People referred to as "socially vulnerable": • 11 of 16 people had a chronic disease • 9 of 16 people had a low-income status • 5 of 15 people did not finish high school
Outcomes of effectiveness	Patients' expectations and needs
Study conclusions	Results: "Three main expectations and needs of patients for navigation interventions were identified: communication expectations (support to understand providers and to be understood by them, discuss about medical visit, and bridge the communication cap between patients and PHC providers); relational expectations regarding emotional or psychosocial support; and pragmatic expectations (information on available resources, information about the clinic, and physical support to navigate the health care system) (p. 1)." Conclusions: "SV [socially vulnerable] patients need support to understand health and social providers, to make themselves understood or heard by providers, to discuss medical appointments in advance, and to bridge the communication gap between themselves and their PHC providers (p. 10.)"
Intervention reach to patients	Unclear
Paré et al. (2021)[29]	
Study design	Qualitative study (surveys, interviews)
Practice or model studied	Medical appointment scheduling and interoperable medical appointment scheduling
Type of primary care practice	Family medicine clinics (family medicine groups and non–family medicine groups)
Setting	NR
Canadian province or territory where the intervention was used	Quebec
Age of population in study	NR
Groups included for whom health equity is a priority issue	NR
Outcomes of effectiveness	Implementation, integration with the clinic's electronic medical record, adoption

Criteria	Description
Study conclusions	"…greater integration and assimilation of MAS [medical appointment scheduling] systems in family medicine clinics lead to greater accessibility and availability of care for their patients and the general population (p. 18)."
Intervention reach to patients	People receiving care from family medicine clinics in Quebec
Davie and Kiran (2020)[13]	
Study design	Qualitative study (root-cause analysis, surveys, questionnaires, interviews)
Practice or model studied	After-hours care at multiple sites
Type of primary care practice	Primary care practice
Setting	Urban
Canadian province or territory where the intervention was used	Ontario
Age of population in study	NR
Groups included for whom health equity is a priority issue	NR
Outcomes of effectiveness	Access during evening, weekend, or holiday; awareness about after-hours services; visits to after-hours care; number of after-hours phone calls
Study conclusions	Results: There was a 26% increase in awareness of weekday evening clinics. There was a 23% increase in awareness of weekend clinics. There was a 17% increase in awareness of after-hours phone services. There was a 16% increase in patients indicating somewhat or very easy to receive care on weekend, evenings, or holidays. Conclusions: "Implementation of patient recommendations resulted in sustained improvements in self-reported ease of after-hours access and a corresponding increase in after-hours phone calls. Although it is unclear if our efforts have impacted other health system use, feedback from patients is positive. Overall, our efforts have supported our primary care team in providing timely, continuous care to patients regardless of the time of day (p. 6)."
Intervention reach to patients	People receiving care from 5 sites in inner-city Toronto, Ontario
Morgan et al. (2019)[26]	
Study design	Qualitative longitudinal process evaluation
Practice or model studied	Rural primary health care memory clinic in the community • team-based care • decision-support tools • specialist-to-provider support
Type of primary care practice	Primary health care team
Setting	Rural
Canadian province or territory where the intervention was used	Saskatchewan
Age of population in study	NR

Criteria	Description
Groups included for whom health equity is a priority issue	NR
Outcomes of effectiveness	Facilitators and barriers
Study conclusions	Results: "Across all domains, 14 constructs influenced development and implementation. Three domains (innovation characteristics, inner setting, process) were most important. Facilitators were the relative advantage of the intervention, ability to trial on a small scale, tension for change, leadership engagement, availability of resources, education and support from researchers, increased self-efficacy, and engagement of champions. Barriers included the complexity of multiple intervention components, required practice changes, lack of formal incentive programs, time intensiveness of modifying the EMR [electronic medical record] during iterative development, lack of EMR access by all team members, lack of co-location of team members, workload and busy clinical schedules, inability to justify a designated dementia care manager role, and turnover of PHC team members (p. 1)." Conclusions: "Study findings indicate that even within rural settings that typically have fewer resources to draw on, evidence-based interventions can be successfully developed and implemented. The researcher-academic partnership and use of an implementation framework were important to this outcome (p. 16)."
Intervention reach to patients	People receiving care from 1 rural clinic
Oosman et al. (2019)[28]	
Study design	Qualitative study (surveys, interviews)
Practice or model studied	Onsite support at the Lighthouse Supported Living facility • part-time psychiatric nurse, nurse practitioner, special care aid, and paramedics
Type of primary care practice	Primary health care community-based setting
Setting	NR
Canadian province or territory where the intervention was used	Saskatchewan
Age of population in study	Clients aged 21 to 72 years
Groups included for whom health equity is a priority issue	People experiencing poverty, people experiencing homelessness, people experiencing addictions
Outcomes of effectiveness	Functional activity, health-related quality of life, satisfaction, challenges and unmet needs, overcoming barriers, impact of intervention, context and environment, maintaining access to physical therapy care
Study conclusions	Results: "Analysis of the qualitative data gathered from client and provider participants revealed the following four overarching themes: (1) complex health challenges, unmet needs; (2) overcoming access barriers and impact of physical therapy services; (3) respecting and responding to context and environment; and (4) moving forward to enhance access to physical therapy care (p. 176)." Conclusions: "the client participants were satisfied overall with having access to physical therapy services at The Lighthouse Supported Living facility, and they believed that it had a positive impact on their general health and well-being (p. 184)."
Intervention reach to patients	Clients of The Lighthouse Supported Living facility
Shrivastava et al. (2019)[33]	
Study design	Qualitative study with case studies

