Access Alliance
Multicultural Health and Community Services

“It’s like my second home”

2018 Client Experience Survey Report

November 2018

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Disclosure:
This evaluation report has been prepared by an external team of practicum students, volunteers and a project coordinator with the support of an Access Alliance Multicultural Health and Community Services research assistant as project lead. This report reflects the findings gathered from clients. For any questions or concerns regarding this report please contact Akm Alamgir, PhD, Manager of Quality and Accountability Systems, at aalamgir@accessalliance.ca.

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Introduction

Access Alliance Multicultural Health and Community Services (Access Alliance) facilitates access to a wide variety of programs including primary healthcare, social, settlement, youth and LGBTQ services for immigrants, refugees and the communities they live in. There are four main sites across the City of Toronto: AccessPoint on Danforth (APOD), AccessPoint on Jane (APOJ), College and Barrington. Access Alliance conducts the Client Experience Survey annually to ensure accountability to their stakeholders. Specific indicators from the survey are reported to Health Quality Ontario (HQO) and the Toronto Central Local Health Integrated Network (TC LHIN). Client reflections and suggestions are also used to determine drivers of satisfaction and opportunities for improvement which have implications with respect to program planning and quality improvement.

This report summarizes the results of this year's survey. The client experience has been organized into the following five themes:

Accessibility	Effectiveness	Equity & Anti-Oppression	Client-Centeredness	Client Satisfaction

Methods

This evaluation employed a mixed method approach comprising 508 quantitative surveys and three focus groups with clients who accessed programs and services at least once prior to the date of data collection (Figure 1). The survey included 32 standardized questions (primarily quantitative with some open-ended) consistent with the tools recommended by HQO, TC LHIN, and other provincial surveys (e.g. Be Well Survey). Focus group participants were selected from among clients who filled out the survey. A team of eleven volunteers and two practicum students administered the surveys at all four sites of Access Alliance, while the project coordinator and two practicum students facilitated the focus groups. All data was collected between May 17th and June 29th, 2018. Data processing and analysis was performed using SPSS analytical software. A detailed version of the methodology is included as Annexure A.

