GUIDED

GUIDance for the rEporting of interventions Development (GUIDED).

Special note: We used the GUIDED as the reporting guideline for our study as it involved consultation as well as consensus development and as is the closest reporting guideline to our multi-method consultation process.

Item 1. Understanding the context for revision of the model Page 4	AA practice, based on the five pillars proposed by Murray et al. more than 20 years ago, has been widely promoted in Quebec and over the last 6 years, the majority of PHC family physicians in Quebec have introduced AA in their organisations at varying level of implementation. However, there is a need to develop a tool to support AA implementation and improvement by PHC providers. From page 4: *Over the last two decades, PHC practice has evolved to increase interdisciplinarity in clinical teams. Thus, the need for a model that incorporates new practices and professionals has necessitated development of an updated AA model. Furthermore, AA was originally developed in a context that prioritized implementing a new way of doing, with less emphasis on the ongoing practice and sustainability of the model.*
Item 2. Purpose of the revision process for the model Page 5	The purpose of this article is to describe the revision of the advanced access model pillars in primary healthcare to ensure that the tool is based on a contemporary AA model. From page 5: *The objective of this study was to revise and operationalize the pillars and sub-pillars of the AA model.*
Item 3. Target population for the model Page 5	While, changes in PHC practice require revisions to the AA model to adapt it to the contemporary context, the development will consider enlargement of the model to other healthcare professionals working in primary healthcare. From page 5: *This study redefines the pillars and sub-pillars of the AA model by integrating an interdisciplinary team-based focus, while considering the integration of PHC professionals, such as nurse practitioners, registered nurses, social workers, and other allied professionals, in PHC practices.*
Item 4. Publication that contributed to the revision of the model Page 5	Our approach was highly based on a modified Delphi technique for the development of consensus having as a base the AA model developed by Murray et al. and additional information gathered through a systematic literature review to nurture the expert panel with contemporary concepts. This method was selected because of its rigour along with its flexibility which was well suited for the revision of the AA model in a contemporary context involving an expert consultation and for the building of consensus, based on an iterative process. From page 5: *This study was based on a sequential multi-method consultation process (12) informed by a literature synthesis and a three-phase consultation with AA experts :1) a deliberative face-to-face meeting; 2) an e-survey; and 3) two final virtual validation meetings.*
Item 5. How evidence from different sources informed the model pp. 5-6	The different methods used a systematic realist review and Murray's AA model as defined in 2003. From page 5: *The research team used an inductive approach (Straus et al. 1990) to analyze the literature and identify concepts that emerged from past PHC practice-based use of AA (e.g. need for regular adjustment, integration of new appointments and consultation modalities, continuity, communication and satisfaction). Concepts were integrated to delineate pillars and sub-pillars defined across models of AA developed over time.* These findings will then be submitted to consultation of the AA expert panel through diverse consultation modalities: a deliberative face-to-face meeting, an electronic survey and two validation meetings.

	From page 6: *In November 2019, we identified a variety of key stakeholders suggested to be AA leaders in Quebec. Provincial and regional decision-makers, family physicians, nurse practitioners, registered nurses, quality improvement coaches, administrative staff and patients were invited by email to join the research team as part of an expert panel. To be considered an expert, participants needed to be involved with an organization working closely with PHC professionals, speak French and have extensive experience with AA (5+ years). A list of experts was shared with key informants and purposive and snowballing techniques were used to complete the list.*
Item 6. How published theory informed the AA model revision	Rather than creating a totally new AA model, we used as a base the AA model developed by Murray et al. and additional information gathered through a systematic literature review to nurture the expert panel with contemporary concepts. The model has inspired the development of several implementation and/or improvement guides about an advanced access practice. These documents or websites used Murray's advanced access model as a base without revising it *per se*, but did address new, more contemporary practices that inspired our discussions and consultations with our experts.
Item 7. Use of components from existing model	Please see response to item 6
Item 8. Guiding principles, people or factors that were prioritised when making decisions during the revision of the model Page 10	From page 10: *The involvement of AA experts from different backgrounds and health professions ensured that the model reflected the current context of PHC practice and was not restricted to a family physician perspective. Considerations such as the importance of involving not only PHC professionals but also managers, decision-makers and patients helped redefine pillars.*
Item 9. Stakeholders contribution pp. 6, 8 and 12	Good and diverse representation of stakeholders on the expert panel was an important ongoing concern throughout the consultation to make sure to cover different point of view and be as thorough as possible in the revision of the AA model that would integrate an interdisciplinary team-based focus. From page 8: *Participation was high throughout the consultation process, and a high degree of consensus was obtained. Although the expert panel was heterogeneous in composition, representing different roles in PHC, no polarization by expert role or group was observed.* Moreover, we used diverse type of activities throughout the consultation such as a World Café (Hyper Island; The World Café) method, a carrousel technique, an electronic survey to ensure participation was facilitated. Page 12: *The overall consultation process involved multiple methods that provided experts the opportunity to express themselves in various ways and at different times throughout the iterative process. Confirmation of various aspects of the model by patients and the addition of important elements specific to the patient experience also represent important additions to the original AA model.* Page 6: *Consensus on the relevance of a sub-pillar was considered obtained when 75% or more of the responses were in the high agreement zone (6 to 9), with a median in the high zone and an interquartile range of 0 or 1. Sub-pillars that did not meet these levels of consensus were kept for further reflection or clarification in the last phase.*
Item 10. Change in content and format from the start Figure 2	The mix of structured but varied activities, sometimes with a more circumscribed focus and sometimes with an idea-busting focus, helped to evolve pillar understandings and content. Starting with a broader idea and gradually refining it built on a solid foundation while adding precision during development/revision. These sequential steps allowed the research