Criteria	Description
Practice or model studied	Integrated oral health care in Indigenous primary health care organization
Type of primary care practice	Primary health care
Setting	Remote
Canadian province or territory where the intervention was used	Quebec
Age of population in study	Patients were aged 31 to 60 years
Groups included for whom health equity is a priority issue	Cree communities
Outcomes of effectiveness	Supportive environment, trust, public health program appreciation, oral health awareness, health care provider's cultural humility
Study conclusions	Results: "Data analysis generated six major themes: enhanced accessibility, creating supportive environment, building trust through shared decision making, appreciation of public health programmes, raising oral health awareness and growing cultural humility among healthcare providers. Patients identified the integration of dental care into primary healthcare with respect to co-location, provision of free oral healthcare services, care coordination and continuity of care, referral services, developing supportive environment, shared decision making, oral health promotion and culturally competent care (p. 1)." Conclusions: "These results confirmed that patient-centered care is an important element of integrated care. Patients valued the use of this concept in all domains and levels of integration. They recommended to further strengthen the clinical integration by involving parents in oral health promotion as well as optimising care coordination and empowering a supportive environment in organizational integration (p. 1)."
Intervention reach to patients	People receiving care from northern Quebec Indigenous primary health care organizations
Shrivastava et al. (2019)[34]	
Study design	Qualitative study
Practice or model studied	Integrated oral health care in Indigenous primary health care organization
Type of primary care practice	Primary health care
Setting	Remote
Canadian province or territory where the intervention was used	Quebec
Age of population in study	NR
Groups included for whom health equity is a priority issue	Cree communities
Outcomes of effectiveness	Facilitators and barriers
Study conclusions	Results: "A total of six focus group discussions and 36 individual interviews were conducted. Five major themes emerged from the thematic analyses for barriers (two) and enablers (three). Themes for barriers included impermanence and lack of effective communication, whereas themes for enablers included culturally competent professionals, working across professional boundaries, and proactive organizational engagement (p. 1)." Conclusions: "impermanence of dental health providers and lack of effective communication skills in local language were key barriers in providing relational continuity of care; however, cultural competence of health care providers and team working across primary health

Criteria	Description
	services appear as major enablers. Based on the study findings, relational continuity can be empowered by effective strategies for overcoming barriers and encouraging enablers such as recruitment of permanent professionals, organizing cultural competency training, encouraging inter-professional collaboration, and promoting the organization's efforts. (p. 7)." "Based on these findings, relational continuity can be empowered by effective strategies for overcoming barriers and encouraging enablers, such as recruitment of permanent professionals, organizing cultural competency training, development of a Cree language dental glossary, encouraging inter-professional collaboration, and promoting the organization's efforts (p. 1)."
Intervention reach to patients	People receiving care from a primary health care organization serving a community of Cree people in northern Quebec
Abou Malham et al. (2018)[4]	
Study design	Qualitative case studies (interviews)
Practice or model studied	Advanced access model • balance patient demand • minimize backlog of appointments • restructure appointment system • interdisciplinary practice integration • plans when providers are absent
Type of primary care practice	University family medicine groups
Setting	1 rural and 3 urban university family medicine groups
Canadian province or territory where the intervention was used	Quebec
Age of population in study	NR
Groups included for whom health equity is a priority issue	3 university family medicine groups were for any population, 1 university family medicine group was for young families, pregnant people, pediatric patients, and patients described as "vulnerable"
Outcomes of effectiveness	Challenges and solutions reported by family physicians, unit medical directors, nurse practitioners, clerical staff, and clinical nurses
Study conclusions	Results: "Five challenges emerged from the data: 1) choosing, organizing residents' patient; 2) managing and balancing residents' appointment schedules; 3) balancing timely access with relational continuity; 4) understanding the AA model; 5) establishing collaborative practices with other health professionals. Several promising strategies were suggested to address these challenges, including clearly defining residents' patient panels; adopting a team-based care approach; incorporating the model into academic curriculum and clinical training; proactive and ongoing education of health professionals, residents, and patients; involving residents in the change process and in adjustment strategies (p. 1)." Conclusions: "The process entails numerous challenges for residents, which require a proactive change approach. Rethinking the training of residents, their role as an active member of the team in implementing AA, and the modalities of their intra- and inter-professional collaboration are strategies to consider, given their potential capacity to anticipate such challenges (p. 10)." "To meet the challenges of implementing AA, decision-makers should consider exposing

Criteria	Description
	residents to AA during academic training and clinical internships, involving them in team work on arrival, engaging them as key actors in the implementation and in intra- and inter-professional collaborative models (p. 1)."
Intervention reach to patients	People receiving care from 4 university family medicine groups
Abou Malham et al. (2017)[5]	
Study design	Qualitative case studies (interviews)
Practice or model studied	Advanced access model • balance patient demand • minimize backlog of appointments • restructure appointment system • interdisciplinary practice integration • plans when providers are absent
Type of primary care practice	University family medicine groups
Setting	1 rural and 3 urban university family medicine groups
Canadian province or territory where the intervention was used	Quebec
Age of population in study	NR
Groups included for whom health equity is a priority issue	Three university family medicine groups were for any population, 1 university family medicine group was for young families, pregnant people, pediatric patients, and patients described as "vulnerable"
Outcomes of effectiveness	Implementation, factors that influenced implementation of the intervention, recommendations
Study conclusions	Results: "Three out of four FMUs [family medicine units] implemented the key principles of advanced access at various levels. One scheduling pattern was observed: 90% of open appointment slots over three- to four-week periods and 10% of prebooked appointments. Structural and organizational factors facilitated the implementation: training of staff to support change, collective leadership, and openness to change. Conversely, family physicians practicing in multiple clinical settings, lack of team resources, turnover of clerical staff, rotation of medical residents, and management capacity were reported as major barriers to implementing the model (p. 1)." Conclusions: "Although all factors should be a key priority for effective implementation, paying particular attention to key organizational factors (resources, leadership, and teamwork approach) increases the likelihood of achieving successful implementation of advanced access (p. 13)."
Intervention reach to patients	People receiving care from 4 university family medicine groups
Breton et al. (2017)[8]	
Study design	Qualitative study (interviews)
Practice or model studied	Advanced access model • balance patient demand • minimize backlog of appointments • restructure appointment system