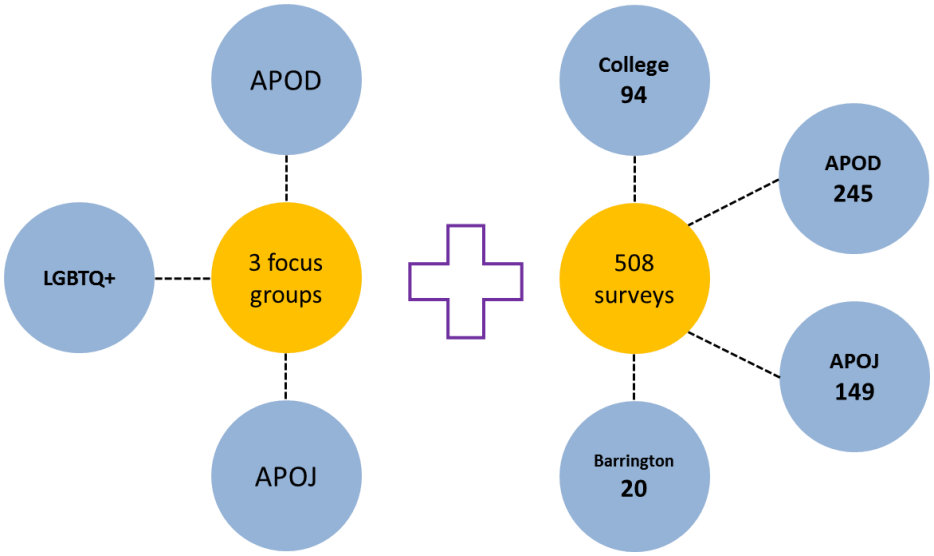


Figure 1: Data collection across Access Alliance sites

Findings

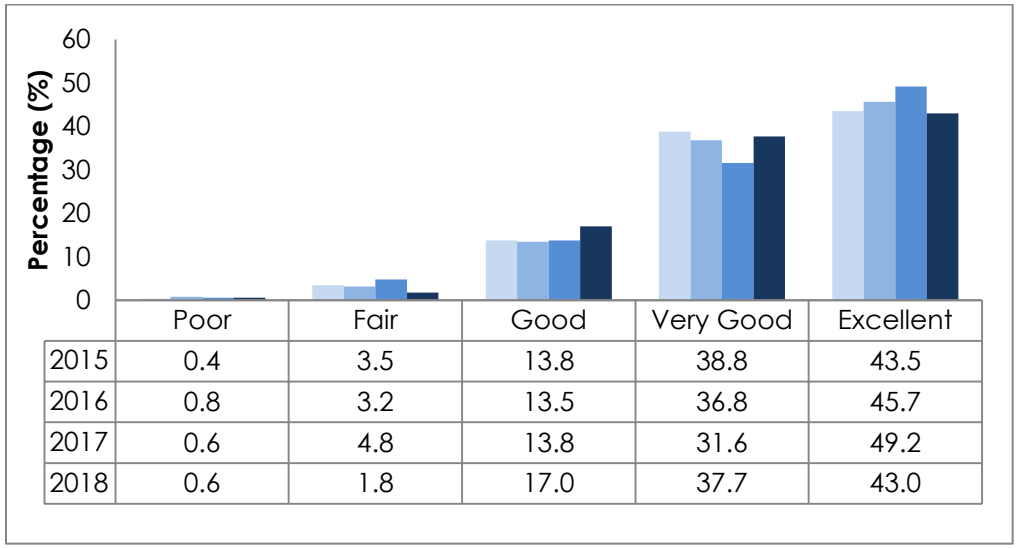
Satisfaction

When asked to rate the care and services they received at Access Alliance, respondents reported a high level of satisfaction, with 97.6% (n=507) reporting 'good', 'very good', or 'excellent' across all sites (Table 1).

Location	Percentage Satisfied
APOD	97.1% (n=244)
APOJ	99.3% (n=149)
College	96.8% (n=94)
Barrington	95.0% (n=20)
Total	**97.6%** (n=507)

Table 1: Percentage of satisfied clients across sites

Figure 2 demonstrates how these satisfaction ratings have fluctuated since 2015. The proportion of 'poor' and 'fair' ratings has generally reduced over time which is a positive result. Also, while more people are rating Access Alliance as 'good' and 'very good', fewer people are rating it as 'excellent'. When asked if they would recommend Access Alliance services to friends or family, 97.6% (n=506) of respondents said they probably or definitely would. When combined, these two indicators create a composite indicator of yielding an overall satisfaction rating of 95.7% (n=506).



	Poor	Fair	Good	Very Good	Excellent
2015	0.4	3.5	13.8	38.8	43.5
2016	0.8	3.2	13.5	36.8	45.7
2017	0.6	4.8	13.8	31.6	49.2
2018	0.6	1.8	17.0	37.7	43.0

Figure 2: Trend analysis of overall satisfaction (2015-2018)

Several drivers of client satisfaction emerged from the qualitative analysis (i.e. focus groups and open-ended survey questions), including:

- Staff characteristics such as patience, friendliness, helpfulness, and respect;
- The effectiveness and variety of programs;
- Perceived high quality of healthcare services; and
- The organization's focus on equity and anti-oppression.

"When I needed it the most and I didn't have health insurance, I was well-attended. When I most needed it, I received a lot of care and attention. I love this community."
-survey comment

A statistical analysis of the quantitative data (factor analysis) was also carried out. Interestingly, the themes that emerged through the factor analysis overlay the qualitative findings quite well, reinforcing these findings as drivers of satisfaction:

- Individual staff and service providers' behaviour
- Population/community health focus
- Need-based programming and service delivery
- Cultural sensitivity

When discussing reasons for dissatisfaction with Access Alliance programs and services, multiple clients speculated that staff may be overworked, implying that this may result in low client satisfaction ratings. They also highlighted logistical issues such as scheduling concerns, difficulty around reaching the organization on the phone, and the need for more streamlined information-sharing among frontline staff.

Accessibility

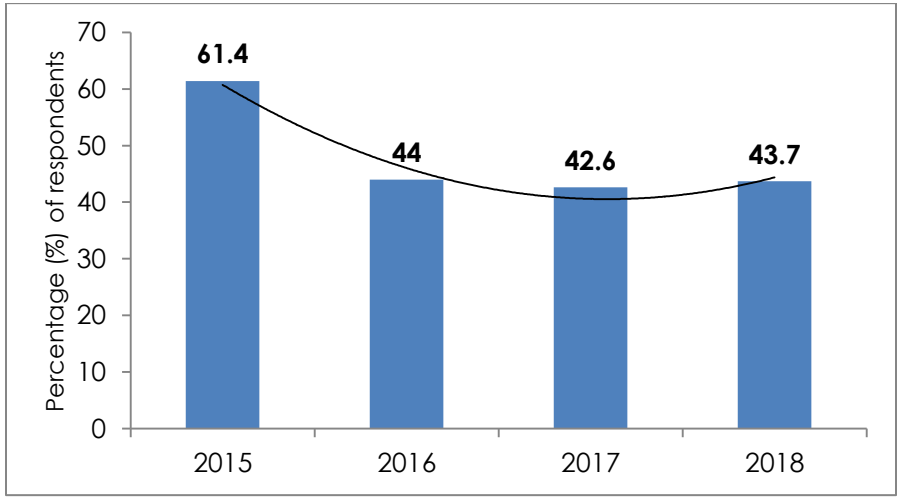
In terms of physical accessibility, 97.6% (n=503) of survey respondents agreed that it is easy for them to travel to the Access Alliance location they visit most often, and 97.2% (n=505) agreed that the hours of service at that location meet their needs. Regarding the physical design of Access Alliance locations, several clients expressed frustration at having to leave strollers outside in a non-sheltered area during inclement weather. Other accessibility measures that assessed the functionality of programs and services were rated fairly well overall (Table 2). However, another common source of dissatisfaction regarding accessibility was that childcare was not offered at all programs, making participation difficult for parents of young children.