	team to analyze and suggest progression for the reflection. It also allowed the maturation of ideas from the research team as well as from AA experts. Figure 2 shows the evolution of the model through expert consultation
Item 11. Changes required or likely to be required for subgroups Page 12	Page 12: There were limitations to this study. The entire consultation process took place in a very supportive organizational and political context for AA, potentially limiting the generalizability of our findings. Indeed, the experts consulted are early promotors or adopters of AA and are convinced of the benefits of an AA practice. AA practice is also actively promoted by Quebec's Ministry of Health and Social Services as a model for improving access not only to family physicians but to all professionals in PHC clinics. However, we are confident that the model applies to other PHC contexts, as it is based on general concepts central to PHC practice. An interpretation of the model will have to be made for professionals working in PHC but whose practice is related to the psychosocial field, a field that involves management and follow-up of a different kind.
Item 12. Uncertainties	The revised AA model has the potential to be applied to all PHC professionals in its definition. However, when applying/operating the model, additional thinking will be required to ensure that the concepts of the model are implemented.
Item 13. TIDieR guidance	1. **Brief name**: p. 5 *This study redefines the pillars and sub-pillars of the AA model by integrating an interdisciplinary team-based focus, while considering the integration of PHC professionals, such as nurse practitioners, registered nurses, social workers, and other allied professionals, in PHC practices. The objective of this study was to revise and operationalize the pillars and sub-pillars of the AA model.* 2. **Why**: pp. 4-5 *Over the last two decades, PHC practice has evolved to increase interdisciplinarity in clinical teams. Thus, the need for a model that incorporates new practices and professionals has necessitated development of an updated AA model. Furthermore, AA was originally developed in a context that prioritized implementing a new way of doing, with less emphasis on the ongoing practice and sustainability of the model.(10,11) However, changes in PHC practice require revisions to the AA model to adapt it to the contemporary context.* *OU (justification de la méthode)* *This multi-method was selected because of its flexibility and high level of rigour applied over the iterative process which was well suited for the development of a consensus over the revision of the AA model in a contemporary context involving an expert consultation.* 3. **What** (material provided): the electronic survey is available in appendix 2 4. **Procedures**: A summary of the multi-method consultation process is shown in figure 1. The World Café and Carrousel are briefly described and referenced on pages 6-7 and the e-survey provided in appendix 2 5. **Who provided**: Demographic characteristics of the AA experts in each of the consultation phases are presented in table 1 6. **How** (modes of delivery): Modes of delivery are also mentioned in the summary of the multi-method in figure 1 7. **Where** (location): Idem as "how" 8. **When and How much** (number of times the intervention was delivered): Dates of each phase of consultation are appearing in figure 1. 9. **Tailoring**: p.12

	There were limitations to this study. The entire consultation process took place in a very supportive organizational and political context for AA, which may limit the generalizability of our findings. Indeed, the experts consulted are early promotors or adopters of AA and are convinced of the benefits of an AA practice. AA practice is also actively promoted by Quebec's Ministry of Health and Social Services as a model for improving access not only to family physicians but to all professionals in PHC clinics. 10. **Modifications**: *The length of the e-consultation was extended due to the beginning of the Covid-19 pandemic and overload of actors and stakeholders working in the healthcare area.* 11. **How well** (adherence or fidelity of intervention assessment): p.11 *The overall consultation process involved multiple methods that provided experts the opportunity to express their voice in various ways and at different times throughout the iterative process. The confirmation of various aspects of the model by patients and the addition of important elements specific to the patient experience also represents an important addition to the original AA model.* 12. **Actual** As mentioned in the protocol, strategies to maximize the retention rate including personalized reminders from principal investigators were used. On page 7: *The participation rate was high throughout the consultation process, and a high degree of consensus was obtained. Forty-five experts participated in at least one consultation phase, and 17 experts participated in all of them.*
Item 14. Model development process in an open access format	Please see the protocol article for further information: Breton M et al. 2021: Development of a self-reported reflective tool on advanced access to support primary healthcare providers: study protocol of a mixed-method research design using an e-Delphi survey. BMJ Open [Internet]. 2021;11(e046411). Available from: (http://dx.doi. org/10.1136/bmjopen-2020- 046411