Criteria	Description
	• interdisciplinary practice integration • plans when providers are absent
Type of primary care practice	Primary care
Setting	One physician quote mentioned rural region
Canadian province or territory where the intervention was used	Quebec
Age of population in study	NR
Groups included for whom health equity is a priority issue	NR
Outcomes of effectiveness	Physicians' perceptions of the intervention, factors impacting the intervention, impact of intervention
Study conclusions	Results: 16 of 21 physicians were able to implement all 5 principles of the model. Conclusions: "Core implementation issues revolved around the dynamics of collaboration between physicians, nurses and other colleagues. Secretaries' functions, in particular, had to be expanded. Facilitating factors were mainly related to the physicians' leadership and the professional resources available in the organizations. Impediments related to resource availability and team functioning were also encountered (p. e316)."
Intervention reach to patients	Unclear
McCutchen et al. (2017)[24]	
Study design	Qualitative study (interviews)
Practice or model studied	PAs helping with physical examinations, intake psychiatric evaluations, prevention care, complaint follow-ups
Type of primary care practice	Assertive community treatment team
Setting	NR
Canadian province or territory where the intervention was used	Ontario
Age of population in study	NR
Groups included for whom health equity is a priority issue	Patients with severe and persistent mental illness
Outcomes of effectiveness	Access to primary care, access and quality of psychiatric care, health system navigation
Study conclusions	Patients reported better access to primary care, better coordination of care with family physicians, better prevention care by the PA, timely access to mental health care, more collaborative and longer appointments, more home visits, more continuity of care while physicians were unavailable, equal satisfaction between psychiatrist and PA, decreased wait times, improved access to screening.
Intervention reach to patients	Roster expanded from 75 to 85 patients
Montesanti et al. (2017)[25]	
Study design	Qualitative study with case studies
Practice or model studied	Ontario community health centres • serving 74 high-risk communities

Criteria	Description
Type of primary care practice	Community-based primary health organizations
Setting	Rural, urban, and northern communities
Canadian province or territory where the intervention was used	Ontario
Age of population in study	NR
Groups included for whom health equity is a priority issue	Populations at higher risk of experiencing systemic health disparities (4 case studies) • Case 1: Mennonite farming populations • Case 2: Immigrants, refugees, people in the LGBTQ community • Case 3: Newcomers and immigrants, people experiencing homelessness, First Nations populations, francophone populations, older adults • Case 4: Immigrants and refugees (Roma refugees from Czech Republic), youth experiencing homelessness
Outcomes of effectiveness	Barriers to participation, strategies to address barriers, challenges
Study conclusions	"The impediments to participation that relate to cultural values and beliefs suggest that there may be different levels of willingness to participate among different marginalized populations. Given these findings, the claims made for community development, as the one-size-fits-all approach to enabling community participation with marginalized populations, should be re-considered in the context of a population's values toward participating in planning for and decision making about their health care. The challenge for community development is to both enable marginalized populations to have a voice and influence, and help provide whatever support is needed — capacity building, self-esteem and building relationships — while also acknowledging the different underlying values that marginalized populations hold toward participation in health service planning and decision making (p. 648)."
Intervention reach to patients	Unclear

LGBTQ = lesbian, gay, bisexual, transgender, and queer; NR = not reported; PA = physician assistant; PHC = primary health care.

Table 3: Annotated Reference List — Reviews

Criteria	Description
Ratnayake et al. (2022)[31]	
Study design	Scoping review of 8 relevant primary studies based on various designs and methods including quantitative surveys, qualitative interviews, qualitative focus groups, direct observation, time-series analyses, case studies
Practice or model studied	Local non-medical immigrant settlement organizations Provide support to access health care services
Type of primary care practice	Settlement or community organizations
Setting	Urban (when reported)
Canadian province or territory where the intervention was used	Studies took place in Canada; province or territory were not specified
Age of population in study	Patients 16 years and older

Criteria	Description
Groups included for whom health equity is a priority issue	Asylum seekers, refugees, immigrants
Outcomes of effectiveness	Cultural competency, trust, knowledge, network cohesiveness/density, services offered, organization capacity, collaboration, self-reported mental health, timely access to care, barriers to access of services
Study conclusions	"Local non-medical immigrant settlement organizations support immigrant access to primary healthcare; however, the scope and quality of services available to immigrants may not be uniform across settlement organizations (p. 11)."
Intervention reach to patients	Unclear
Li et al. (2020)[22]	
Study design	Rapid review summarizing 26 resources: • 3 literature reviews • 1 mixed-methods study • 1 pilot study • 1 observational study • 11 technical evaluative reports • 3 presentations • 3 case studies • 2 conference proceedings. 15 interviews with physicians, nurses, and researchers from Ontario, British Columbia, and Northwest Territories
Practice or model studied	Virtual care including distance care, using information or communications technology
Type of primary care practice	Virtual primary care
Setting	Rural and remote
Canadian province or territory where the intervention was used	Across Canada and interviews for providers in British Columbia, Northwest Territories, Ontario
Age of population in study	NR
Groups included for whom health equity is a priority issue	People in rural and remote northern Canada
Outcomes of effectiveness	Continuity of care, health outcomes, accessibility, cost-effectiveness, patient-centredness, satisfaction, equity
Study conclusions	"The availability of virtual care applications varies in these northern, rural, and remote communities, and they have not yet been widely adopted…a consistent finding in this review was that virtual care alone will be insufficient to solve these major access and quality-of-care challenges. Also, there may be some communities who prefer not to engage in virtual care models of care, and the needs and priorities of such communities should be considered in any reforms. Given this context, however, there is a need to bring the level of virtual care (both in quality and scale) up to the level of the best practices seen in Canada, or even beyond (p. 17)." "This review uncovered several potential and realized benefits of virtual care. These include increased physical accessibility, greater patient and provider satisfaction, continuity of care, cost effectiveness, better health outcomes for patients, and equity. With regard to continuity