> ***"Please let we keep our strollers in during winter and rain."*** - Survey comment

Indicator	% who responded 'always'/'often'
Can get an appointment when needed	73.6% (n=477)
Staff explain things in a way that is easy to understand	81.3% (n=470)
Staff are easy to talk to/encourage questions	83.1% (n=503)
Know how to make a suggestion or complaint	80.6% (n=495)
Received services in their language of choice	70.4% (n=142)

Table 2: Client satisfaction with accessibility indicators

Primary care clients were asked additional questions regarding clinical accessibility. Of these respondents, ***87.8% (n=238) said that the last time they were sick or concerned they had a health problem they were able to get an appointment on the date they wanted*** and ***43.7% (n=231) of respondents said they were able to book an appointment for the same day or next day***, an increase of 1.1% from the previous year (Figure 3).



"I went to…Access, that was last year…but I really needed a doctor, and they told me the person who would see me was fully booked for 3 months." - LGBTQ focus group participant

Figure 3: Percentage of survey respondents who got appointments on same or next day

When discussing the number of waiting days to get an appointment, clients expressed frustration at the length of time they were required to wait. Thus, while clients were satisfied with the quality of primary care services, they were simultaneously dissatisfied with the time it took to access these services.

Effectiveness

Through program and service delivery, Access Alliance aims to positively impact clients' physical, mental, and social well-being, as well as the population health of the communities it serves.

"If I stay home I feel like a stress. If I come here, if I uh, join the yoga, or Zumba, I feel free of stress…and I make a lot of friends, so like uh, my community, and I speak only English here. I also learning English too. It's helping to me."

-APOD focus group participant

Some important metrics in this evaluation are those associated with the effectiveness of these efforts. **When asked if the programs and services at Access Alliance have helped them improve their health and well-being, 89.5% (n=497) of clients agreed or strongly agreed**. In terms of physical health and well-being, many clients noted that food and nutrition programming, especially community cooking activities, had helped them improve their physical health. Many clients expressed similar feelings around opportunities for physical activity (especially yoga and Zumba classes), and quite a few mentioned the positive impact of diabetes education programming. When asked to rate their own physical health, 45.1% (n=506) reported that it was excellent or very good, while 36.8% reported it as good, 13.8% as fair, and 4.3% as poor. In terms of mental health and well-being, clients discussed a variety of mental health concerns (commonly noted were stress and mood disorders) with which Access Alliance had helped them to cope, either via counselling or participation in other programming. When asked to rate their own mental health, 53.3% (n= 501) reported that it was excellent or very good, while 31.7% reported it as good, 12.0% as fair and 3.0% as poor.

> ***"Downtown, no my culture. And I am very alone there. I can't feel good. I come here, I am very good here. After I go back, OK, no problem."*** -APOD FG participant

> ***"Everybody at home alone, no family here, no cousin or anything, but when you come see family, friends. Happy, laughing, talking."*** -APOD FG participant

In terms of social well-being, a recurring theme expressed by participants in this year's survey process was the sense that Access Alliance was like a "second home," or a place where clients felt welcome and among friends. Clients discussed feeling isolated as newcomers without family members living nearby, and feeling that Access Alliance decreased this sense of isolation. Several clients also spoke of volunteer opportunities and other chances to build leadership skills at Access Alliance having positive effects on their well-being. **Finally, in terms of population health, 90.9% (n= 497) of clients agree or strongly agree that Access Alliance has a positive impact on their community.**

> ***"Access Alliance has a positive impact on people belonging to the LGBTQ community. I feel safe while there. Very free, loved, inspired and this gives me a sense of belonging."*** - Survey comment

