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Title: The association between timely access to patient's usual primary care physician and use of walk-in clinics in Ontario, Canada: a population-based cross-sectional study
Authors: Bahram Rahman MD MPP, Andrew Costa PhD, Anastasia Gayowsky MSc, Ahmad Rahim MSc, Tara Kiran MD MSc, Noah Ivers MD PhD, David Price MD, Aaron Jones PhD, Lauren Lapointe-Shaw MD PhD

Reviewer 1: Melissa Wan
Institution: Queen's University
General comments (author response in bold)

Thank you for reviewing our manuscript. No revisions were requested. (NA)

Reviewer 2: Denis Pereira Gray
General comments (author response in bold)

The article is unbalanced with good detail on the method and almost a page on acknowledgements but no introduction about why it may be important if patients do not use their primary care practice and the discussion section and references are limited.
Thanks for reviewing our manuscript. As suggested, additional content was added in the Introduction and Discussion sections. (Introduction, p. 5; Discussion, p. 16-18)

The statement that continuity is not provided in walk-in clinics is properly made but needs some text on why and how much this matters.
We have included additional content on the importance of continuity of care in our manuscript's introduction and discussion sections. (Introduction, p. 5; Discussion, p. 16-18)

For example, most-walk clinics do not provide much personal preventive medicine and offer much less anticipatory care. The article rightly states that continuity is rare in walk-in clinics but does not explain the significance of this; Continuity of care has now been shown to be associated with higher levels of patient satisfaction (Adler et al., 2010), higher quality of primary care (Delgado et al (2022) better take up of personal preventive medicine (Chistakis et al., 2000); O'Malley et al., 2002) and even lower mortality Pereira Gray et al (2018) [declare an interest.]
We have included additional content on the importance of continuity of care in our manuscript's introduction and discussion sections.
Introduction:
"…continuity of care, which is associated with greater patient satisfaction and better clinical outcomes.[9,10]"
Policy implications:
"… could reduce duplication of services and improve continuity and quality of care." (Introduction, p. 5; Discussion, p. 16-18)

The reader needs to understand about charges and this article should explain what costs patients meet when they attend a primary care practice or a walk-in centre and if there is any significant difference?
There are no charges for OHIP covered services in walk-in clinics. Patients in our sample did not pay out of pocket for publicly insured services in walk-in clinics.
Methods:

"Primary care in Ontario is publicly funded and, in most cases, delivered by private physician practices through different payment models. There are no charges to patients for seeing a primary care physician or for using a walk-in clinic: these services are entirely publicly funded." (p. 7)

At a time when costs are a problem in all health system, the discussion section needs to comment on if it is more expensive for the Ontario Health System for patients to attend one facility or the other? For example, in the UK it costs the health system more for a patient to attend a walk-in clinic. If the authors do not know they need to say, so but costs are probably available in Canada.
Thank you for the suggestion. We have included revision in the Policy Implications section.
Policy implications:
"Tools such as integrated funding and information-sharing between the patient's usual primary care physician and the walk-in clinic could reduce duplication of services…"
"Canadian studies comparing the costs of health care delivery in walk-in versus other settings are lacking, and the results of an ongoing study will be informative in this regard.[38]" (pp. 17-18)

On page 17 line 38 a statement is made that Ontario has a "high level" of primary care enrolment. It depends on perspective. In the Netherlands and in UK much higher enrolment percentages in the high 90%s occur.
Patient attachment to a primary care physician in Ontario during our study period was above 94% and is higher than the Canadian average and the US and we recognize that more could be done to improve these issues. We have added a reference as well.
Reference:
OECD Interactive Tool: International Comparisons - peer countries, Ontario [Internet]. Canadian Institute for Health Information (CIHI). [cited 2022Dec13]. Available from: https://www.cihi.ca/en/oecd-interactive-tool-international-comparisons-peer-countries-ontario (p. 33)

Many journals now have a limitations section near the start of the Discussion section. Such a section would strengthen this article as limitations are scattered in the methods and discussion sections eg not accessing patients who did not have a telephone and that the study was pre-pandemic. Patient memories are a limitation.
We have added a sub-heading, 'Limitations," to delineate it from the broader policy implications. (p. 18)

As the CMAJ is an international peer-reviewed journal with a good impact factor context and an international perspective can be expected. Some references to walk-in clinics are omitted including one international review of the literature eg Salisbury et al.
a. Salisbury, C., Chalder, M., Scott, T.M., Pope, C. and Moore, L. (2002) What is the role of walk-in centres in the NHS? BMJ; 324(7334) :399-402.
b. Salisbury, C. and Munro, J. (2003) Walk-in centres in primary care: a review of the international literature. British Journal of General Practice; 53(486) :pp.53-59.
We welcome the suggestion and have included the reference in the introduction and discussion sections.
We recognize that walk-in clinics exist in many jurisdictions. However, their scope, the most responsible provider and role within the sector are quite different