Criteria	Description
	of care, there was little evidence that virtual care improved care continuity, and this was recognized as a vital consideration in the development and implementation of future virtual care initiatives, such that it can facilitate communication with patients and care providers not only for episodic consultation but for continuous care that includes all the members of the care team. In terms of equity, there was seen to be potential for virtual care to improve equity in access to care, by overcoming some of the physical, temporal, and geographical barriers to access. However, on the other hand, there were concerns that virtual care could exacerbate inequities given the need for internet connectivity and smart phones for some more advanced technologies that are not widespread in many communities and among socially excluded groups (p. 17)."
Intervention reach to patients	Unclear
Lamontagne-Godwin et al. (2018)[19]	
Study design	Realist review, 1 before-and-after study relevant to current report
Practice or model studied	Navigation intervention • Drop-in centre staff took patients to mammography screening visits at St. Michael's Hospital in Toronto
Type of primary care practice	Inner-city drop-in centre
Setting	Inner-city
Canadian province or territory where the intervention was used	Ontario
Age of population in study	Patients aged 50 and 70 years eligible for mammography screening
Groups included for whom health equity is a priority issue	Patients were described as "disadvantaged women who attended an inner-city drop-in centre"
Outcomes of effectiveness	Mammography screening
Study conclusions	Increase in mammography participation from 4.7% to 29.2%
Intervention reach to patients	Unclear
Ansell et al. (2017)[6]	
Study design	Systematic review, 1 before-and-after study relevant to current report
Practice or model studied	Open-access scheduling to reduce primary care appointment wait times
Type of primary care practice	Family medicine academic clinic
Setting	NR
Canadian province or territory where the intervention was used	Nova Scotia
Age of population in study	NR
Groups included for whom health equity is a priority issue	NR
Outcomes of effectiveness	Primary care wait times, patient satisfaction, missing scheduled appointments
Study conclusions	There was a 10.1-day reduction in wait times after the intervention compared with before the intervention.

Criteria	Description
	There was a 1.44% reduction in missed scheduled appointments after the intervention compared with before the intervention.
Intervention reach to patients	NR

NR = not reported.

Table 4: Annotated Reference List — Longitudinal Studies

Criteria	Description
Hong et al. (2021)[14]	
Study design	Longitudinal study
Practice or model studied	Incentives for physicians to work after-hours (weekdays from 5 p.m. to 8 p.m., weekends, holidays): • April 1, 2002, to March 31, 2006: premiums increase from 10% to 15% • April 1, 2005, to March 31, 2016: 15%, 20%, 30% premium increases over time
Type of primary care practice	Primary care physicians in patient enrolment models
Setting	Non-rural
Canadian province or territory where the intervention was used	Ontario
Age of population in study	0 to 66+ years
Groups included for whom health equity is a priority issue	NR
Outcomes of effectiveness	ED visits per patient per month Classified by urgency (very urgent, urgent, and less urgent) and timing (regular or after-hours)
Study conclusions	Results: • Introduction of the after-hours intervention was associated with a decrease in less-urgent ED visits (1.26 reduction per 1,000 patients per month; 95% CI, −1.48 to −1.04). This decrease was greater for the after-hours period compared with the regular hours period. There were slight increases in urgent and very urgent ED visits. • Further increases in incentives were associated with a small decrease in less-urgent ED visits. Conclusions: "Ontario's experience suggests that incentivizing physicians to improve access to after-hours primary care reduces some less-urgent visits to the emergency department (p. E85)."
Intervention reach to patients	Ontario residents
Abou Malham et al. (2020)[3]	
Study design	Longitudinal qualitative study (interviews) with recurrent cross-sectional methods
Practice or model studied	Advanced access model • balance patient demand • minimize backlog of appointments • restructure appointment system