Equity and Anti-Oppression

Several questions on the survey assessed the degree to which Access Alliance is anti-oppressive and treats clients equitably. For example, 97.8% (n=505) of survey respondents indicated that they always feel comfortable and welcome

at Access Alliance (a measure of equity). Similarly, 91.5% (n=507) agreed or strongly agreed that Access Alliance staff members treat them with dignity and respect, 91.4% (n=502) agreed or strongly agreed that staff respect their culture, and 88.8% (n=500) agreed or strongly agreed that staff respect their spiritual or religious beliefs. The latter three indicators were combined, to create a composite indicator for anti-oppression which yields a score of 94.2% (n=498). Reinforcing this, a recurring theme in the qualitative responses was that clients described Access Alliance as a safe space. As noted above, they also expressed that Access Alliance represented a welcoming environment, and multiple respondents noted specifically that the organization is multi-cultural and provides services to people without health insurance.

"They treat me with respect. I get to see a doctor when I didn't have document." - Survey comment

"It welcomes everybody irrespective of cultural background or country." - Survey comment

However, clients did raise some concerns around inequity within Access Alliance. Many of these concerns centred around the behaviour of frontline staff. More specifically, multiple clients reported experiencing or observing incidents of frontline staff members exhibiting poor customer service or judgmental behaviour toward clients with disabilities, clients with language barriers, and clients who are members of the LGBTQ community (especially trans clients). As well, while many LGBTQ clients appreciated Access Alliance's LGBTQ programming, many also noted that they did not always feel welcome at the agency as whole. They expressed frustration at a perceived divide between LGBTQ programming and other aspects of Access Alliance, in the sense that LGBTQ programming was treated as an afterthought by the organization, and that some staff members might harbour homophobic or transphobic attitudes.

"Is this LGBTQ program here the equivalent of an after school program, where it's not really in the curriculum and you're just, you know, kind of giving it a little space. And if that is the case, I think it needs to be re-worked, there needs to be staff placed directly in…so that, you know, we don't feel like the adopted child who comes here when the lights are off." - LGBTQ focus group participant

Finally, when asked if they trusted staff to keep personal information confidential, 90.2% (n=502) of respondents agreed or strongly agreed. Qualitative findings indicated that some Access Alliance clients have privacy concerns surrounding

printing and scanning services at the Computer Resource Centre. Specifically, clients raised concerns around the lack of a shredder or other means to dispose of sensitive documents, and the perception that no measures exist to prevent the possibility of staff members and volunteers reading client documents while operating the scanner. This indicates that a gap exists in privacy and confidentiality procedures at Access Alliance.

Patient/Client-Centeredness

Primary care clients were asked to respond to questions measuring the patient-centeredness of Access Alliance (Table 3). When asked how often healthcare staff give them an opportunity to ask questions about recommended treatment, 85.8% (n=240) responded always or often. Similarly, when asked how often staff involved them as much as they want to be in decisions about their care and treatment, 89.0% (n=237) responded always or often. Finally, when asked how often staff (e.g. MD or NP) spend enough time with them, 91.6% (n=238) answered always or often. When these three questions were combined to create a composite score patient-centeredness, the overall rating was 94.1% (n=237).

All respondents, regardless of whether or not they accessed primary care services, were asked how often the programs and services meet their needs—to which 80.2% (n=491) answered always or often (Table 3). They were also asked how often staff help connect them to the services and programs they need, at Access Alliance or in the community—to which 78.9% (n= 492) answered always or often. Clients also offered a variety of suggestions for how programs and services could further meet their needs. These are detailed in the Client Suggestions section below. Suggestions included requests for more funding, staff members, specialized healthcare professionals, streamlined intake and appointment processes, programs, and outreach.

Indicator of Patient/Client Centeredness	Respondent group	% who responded 'always'/'often'
Have the opportunity to ask questions about treatment	PC Clients only	85.8% (n=240)
Are involved in decisions about care/treatment	PC Clients only	89.0% (n=237)
MD/NP spends enough time with them	PC Clients only	91.6% (n=238)
Programs/services meet needs	All Clients	80.2% (n=491)
Staff connect them to programs/services needed	All Clients	78.9% (n= 492)

Table 3: Satisfaction with indicators of patient and client centeredness among respective clients

Client Suggestions

Resource Investment

Many clients described how additional resource investment would improve Access Alliance's programs and services (Table 4). These included human resources (e.g. additional primary care and program staff, volunteers), financial resources, equipment (e.g. advanced medical equipment), food for programs and staff training (e.g. equity and customer service training for front-facing staff). Related to this, many clients requested extended hours of service, such as on the weekend and in the evenings.

