Appendix 1: Interview guide

The interview guide was developed by LG, IA, MV based on key issues identified in the literature, by our CFPC partners, and the members of the research team. The interview guide underwent extensive piloting starting with the clinician members of the research team and proceeding throughout the first (Pilot) case. For each case, we consulted with a local regional representative and revised the interview guide to add regionally specific terms and names to the interview guide to make it specific to the case. For each interview, the guide was personalized based on the professional designation of the interviewee (e.g. type of physician), data already gathered about that case, and emerging understanding of the phenomenon as the project progressed. The interview guide below is the core guide.

Physician Interview Guide

Thanks for participating in this research study. As you know, we have been contracted by the CFPC to study the impact of the Certificates of Added Competence. We're especially interested in the CACs in Care of the Elderly, Palliative Care, Family Practice Anesthesia, and Sport and Emergency Medicine. Our research objective is to understand how CACs impact the scope of the care that family physicians provide, as well as how they impact regulatory status and fee structures.

We're undertaking this research by studying particular family practices or inter-connected communities of primary care, and looking deeply at how CACs impact practice in those groups. We'll then compare how they are working across groups. Finally, we'll conduct a pan-Canadian survey to see whether our findings are representative of how CACs impact practice across the country.

Right now we are at the beginning of this research, still trying to explore what factors may be relevant or influential. I have a number of questions for you, but I'd also invite you to tell me anything you think is important for us to know about how CACs impact your own practice or how your practice group works together.

1. To begin, let's talk a little bit about you. What's your job here at [PRACTICE]?
    a. How long have you been in independent practice?
        i. Do you hold a CAC? In what? When/how achieved?
    b. Please describe the type of practice group you work in.
    c. What's your role within this group?
        i. Do you have any clinical specialties, or groups of patients that you tend to see more frequently than others?

2. [**If yes to 1.a.i, they have a CAC**] So, you have a CAC in [TOPIC]. Tell me about why you decided to pursue that, and what you had to do to get that certification.
    a. Were you in independent practice before getting that CAC, or did you earn it as part of your residency training?
    b. What motivated you to apply for a CAC? What benefit did you perceive from obtaining it? Was the benefit realized?
    c. [If yes to 2a, they were in independent practice before getting that CAC] Could you think back to what your practice looked like before getting that CAC and compare that to the work you started doing after earning the CAC? What changed?

i. {probes if needed} patient population, relationship to colleagues within practice, relationship to FP colleagues outside of practice, relationship to specialist colleagues, fee structure, involvement in research, geographical reach of care, physical place of work (e.g. specialized clinic or hospital privileges)

d. We're interested in referral patterns within [PRACTICE]. Many of these CACs provide specialized training in aspects of care that are part of what every family physician will encounter in a general practice. When should your colleagues refer patients with needs relevant to [your CAC] to you, and when should they maintain care of these individuals themselves?

e. Is this typically how it happens? Talk to me about actual practices in terms of where your FP referrals come from. Why do you think it is like this?
    i. Are patients aware of why they are being referred to you?

3. [**If no to 1ai, they do not have a CAC**]. Could you identify for me which of your colleagues at [PRACTICE] have a CAC?
    a. [note to analyst- compare to list of CACs- who is a visible CAC holder?]
    b. Think about your patient population compared to the groups seen by these colleagues. How are they different?
    c. Under what circumstances would you refer a patient to one of your colleagues at this practice who holds a CAC? When might you keep them yourself?
        i. [if needed- what about elderly patients, or those you have seen for a long time but now reaching end of life- how do you decide what is outside of your own scope]
        ii. I'm going to ask you to think about a particular patient in your practice who came to you with a sports-related injury [or needed palliative care, or other CAC present in their practice]. Could you give me a high level description of their case? How did you decide whether or not to refer this person to [Previously identified CAC holder].
            1. What would have changed your decision? You could think of factors related to the patient's presentation, their social needs, your practice load etc.
    d. Have you considered obtaining a CAC? Why or why not? (Probe: perceived benefit, impact on scope of care/individual practice)

4. Let's talk about the comprehensiveness of care provided by the group at [PRACTICE]. We know that while it's a CFPC priority, there are many difficulties associated with providing care from birth until death. We're interested in understanding whether the CACs help this, and if so, how.
    a. Please tell me about the comprehensiveness of the care you personally provide. Are there some areas of family medicine that aren't part of your practice? [probe: *Obstetrical care, palliative care, care outside of office, e.g. in hospital or home]*
    b. And thinking about your whole group, are there others who you can refer your patients to if they need someone who does [tasks identified previously?].
    c. What are the holes or gaps in the care your practice group is able to provide?

Appendix 1, as supplied by the authors. Appendix to: Grierson L, Allice I, Baker A, et al. Impacts of the Certificates of Added Competence credentialling program: a qualitative case study of enhanced-skill family medicine practice across Canada. *CMAJ Open* 2021. DOI:10.9778/cmajo.20200278.

i. Why do these exist? What are some of the reasons that this care isn't provided?
ii. Where do patients go for this?
iii. Is it accessible?
iv. Who is providing this care?

d. With these gaps we just discussed, would additional training in the form of a CAC help?
i. Are there any other areas of practice that you wish additional specialization was possible in?

5. Let's talk about regulatory status and credentialing. What are the challenges in this area?
6. I'd like to turn now to talking about fee structures and compensation. How is your practice funded?
    a. What are some of the benefits of this funding structure?
    b. What aspects of practice are challenging under this funding structure?
    c. All forms of fee structures incentivize some types of practice behaviours and dis-incentivize others. I'd like to go through the four practice areas relevant to the CACs and talk about what your funding structure enables and what it constrains. I'll give you an example related to a practice which receives funding based on how many patients are rostered. This model might discourage physicians in that practice from rostering high-needs patients, such as elderly people with multiple chronic conditions. [Team-members: is this accurate? Another suggestion?]
    d. Under a [PRACTICE FEE STRUCTURE], what types of practice related to Care of the Elderly are constrained or enabled?
        i. Can you think of what type of fee structure would enable your practice group to focus more time on these types of patients?
    e. Under a [PRACTICE FEE STRUCTURE], what types of practice related to Palliative Care are constrained or enabled?
        i. Can you think of what type of fee structure would enable your practice group to focus more time on these types of patients?
    f. Under a [PRACTICE FEE STRUCTURE], what types of practice related to Family Practice Anesthesia are constrained or enabled?
        i. Can you think of what type of fee structure would enable your practice group to focus more time on these types of patients?
    g. Under a [PRACTICE FEE STRUCTURE], what types of practice related to Sports and Exercise Medicine are constrained or enabled?
        i. Can you think of what type of fee structure would enable your practice to focus more time on these types of patients?
7. The last topic we'll discuss is future directions for CACs. There is the possibility that CFPC may develop additional CACs.
    a. Thoughts on the availability of a CAC in Enhanced Surgical Skills?
        i. What topics/expertise should this include?
        ii. Who would be interested in obtaining this?
        iii. What patient populations would benefit from FPs working in this area?
        iv. Any cautions?
    b. Thoughts on the availability of a CAC in Addiction Medicine?
        i. What topics/expertise should this include?

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    ii. Who would be interested in obtaining this?
    iii. What patient populations would benefit from FPs working in this area?
    iv. Any cautions?
c. What about other areas? Any other clinical areas that the CFPC should consider establishing a CAC in?
    i. [Probe the gaps mentioned in question 4]