Criteria	Description
	• interdisciplinary practice integration • plans when providers are absent
Type of primary care practice	University family medicine groups
Setting	1 rural and 3 urban university family medicine groups
Canadian province or territory where the intervention was used	Quebec
Age of population in study	Nurses who were interviewed were aged 28 to 58 years
Groups included for whom health equity is a priority issue	3 university family medicine groups were for any population, 1 university family medicine group was for young families, pregnant people, pediatric patients, and patients described as "vulnerable"
Outcomes of effectiveness	Appointment scheduling models, factors that influenced nursing procedures, interprofessional collaboration
Study conclusions	Results: "Over time, RNs were not able to review the appointment system according to the AA [advanced access] philosophy. Half of NPs managed to operate according to AA. Regarding collaborative practice, RNs were still struggling to participate in team-based care. NPs were providing independent and collaborative patient care in both consultative and joint practice, and were assuming leadership in managing patients with acute and chronic diseases. Thematic analysis revealed influential factors at the institutional, organizational, professional, individual and patient level, which acted mainly as facilitators for NPs and barriers for RNs. These factors were: 1) policy and legislation; 2) organizational policy support (leadership and strategies to support nurses' practice change); facility and employment arrangements (supply and availability of human resources); Inter-professional collegiality; 3) professional boundaries; 4) knowledge and capabilities; and 5) patient perceptions (p. 1)." Conclusions: "Healthcare organizations need to customize training to nurses' needs and provide coaching tailored to each category of nurse, as well as critically re-examine NP and RN professional boundaries within AA, and provide the optimal professional and organizational contexts to support nurses' practice transformation. A significant investment must be made ensuring that RNs are not marginalized, but rather involved as key actors in the implementation of AA. Thus, the study highlights the crucial need to align all team members in the current transition to AA in order to achieve the desired reductions in waiting times (p. 15)."
Intervention reach to patients	People receiving care from 4 university family medicine groups
Cook et al. (2020)[12]	
Study design	Longitudinal study
Practice or model studied	Chinook Primary Care Network in Alberta communities (Lethbridge and 12 rural communities) • measured third-next appointment • tracked physician appointment delays • coordinated physician supply and patient demand
Type of primary care practice	Primary care network (physicians and allied health care professionals)
Setting	Rural, urban
Canadian province or territory where the intervention was used	Alberta

Criteria	Description
Age of population in study	Mean age range of patients (2009 to 2016): 39.1 to 40.3 years
Groups included for whom health equity is a priority issue	NR
Outcomes of effectiveness	Continuity of care, discontinuity, ED visits
Study conclusions	Results: "Physicians with improved access increased provider continuity by 6.8% per year, reduced discontinuity by 2.1% per year, and decreased emergency department encounters by 78 visits per 1,000 patients per year compared to physicians with stable access. Physicians with worsening access had a 6.2% decrease in provider continuity and an increased number of emergency department encounters (64 visits per 1,000 panelled patients per year) compared to physicians with stable access (p. E722)." Conclusions: "Our findings suggest that changing appointment delay in primary care can influence how patients choose to use the health care system. Furthermore, it can affect provider continuity, discontinuity and emergency department use, which, in turn, can affect health and system outcomes. As Alberta and other jurisdictions reform their health care systems to ensure patients receive appropriate care in the community, focusing on reducing delay in obtaining appointments with physicians practising in the community should be considered as a focal point of primary care form. However, improving access to primary care should be not done at the expense of continuity of care (p. E729)."
Intervention reach to patients	Unclear
Batista et al. (2019)[7]	
Study design	Longitudinal study
Practice or model studied	Primary health reform • patient enrolment model • incentive payments (including after-hours care) • capitation-based remuneration • interprofessional team supports
Type of primary care practice	Primary health care
Setting	Rural, suburban, urban
Canadian province or territory where the intervention was used	Ontario
Age of population in study	Average (IQR) • immigrants: 40.24 (29 to 47) years • long-term residents: 46.42 (33 to 59) years
Groups included for whom health equity is a priority issue	Immigrants identified from the Landed Immigrant database (45% from the Asia-Pacific, 22% from Europe)
Outcomes of effectiveness	Enrolment
Study conclusions	Results: "Overall enrolment in primary care practices increased gradually after 2004, until 2012, when two-thirds of the cohort (67%) were enrolled. The immigrants' enrolment level remained consistently lower than that of long-term residents over the study period. By 2012, enrolment of immigrants in capitation-based models was significantly lower (17.3% versus 25.4%). In particular, enrolment in Family Health Teams, considered the most comprehensive care model, was considerably lower in immigrants compared with long-term residents (5.6% versus 18.0%; OR = 0.40, 95% CI: 0.40 to 0.41) (p. 445)."

Criteria	Description
	Conclusions: "Enrolment in primary care has increased in Ontario for both in long-term residents and among immigrants; however, immigrants continue to be significantly more likely to be enrolled in more traditional primary care practices. Also, enrolment in the most advanced family health care practices was three times lower among immigrant compared with long-term residents. Immigrants continue to rely on traditional models without benefiting from the advantages of integrated primary care. These results suggest that, at a population level, immigrants in Ontario have relatively lower access to physicians in comprehensive primary care models, which has implications for equity in access and use of high-quality health services (p. 450)."
Intervention reach to patients	Ontario residents
Singh et al. (2019)[35]	
Study design	Longitudinal study
Practice or model studied	Patient rostering enhanced fee-for-service model • incentives to roster patients or take on new patients that did not previously have a family physician • each physician to be available 3 extra hours per week in the evening or weekend
Type of primary care practice	Physician health group
Setting	Urban
Canadian province or territory where the intervention was used	Ontario
Age of population in study	Patients mean age was 41.4 years (SD = 22.1)
Groups included for whom health equity is a priority issue	NR
Outcomes of effectiveness	ED visits, usual provider of care index, referrals
Study conclusions	Results: "Prior to transitioning, UPC [usual provider of care] was decreasing at a rate of 0.27%/year (95% CI: −0.34 to −0.21, P < 0.0001). Following the transition, UPC began decreasing by an additional 0.59%/year (95% CI: −0.69 to −0.49, P < 0.0001) relative to the pre-transition rate. RI [referral index] decreased by an additional 0.34%/year (95% CI: −0.43 to −0.24, P < 0.0001) relative to the pre-transition period, where it had been stable. The transition had minimal impact on FPSC [family practice sensitive condition] ED visits (p. 1)." Conclusions: "Continuity and coordination of specialized care slightly decreased upon transition from tFFS [traditional fee-for-service] to eFFS [enhanced fee-for-service]. This is likely due to physicians working in groups and sharing patients following the transition to the eFFS model. Adoption of an enrolment model with after-hours care did not decrease non-urgent ED use, which may reflect the small impact that primary care access has on these types of ED visits (p. 1)."
Intervention reach to patients	Ontario residents
Lofters et al. (2018)[23]	
Study design	Longitudinal study
Practice or model studied	Ontario reform • Switch from traditional fee-for-service to enhanced fee-for-service (incentives for meeting cancer targets)
Type of primary care practice	Primary health care