Type of resource investment	# times suggested (qualitative data)
Human resources	19
Financial resources	6
Equipment	5
Food	3
Staff training	1

Table 4: Client suggestions around additional resource investment

Outreach

Clients identified outreach and publicity as an opportunity for improvement. This opportunity is further demonstrated by the many requests made by clients for programs that already exist at Access Alliance (e.g. youth programs, seniors' programs, etc.). The optimal outreach mediums suggested by clients are shown in Figure 4.

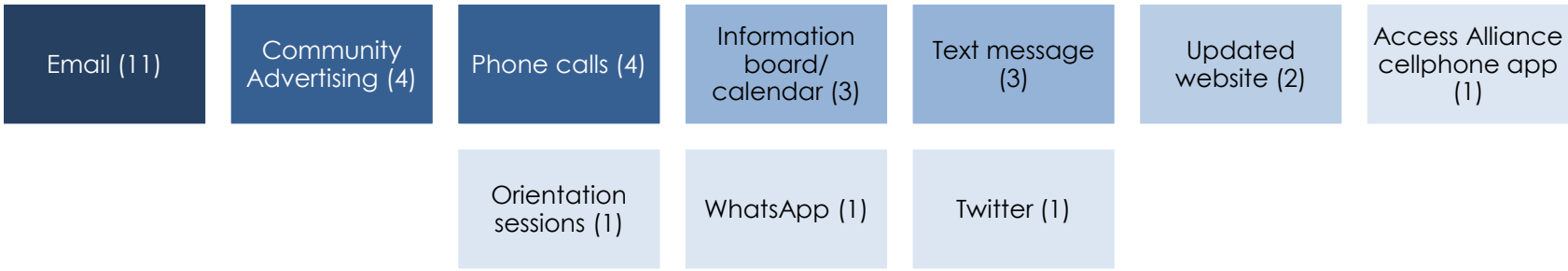


Figure 4: Client suggestions around outreach and publicity

Focus group participants suggested introducing orientation sessions to help familiarize the community with Access Alliance programs and services, elaborating that these sessions could be catered to the general community as well as to particular communities with unique needs (e.g. one specific to LGBTQ newcomers). Clients also expressed that newcomers could gain from learning about Access Alliance's services prior to arriving in Canada.

Additional Programming

Clients offered many insights around programming. These included suggestions for new programs, as well as suggestions around publicity for and expansion of existing programs (Figure 5).

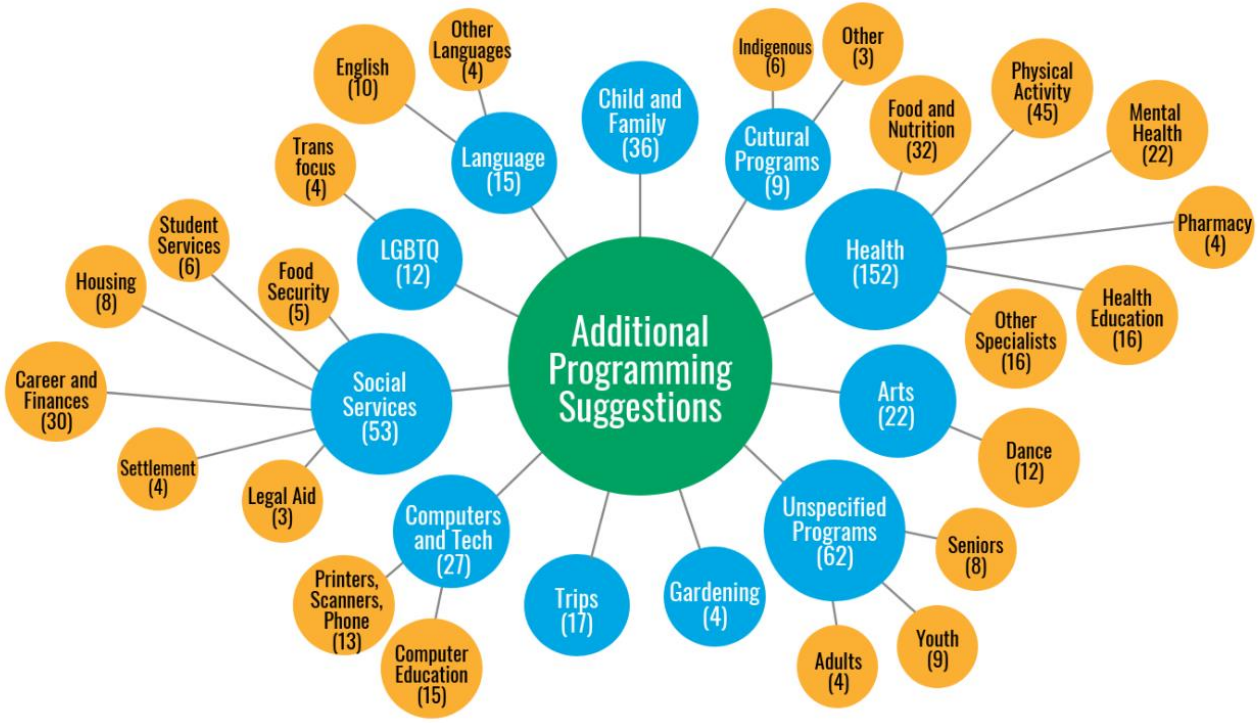


Figure 5: Client suggestions for new programs, expanded programs and additional program publicity