(e.g., in NHS England walk-in centres were managed by a nurse instead of a physician).
Reference:
Salisbury C, Munro J. Walk-in centres in primary care: a review of the international literature. Br J Gen Pract. 2003;53(486):53-59. (p. 30)

The findings are repeated too often and need editing.
Thank you for the suggestion. We have edited the Results section, focusing on key findings. (pp. 13-15)

Reviewer 3: Lisa Cook
Institution: Primary Health Care, Alberta Health Services
General comments (author response in bold)

Thank you for reviewing our study. No revisions were requested. (NA)

My only critique for the study, and it is a minor one, is I would have liked to see a more fulsome discussion on where walk-in clinics were/are available in Ontario. I realize that may be difficult to determine using the data sources the authors used, but it may explain why walk-in clinics were used by people living in large and medium-sized urban areas – perhaps the option does not in rural communities. As I mentioned, this is a minor suggestion.
Thank you for the comment. We agree that our study could have benefited from the location of the walk-in clinics. However, that information is not available in the current databases. We have highlighted this issue as a limitation and suggested the introduction of a location identifier in the physician billing system for walk-in clinics to allow better data collection in the policy implication section.
Introduction:
"Research into walk-in clinic use patterns in Ontario has been limited as walk-in clinic encounters are not uniquely identifiable in the health administrative billing system.[11,12]"
Policy implications:
"There is also a need for a registration process for walk-in clinics, which would make them identifiable in health administrative data."
Limitations:
"Further, perceived access to primary care is multifaceted and could be influenced […], geographic proximity of patients to a walk-in clinic or to their primary care physician,…" (Introduction, p. 5; Policy Implications, p. 17; Limitations, p. 18-19)

Reviewer 4: Maria Mathews
Institution: Family Medicine, Schulich School of Medicine and Dentistry
General comments (author response in bold)

It would be helpful to state up front (in the introduction) that the analysis does not look at specific episodes of care, but rather the general association between timely access to their primary care physicians and general use of walk-in clinics at some point in the previous year. I did not realize this was the case until I reviewed the supplementary. The survey (and approach) is different than the framing of the access to care question in the CCHS survey (that may be more familiar to readers) and other studies of WIC use.

Thank you for reviewing our manuscript. We have further clarified this point in the introduction section.
Introduction:
"…whether there is an association between patient-reported measures of timely access to their primary care physician and their use of walk-in clinics in the previous 12 months." (p. 6)

With this realization, the methods and analysis make more sense. Terminology however could more accurately reflect that there is no time/event connection between knowing about afterhours arrangements and use of walk-in clinics. For example, P7; line 30: even in a cross-sectional study, the "exposure" should at least theoretically occur before the outcome, but without knowing the specific circumstances of the walk-in clinic visit (i.e. away from home, nature of need etc.), I think it's better to describe knowledge of after hours arrangement as a correlate.
Thank you, we have further clarified this point in the Methods section.
Methods:
"The key variables of interest were responses to the questions related to timely access…" (p. 9)

There are some inconsistencies between the variables described in the methods and the results. For example, P 9 Line 31 – self reported attempt to call their primary care physician – there is no information about this variable in the appendix A, or if it was included in inclusion/exclusion. It's not clear to which question in the survey this variable corresponds.
Thank you for the suggestion. The survey question for the indicator, "Have called or tried to call primary care physician with a medical question or concern during the day on a Monday to Friday (access_1)," is included in Appendix C. (p. 37)

P9 Lines 35-45 states – For the variables 'total number of primary care visits', 'the number of primary care visits to a physician outside the usual primary care physician group', 'patient-reported quality of care received in walk-in clinics', and 'the main reason respondents reported for going to a walk-in clinic'; the methods say these variables were included for descriptive purposes but next page says these variables were included in regression model.
We have clarified which indicators are provided for descriptive purposes under the "Other Variable" subsection and which ones are included in the regression model in the Analyses section. Complete description of all variables is included in Appendix C. (Other Variables, p. 10-11; Appendix C, p. 36-39)

The authors also seem to have included survey waves (year; see p11; lines 18-23) but this variable is not described (or included in Appendix A). Did analyses control for year? Descriptive analyses of these variables are not described, and not consistently described in the results.
We have not included the survey year in the regression model. We tested it, but the variable was not statistically significant. The year was used only to describe the proportion of walk-in years over time as the survey expands over multiyear included in Appendix E. Survey waves are used during sorting and cohort creation. We have added the Wave and Year in Appendix C. (Appendix C, p. 39; Appendix E, p. 42)

Sensitivity analyses of low response rate survey waves (p10 line 53) are not reported.