Criteria	Description
Setting	Rurality was adjusted for in the analysis
Canadian province or territory where the intervention was used	Ontario
Age of population in study	NR
Groups included for whom health equity is a priority issue	Immigrants and refugees identified from the Immigration, Refugees and Citizenship Canada database with landing visas since 1985, and people with income in the lowest quintile
Outcomes of effectiveness	Adherence to screening recommendation for cervical, colorectal, and breast screening
Study conclusions	Results: "Throughout the study period, cancer screening was consistently lower among immigrants and among people in the lowest income quintile. Transition to enhanced fee-for-service was generally associated with increased screening uptake for all, however for most years, ratios of ratios were significantly less than 1 for all three cancer screening types, indicating that there was a widening of the screening gap between immigrants and long-term residents and between people living in the lowest vs. highest income quintile associated with transitions (p. 1)" Conclusions: "The transition to enhanced fee-for-service in Ontario was generally associated with a widening of screening inequities for foreign-born and low-income patients (p.1)."
Intervention reach to patients	Ontario residents
Callaghan et al. (2017)[10]	
Study design	Longitudinal study (surveys)
Practice or model studied	Nurse practitioners in primary health care
Type of primary care practice	Multiprofessional, dyad, consultive
Setting	Some results mentioned rural communities
Canadian province or territory where the intervention was used	Nova Scotia
Age of population in study	NR
Groups included for whom health equity is a priority issue	NR
Outcomes of effectiveness	Nurse practitioner appointment wait times, acceptance of new patients, after-hours coverage
Study conclusions	Results: "…multiprofessional structures had shorter median NP appointment wait times: 0.5 days for urgent appointments versus 6.5 days (dyad, P = 0.004) and 4.5 days (consultative, P = 0.003), 4 days for non-urgent appointments versus 15 days (dyad, P = 0.020) and 4.5 days (consultative, P > 0.05). Only NPs in the multiprofessional structure provided after-hours coverage and over half the NPs in each structure were accepting new patients (p. 67)." Conclusions: "Although NPs in consultative, dyad and multiprofessional team structures provide similar services and were accepting new patients, access to the NP was greatest in the multiprofessional structure when examining appointment wait times and after-hours coverage (p. 77)."
Intervention reach to patients	Unclear
Carter et al. (2017)[11]	
Study design	Longitudinal study

Criteria	Description
Practice or model studied	Family medicine group model of primary care • multidisciplinary care • continued patient enrolment with family physician • longer hours for clinics • funding incentives for physicians
Type of primary care practice	Team-based practice
Setting	Rural, urban
Canadian province or territory where the intervention was used	Quebec
Age of population in study	Mean age range of patients living with diabetes (2004 to 2012): 64.79 to 13.62 years
Groups included for whom health equity is a priority issue	People living with diabetes
Outcomes of effectiveness	ED visits
Study conclusions	Results: "Our results indicated that for every 10-percentage point increase in the population enrolled with an FMG in the year prior to an event, there was a 3% reduction in avoidable visits to the ED made by an individual (RR = 0.97; 95% CI = 0.95, 0.99). We found a significant reduction among diabetic patients who had at most 1 visit to the ED per year (RR = 0.97; 95% CI = 0.95, 0.99) and nonsignificant effects among more frequent users. Within low-enrolment regions, a 10-percentage point increase in enrolment in FMG practices at t − 1 led to an 18% decrease in the number of avoidable ED visits (RR = 0.82; 95% CI = 0.78, 0.87). The effect disappeared when the analyses were restricted to the high-enrolment regions (RR = 1.00; 95% CI = 0.92, 1.09). The design and implementation of the incentive to promote team-based practice may not have borne much influence on early adopters who may have been overrepresented by physicians from high-performing practices before the introduction of the reform (p. 1)" Conclusions: "In conclusion, the results of our study suggest the potential for FMGs to increase access to and quality of primary care. However, we also found evidence of a protective effect in the early reform adoption period that may have been diluted over time in certain regions. Our findings support recent reports calling for the need to ensure that contractual arrangements between the territorially defined integrated health and social services centers and physicians in FMGs provide sufficient governance and support in reorganizing primary care practices (p. 375)."
Intervention reach to patients	Unclear

CI = confidence interval; ED = emergency department; FMG = family medicine group; IQR = interquartile range; NP = nurse practitioner; NR = not reported; OR = odds ratio; RR = relative risk; SD = standard deviation.