Knowledge Sharing & Feedback

Reporting the findings back to staff, as well as clients and the broader community, is an important step in validating and contextualizing the ideas and observations. Moreover, this activity allows different groups to become familiarized with the findings, supporting the creation of meaningful planning implications. A structured knowledge mobilization plan was followed as the final stage of the process (Annexure E). Tailored sets of findings were shared to these key stakeholder groups, and their feedback was gathered and compiled for this report. As a final accountability piece, the report will be shared with the Quality Governance Committee in November 2018 and to the Board of Directors in January 2019. Once approved, the report will be published for open access on the Access Alliance website, and findings shared with HQO, TC LHIN, and the sector, as required.

Report Back to Clients and the Community

Key findings were presented at both east and west site Community Reference (CRG) Group meetings, where clients and community members are invited to attend on a quarterly basis to enhance the quality improvement processes of Access Alliance. Members were briefed on how they represent key stakeholders in the overall CES process, and that their feedback on the findings influences program and service delivery and improvement at each site. These forms of client insight are also recorded in meeting minutes which are used directly for Hub planning. At APOD, approximately one third of participants remembered completing the survey, and at APOJ, approximately half (a measure of reach).

Overall, the specific findings were not overly surprising to CRG members, and they were in general agreement that they aligned with their own experiences at Access Alliance. In particular, the high satisfaction scores resonated well with them. Several newer members at each site were surprised to hear Access Alliance offers the range and depth of services mentioned in the presentation. Others described how they had lived in the surrounding neighbourhood for years before discovering the hubs existed.

This led into a deeper discussion around one specific opportunity for improvement that came out of the CES qualitative findings: the need to improve program promotion and outreach. Members were asked to describe their preferred methods to hear about new programs/updates; at APOD, the overall preferred methods were email and phone calls, and at APOJ, the preferred method was advertising in the community. APOJ CRG members went on to provide

suggestions for community-specific strategies for publicity (including flyers posted on the outside of buildings, public spaces such as grocery stores and laundromats, on the Blackcreek CHC bulletin board, and in the apartment buildings behind AccessPoint on Jane). They also highlighted which methods are currently effective (e.g. one member found out about Access Alliance through a flyer placed in her food box from her local food bank).

Report Back to All Staff

Findings that were relevant to all staff from diverse teams (e.g. community programs, primary care, administration/front-line, research, etc.) were presented at the monthly All-Staff meeting. Taking into consideration the scores around satisfaction and equity were so high (97.6% and 97.8%, respectively), staff were asked to reflect on what actions may have been taken by staff as individuals, or in teams, that they believed have had a positive impact on clients' experiences. They were then asked to share those most that were the impactful and transferable between teams. Four key themes emerged around current behaviours and practices, as well as current and suggested strategies for how we can improve.

Table 5: Staff behaviours and strategies for positively influencing the client experience

Key Theme	Examples of behaviour (individual)	Examples of strategies (team-based/structural)
1. Treat clients equitably within an anti-oppressive environment	• Be welcoming/ friendly/ approachable/ cooperative/ smiling when greeting all clients	• Diversity among staff, representative of the community
2. Respond to client needs efficiently and resourcefully	• Handle complaints/concerns in a timely manner • Be proactive in problem solving (think two steps ahead, go the extra mile)	• Engage volunteers more • Share/collaborate around conflict resolution (utilize other staff's skills to collectively solve problems)
3. Respond to client needs effectively and using evidence	• Provide clients with opportunities to ask for help (e.g. if they look lost, direct them) • Listen to community members (i.e. through surveys, suggestion box, complaint forms, managers, Community Reference Groups)	• Have a conversation with clients about setting and managing expectations (e.g. accommodating appointment times and clients' time, outlining program expectations, etc.) • Diversify communication strategies (e.g. Facebook groups for programs)

4. Ensure and improve access	• Provide assistance whether or not a client is scheduled (give them that time) • Be flexible when seeing clients/accommodate those with urgent needs by squeezing them in on the same day	• Reducing wait time is crucial to providing good service • Look at answering services/voicemail to allow patients to call in easier to call or for emergencies