We have included the results of our sensitivity analysis in Appendix H and Appendix I. (Appendix H, p. 45; Appendix I, p. 46)

P11- descriptive results are described in terms of likelihood (e.g., "Walk-in users were less likely to…"). I believe they should be described in terms of proportions (or means).
Thank you for the comment. We have made revisions accordingly.
Results:
"A lower proportion of walk-in users reported same-day/next-day access to their primary care physician or clinic when sick (36.9% vs. 40.3, SMD= 0.08) compared to non-users." (p. 13)

The reasons for not seeing their physician (table 2 p12 line 6) and walk in clinic quality are not reported.
We have updated Table 1 and included reasons for going to a walk-in and whether their condition could have been managed by their own primary care provider variables.
These variables are only for walk-in users, so they are not included in Table 2 which provides descriptive comparison between walk-in users and non-walk-in users. (Tables 1, 2, 3)

Formatting changes to Table 3 are not carried through to other tables (e.g., reporting of reference categories)
Thank you for the suggestion. We have reformatted as suggested. (Table 3, p. 27; Table 4, p. 28; Table 5, p. 29)

The discussion makes it sounds like authors examined specific episodes of care (We found that patients who had poor same-day/next-day access to their primary care physician or clinic had a greater likelihood of going to a walk-in clinic). Authors should clarify that there is a general association between timely access to their primary care physicians and general use of walk-in clinics at some point in the previous year.
We have added clarification.
Discussion:
"We found that patients who had poor same-day/next-day access to their primary care physician or clinic had a greater likelihood of having used a walk-in clinic in the last 12 months." (p. 16)

It would also be helpful to note that authors looked at one dimension of access and other dimensions of access (i.e., geographic proximity) were not considered.
Thank you for the comment. We recognize that geographical proximity to a walk-in clinic and the distance between the patient's residence and their primary care physician's office could impact their decision to go to a walk-in clinic. However, these variables were not measurable using our current data systems. And we have alluded to this as a limitation of our study.
Limitations:
"Further, perceived access to primary care is multifaceted and could be influenced by various factors, including patients' behaviour and expectations, the quality of patients' experiences with the broader health care system, geographic proximity of patients to a walk-in clinic or to their primary care physician, as well as other characteristics of the patient's primary care physician and clinic. (pp. 18, 19)

Page 14 lines 36-38 – it would be helpful to point out which models require after hours coverage. Given that the Auditor General of Ontario reported that 60% of primary care physicians in capitated models and 36% in enhanced fee-for-service models failed to meet their contractual obligations to deliver after-hours care, it may be better to state that "respondents were unaware whether their primary care physician offered after-hours than "that".

Thank you for the comment. We have added clarification and reworded to "whether" instead of "that".

Discussion:

"…,we found that most respondents were unaware whether their primary care physician offered after-hours care." (p. 16)

Many of the HSEC questions, as well as the hypothesis, imply that it's the patients' fault if they went to a walk-in clinic (i.e., did you phone your regular provider). I think there is a need to balance that perception with a greater discussion of the lack of provision of after hours.

We have added further content in the Policy Implications for better monitoring of accessing after-hours care.

Policy implications:

"This should be supplemented with improved monitoring and communication about after-hours clinic availability and patient education on which conditions require urgent assessment and which can wait." (p. 17)

Policy recommendations suggest the need to identify walk-in clinics – but enrolment models allow physicians to provide some services for patients who are not part of their roster. Also, why no mention of the need to monitor provision of after-hour care in response to AG report?

We welcome the suggestion and have added "monitoring of after-hours" as a policy implication. (Policy Implications, p.17)

Abstract; Line 50 – change to patient-reported (add hyphen; otherwise looks like verb-subject disagreement);

Thank you for the suggestion. We have made the revision. (p. 3)

It would also be helpful to state explicitly that you looked only at attached patients

Thank you, we have clarified this in the Abstract.

Abstract:

"Of the 60,935 total responses from individuals who had a primary care physician…" (p. 2)

P7 10-12 repetition of Ontarians/Ontario residents

Thank you for the suggestion. We have revised and used "Ontario Residents" throughout the manuscript. (NA)

P7: line 49 should first word be OR or AND (i.e., did you have to meet both conditions or either condition to be excluded?)

Both conditions had to be met (and those who did not meet these were excluded), "those who reported not having a primary care provider" and "those who could not be linked to a primary care physician using health administrative data on April 1 of the interview year." (NA)

P9: 23-24 – other variables explain formal versus virtual rostering (and consider the term “functionally” in place of “virtually” since virtually conjures different meaning in current context.

We recognize that given the rise of virtual care, the term “virtual rostering” could be confusing. However, to be consistent with all the previous literature using this approach, we have maintained the same language of “virtual rostering”. We are unsure what 'other variables' refers to and welcome further clarifications. (NA)