Table 5: Annotated Reference List — Other Study Types

Criteria	Description
Lane et al. (2021)[20]	
Study design	Descriptive study
Practice or model studied	Provider education and referral through network: • continuing education for primary care providers on prescribing gender-affirming hormones • Halifax Sexual Health Clinic contacting individuals on waiting lists to be seen in timely

Criteria	Description
	manner • community of practice meetings • tracking sheet to monitor patients and providers, and expand network
Type of primary care practice	Primary care network
Setting	NR
Canadian province or territory where the intervention was used	Nova Scotia
Age of population in study	NR
Groups included for whom health equity is a priority issue	Transgender and gender-nonconforming individuals
Outcomes of effectiveness	Registration of providers for continuing education, number of providers in referral network, wait time
Study conclusions	350 health care providers registered for continuing education. There were 12 providers in the network. The average waiting period was 31 days (range = 5 to 52 days). Average wait time was reduced by more than 85%.
Intervention reach to patients	40 patients were referred to a provider to receive gender-affirming hormone.
Spooner et al. (2021)[36]	
Study design	Mixed-methods with before-and-after methods (survey, interviews)
Practice or model studied	Alberta • pop-up events in areas with limited primary care Quebec • navigators for patients in disadvantaged neighbourhoods — phone call before first appointment with new family physician
Type of primary care practice	Pop-up primary care, family physician
Setting	NR
Canadian province or territory where the intervention was used	Alberta, Quebec
Age of population in study	NR
Groups included for whom health equity is a priority issue	People with limited or no access to primary care
Outcomes of effectiveness	Patient knowledge, awareness, perceptions, and ability; primary care practitioners accepting new patients; service provision; service use; collaboration; communication with family physician; satisfaction with care
Study conclusions	"Most of these interventions were followed by changes to patients' abilities to seek and engage with care and with providers' capabilities to provide appropriate care (p. 13)."
Intervention reach to patients	People at 6 Canadian sites
Kaczorowski et al. (2020)[16]	
Study design	Descriptive study

Criteria	Description
Practice or model studied	Cardiovascular health awareness program • Centralized waiting lists and prioritization done by nurses to help patients find a family physician
Type of primary care practice	Community centres
Setting	Community centres where access to primary care was not an issue (i.e., timely and appropriate follow-up was available attainable to clients)
Canadian province or territory where the intervention was used	Quebec
Age of population in study	Patients mean age was 58.1 years (SD = 8.2)
Groups included for whom health equity is a priority issue	Adults aged 40 years and older • at cardiovascular risk • on a waiting list for people without a family physician • require medical care within 6 months
Outcomes of effectiveness	CVD risk profile, referral to health promotion program, return to program, referral to ED, referral to family physician
Study conclusions	Results: • 32 people (11.4%) had a high risk for developing diabetes • 117 people (41.6%) were referred to a health promotion program • 13 people (4.6%) were referred to a family physician • 5 people (1.8%) were referred to an ED Conclusions: "Despite low participation rate, many adults on a waiting list had elevated risk for CVD and would greatly benefit from having a regular source of primary care (p. 1)."
Intervention reach to patients	Unclear
Hudon et al. (2019)[15]	
Study design	Participatory action research study using descriptive methods (surveys, focus groups)
Practice or model studied	Advanced access model • Support clinical preceptor, directors, and deputy directors to teach the advanced access model to family medicine residents
Type of primary care practice	Academic network of 11 family medicine settings
Setting	NR
Canadian province or territory where the intervention was used	Quebec, New Brunswick
Age of population in study	NR
Groups included for whom health equity is a priority issue	NR
Outcomes of effectiveness	Implementation support, challenges, solutions
Study conclusions	Results: "Nearly all of the academic family medicine settings implemented advanced access for their clinical preceptors (90.9%). Four main solutions to teaching advanced access were identified: establishing an optimal panel of patients; ensuring continuity of care during absences and away rotations; optimizing team collaboration; and creating a positive

Criteria	Description
	experience of immersion in advanced access (p. 641)." "The mean (SD) time to the TNAA [third-next available appointment] for preceptors (N = 125) remained stable (10.7 [9.4] days vs 10.5 [7.4] days) and the participation rate for monitoring timely access improved (34% vs 56%) from May through December 2016, respectively. Themes from focus groups: • challenges with defining patient panels • maximizing human resources through interprofessional collaboration • convincing residents that timely access to care for patients is relevant • tensions regarding resident schedules. Conclusions: "An academic-setting community of practice contributed to sharing solutions that were instrumental in broadly implementing the advanced access model and that also paved the way for the integration of advanced access for future family physicians, further supporting timely access to primary care (p. 641)."
Intervention reach to patients	People receiving care from 11 academic family medicine settings
Knight et al. (2019)[18]	
Study design	Interrupted time-series analysis
Practice or model studied	Primary health care reform • interdisciplinary teams • increased patient access • maximization of the scope of services • enhanced information technology
Type of primary care practice	Primary health care
Setting	Rural and urban settings were part of the study; the intervention took place in rural settings
Canadian province or territory where the intervention was used	Newfoundland and Labrador
Age of population in study	Residents mean age was 34.0 years (SD = 24.0)
Groups included for whom health equity is a priority issue	Rural communities
Outcomes of effectiveness	Mortality, ACS hospitalization
Study conclusions	Results: "In rural reform and rural nonreform communities, there was a decreasing trend in ACS hospitalization rates that preceded reforms (rural reform: rate ratio = 0.97; 95% CI, 0.94 to 1.00; rural nonreform: rate ratio = 0.98; 95% CI, 0.96 to 1.00) but no change following reforms. There were no significant changes in the urban group. In all 3 groups, there was a significant increasing trend in ACS-related mortality before reforms (rural reform: OR = 1.09; 95% CI, 1.02 to 1.15; rural nonreform: OR = 1.10; 95% CI, 1.06 to 1.13; urban = OR: 1.09; 95% CI, 1.05 to 1.14), which was reversed after the introduction of reforms (P < 0.01) (p. e296)." Conclusions: "Primary health care reforms in Newfoundland and Labrador had no observed effect on ACS hospitalization rates, but a potential effect might have been masked by a decreasing trend that preceded the introduction of reforms. The increase in mortality rates that was reversed after the introduction of reforms cannot be attributed to the reforms because it occurred in all studied populations including those that did not introduce reforms (p. e296)."