Report Back to the Primary Care Team

Primary-care specific findings were presented at the monthly Primary Care team meeting (MDs, NPs, RNs, management), including satisfaction reported by patients, and indicators around accessibility and patient-centeredness. Discussion took place around what are current methods and strategies that support high performance, with a focus on one reportable indicator: '*Patient feeling involved in decision-making about their care and treatment*'. Staff were invited to refresh a list of best practice techniques and their corresponding actions that was developed in 2017:

Table 6: Clinical best practice techniques for client feeling involved in decision-making

Reportable Indicator	Best Practice Technique	Action/Statement
Patient feeling involved in decision-making about their care/ treatment	a. Give them options (although often patients just want the SP to tell them what to do)	
	b. Ensure that patient understands they have a choice to follow the recommendations provided	"These are recommendations only, you have the choice to do it or not"
	c. Give the patient time to make their decision	Offer to revisit after some time, e.g. in 3 months
	d. Ensure that patient understands we want them to be involved in decision-making (vs. because we have to)	After providing recommendations, ask for their opinion/input; "We would like to know your opinion"
	e. Ask the patient to reflect on the options provided	"How does that sit with you?"
	f. Give the patient a sense of control by being flexible with the logistics of the options offered	Where there is flexibility around the technical specifications of a certain treatment, E.g. for taking medicine, would you prefer to take it with milk? Two options for medications, which would you prefer?

Staff were also invited to discuss any techniques that they may require support to continue doing, with the goal of identifying professional development (PD) needs. For example, challenges and strategies were discussed around how to effectively manage the conversation '*Is there anything else I can help you with?*' with patients. Several PD activities that have taken place over the past year to support clinical providers included: Motivational interviewing; Choices and Changes: Motivating Healthy Behaviours; and Choose Health - the Self-Management Program for the TC LHIN region. The next step is to report these best practice techniques in the 2019/2020 Quality Improvement Plan to Health Quality Ontario.

Conclusion

Overall, satisfaction scored very high across all sites. Programs and services are varied and effective in improving clients' physical and mental health/well-being, as well as in reducing social isolation, and building leadership and skills. In this way, Access Alliance has a positive and recognized impact on the surrounding communities. The agency delivers high quality primary care services, where patient-centeredness is prioritized through individual provider behaviour as well as ongoing professional development for supporting clients' needs. Access Alliance is considered a safe space for most; however, more training around anti-oppression and customer service for front-line staff could improve some of the more marginalized clients' experiences (such as LGBTQ+ clients, those with disabilities, etc.). In addition, some privacy concerns at the Community Resource Centre were identified, which the purchase of a shredder could help to resolve. Lastly, program promotion and outreach has been identified as a key opportunity for improving clients' awareness of existing programming as well as to build and promote the agency's presence in surrounding neighbourhoods. Clients were often surprised to hear of the wealth of programs and services offered, and wished they had known about Access Alliance sooner. In addition to more intentional program promotion by staff, a dedicated promotion/outreach plan that can be tailored to the needs of each site would be effective in this area.

The 2018 Client Experience Survey captured clients' experiences as measured by, but not limited to, their satisfaction. This process also worked to capture clients' expectations around the services/programs they receive which can be mapped against the experiences captured in the 2019 survey. The direct involvement of staff, clients, and the community in processing these findings has provided insight and context, laying the ground work for future planning that is more effective and grounded in evidence.

Appendix A: Materials & Methods

A concurrent mixed method design was used for this evaluation. It integrated the following forms of inquiry to answer the evaluation questions:

1) One self-administered paper-based survey including quantitative as well as open-ended questions
2) Three focus groups with Access Alliance clients to contextualize findings from survey

This design was selected because the qualitative findings explain, provide context to and develop depth for quantitative findings. It allows for better answers to how and why questions and provides a more comprehensive and useful account of the situation than just one method alone. A triangulation design was also employed; the survey instrument and the focus groups were both conducted during the data collection period. In this way, the findings from one method did not influence the findings of the other. Rather, together, they provided more information to enhance discussion of the same evaluation question.

Who completed the survey?

Clients were eligible to participate in CES activities (survey and/or focus group) if they had used Access Alliance's programs or services at least once prior to participation. Ineligible programs and services include the Community Resource Centre (CRC) as well as services hosted by external agencies at Access Alliance sites (e.g. EYET). Surveys completed by respondents who did not meet the age requirements of particular programs were excluded from the data (i.e. senior program, youth program).