Criteria	Description
Intervention reach to patients	Newfoundland and Labrador residents
Prodan-Bhalla et al. (2019)[30]	
Study design	Descriptive study (surveys)
Practice or model studied	Women's-only nurse practitioner primary health care clinic in a non-profit women's resource centre
Type of primary care practice	Nurse practitioner primary health care clinic
Setting	Urban (inner-city)
Canadian province or territory where the intervention was used	British Columbia
Age of population in study	Patients were aged 19 to 55+ years
Groups included for whom health equity is a priority issue	Women who are at risk of experiencing systemic health and social inequities
Outcomes of effectiveness	Accessibility and reduction of barriers, clinic environment, emotional safety and trust, patient acceptance, customized care, quality of care
Study conclusions	Conclusions: "Seeking feedback from patients on their experiences of care using items developed to explicitly tap into equity issues is useful in understanding how patients experience equity-oriented health care. Responses from the women highlight the importance of understanding not only the what of equity-oriented care but also the how (p. 3459)." "Overall, the results of this exploratory study revealed that the women rated the clinic team highly on all questions indicating they were, in fact, practising equity-oriented primary health care (p. 3466)."
Intervention reach to patients	Women receiving care from 1 community clinic
Browne et al. (2018)[9]	
Study design	Mixed-methods study with case studies (surveys, interviews, direct observations of staff)
Practice or model studied	EQUIP Intervention Equity-oriented health care at 4 clinics included 1 or more components, such as: • care based on context • violence- and trauma-informed care • cultural safety
Type of primary care practice	Team-based primary care clinics
Setting	1 rural and 3 urban clinics
Canadian province or territory where the intervention was used	4 primary health care clinics in Canada (study authors were affiliated with organizations in British Columbia, Ontario, Manitoba, and Quebec)
Age of population in study	NR
Groups included for whom health equity is a priority issue	Populations experiencing poverty, homelessness, trauma; Indigenous people; recent immigrants; refugees; farmers
Outcomes of effectiveness	Staff confidence, experiences, and perceptions

Criteria	Description
Study conclusions	Results: "Engagement with the EQUIP intervention prompted increased awareness and confidence related to equity-oriented health care among staff. Importantly, the EQUIP intervention surfaced tensions that mirrored those in the wider community, including those related to racism, the impacts of violence and trauma, and substance use issues. Surfacing these tensions was disruptive but led to focused organizational strategies, for example: working to address structural and interpersonal racism; improving waiting room environments; and changing organizational policies and practices to support harm reduction. The impact of the intervention was enhanced by involving staff from all job categories, developing narratives about the socio-historical context of the communities and populations served, and feeding data back to the clinics about key health issues in the patient population (e.g., levels of depression, trauma symptoms, and chronic pain). However, in line with critiques of complex interventions, EQUIP may not have been maximally disruptive. Organizational characteristics (e.g., funding and leadership) and characteristics of intervention delivery (e.g., timeframe and who delivered the intervention components) shaped the process and impact (p. 1)." Conclusions: "Our findings further suggest that equity-oriented interventions be paced for intense delivery over a relatively short time frame, be evaluated, particularly with data that can be made available on an ongoing basis, and explicitly include a harm reduction lens (p. 2)."
Intervention reach to patients	Populations receiving care from 4 primary health care clinics in Canada
Lavoie et al. (2018)[21]	
Study design	Mixed-methods study with case studies
Practice or model studied	EQUIP intervention • equity-oriented health care at 4 clinics
Type of primary care practice	Team-based primary care clinics
Setting	1 rural and 3 urban clinics
Canadian province or territory where the intervention was used	Study authors indicated that they studied 4 CHCs in the Canadian context; authors were affiliated with organizations in Manitoba, British Columbia, and Ontario
Age of population in study	NR
Groups included for whom health equity is a priority issue	Populations experiencing poverty, homelessness, trauma; Indigenous people; recent immigrants; refugees; farmers
Outcomes of effectiveness	Intervention impact (mandates matching frameworks, resources tailored to needs, funding for priorities)
Study conclusions	"CHCs are an integral part of health systems design, and require a policy enabling environment to achieve their equity potential (p. 11)."
Intervention reach to patients	Populations receiving care from 4 primary health care clinics in Canada
Kiran et al. (2018)[17]	
Study design	Before-and-after study
Practice or model studied	Primary care physicians in patient enrolment models with after-hours care • each physician to be available 3 extra hours per week
Type of primary care practice	Physician groups
Setting	Non-rural areas

Criteria	Description
Canadian province or territory where the intervention was used	Ontario
Age of population in study	Residents were aged 19 to 65+ years
Groups included for whom health equity is a priority issue	NR
Outcomes of effectiveness	ED visits, weekend primary care visits, overall primary care visits, primary care continuity
Study conclusions	Results: ED visits increased 0.8% per year (95% CI, 0.7% to 0.9%) before the intervention and 1.5% per year (95% CI, 1.4% to 1.5%) after the intervention. There was an overall increase of 0.7% per year (95% CI, 0.6% to 0.8%). After the intervention, there were fewer primary care visits, higher proportion of weekend visits, and a minor increase in primary care continuity. Conclusions: Being enrolled in the intervention was associated with more weekend visits and fewer overall primary care visits. The intervention was not associated with reduced ED visits.
Intervention reach to patients	Ontario residents

CHC = community health clinic; CI = confidence interval; ED = emergency department; NR = not reported; OR = odds ratio; SD = standard deviation.

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Appendix 1: References of Potential Interest

Note that this appendix has not been copy-edited.

Previous CADTH Work

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