Surveys were collected using a stratified convenience sampling approach; 245 (48.2%) of surveys were collected from AccessPoint on Danforth (APOD), 149 (29.3%) from AccessPoint on Jane (APOJ), 94 (18.5%) from the College site and 20 (3.9%) from the Barrington site. This is a rough reflection of Access Alliance's client distribution across sites. It was also stratified by gender to be representative of Access Alliance's clientele. The CES team aimed to collect 60% percent of the surveys from women and 40% from men. However, female respondents were slightly overrepresented in the data (Table 7).

Gender	Number of Respondents
Female	318 (62.%)
Intersex	2 (0.4%)
Male	169 (33.4%)

Transgender	5 (1.0%)
Two-Spirit	0
Other	2 (0.4%)
Prefer not to answer	10 (2.0%)
Total	508

Table 7: Overall distribution of Access Alliance clients by gender

Survey collection was also stratified by program and service use. The CES team intended to collect a maximum of 60% of surveys from clients who have used primary care surveys. Among respondents, 266 (52.4%) used primary care.

Surveys were collected from clients above the age of thirteen. The CES team adhered to the guidelines outlined in "TC LHIN CHC Demographic Data Collection of Children & Youth" when collecting surveys from clients under the age of eighteen.

Survey tool

There were 32 main questions in the survey and 51 including sub-questions. Among these, five were open-ended questions (12gi, 14a, 17, 18, 32). The questions speak to the following indicators:

- Physical accessibility
- Design
- Wait times
- Equity
- Effectiveness
- Community health
- Client-centeredness
- Patient-centeredness for primary care clients
- Anti-oppression

The survey included an informed consent statement explaining the agency's privacy, confidentiality and data security policies to which the tool adhered. The survey tool was translated into five of the six top languages spoken at Access Alliance: Arabic, Bengali, Farsi, Portuguese and Spanish. The one top language for which a translated survey was unavailable is Sgaw; this is due to the fact that Language Services did not have access to a Sgaw interpreter this year.

However, Remote Interpretation Ontario (RIO) services were made available for the translation of surveys into languages in which surveys were not available.

Only those surveys where mandatory questions were completed were considered for analysis (Table 8).

	Mandatory Survey Questions
Health Quality Ontario (HQO)	8a, 8b, 9b
Toronto Central Local Health Integration Network (TC LHIN) Data Insight	8a, 8b, 9a, 9b, 9c, 14, 17, 12g
Alliance for Healthier Communities (AFHC)	9b, 19a, 19b, 13, 14
Canadian Centre for Accreditation (CCA)	10d, 5, 6, 16, 12f

Table 8: Mandatory Client Experience Survey questions

Volunteer Orientation

Survey Collection

Five orientation sessions introducing volunteers to the survey collection process were conducted. This included two group sessions and three one-on-one sessions. These sessions covered:

- Agency mission, vision and values
- Purpose of the Client Experience Survey project
- Summary of previous year's survey findings
- Ethical considerations
- Survey collection instructions
- RIO

Volunteers were given the opportunity to rehearse the survey administration procedure. Lastly, they signed up for volunteer shifts. Each volunteer was provided an information package including:

- Collecting Demographic Data from TC LHIN CHC Clients under 18
- Participant recruitment script
- Volunteer surveying checklist
- Comment form

- Glossary of terms related to gender and sexual diversity
- FAQ volunteer information sheet
- Survey tool

Data Entry

One group session was conducted with volunteers interested in being involved in data entry. This session focused on:

- Viewing and editing data and variables in SPSS
- Mixed methods research methodology
- Minimizing errors during data entry

Data Analysis

One group session was conducted with volunteers interested in being involved in the data analysis portion of the project. This session focused on quantitative analysis. It covered the data analysis plan. It ended with a demonstration of relevant descriptive analysis functions on SPSS:

- Simple frequency
- Selecting cases
- Computing and recoding variables
- Creating new variables

Data collection process

Survey collection

Thirteen volunteers were involved in survey collection. Survey collection began on the day of the Client Experience Survey launch: Thursday May 17th at Jane, Danforth and College sites. The CES team, Access Alliance management and employees as well as clients attended.

At the Danforth location, survey administration lasted until June 1st, 2019 at the College site until June 29th and at the Jane site until June 14th. All surveys collected at the Barrington site were administered by an Access Alliance Community Health Worker from her program participants.

At each site, the survey station consisted of a table and Client Experience Survey box. Each box consisted of:

- Standardized surveys in all languages
- Pens and pencils

- Clipboards
- An envelope for completed surveys
- Survey tracking forms
- Gift card receipt forms
- *Collecting Demographic Data from TC LHIN CHC Clients under 18* form
- Participant recruitment script
- Volunteer surveying checklist
- Comment form
- Glossary
- FAQ volunteer information sheet
- Survey tools in Arabic, English, Bengali, Farsi, Portuguese and Spanish
- RIO calls tracking sheet
- Phone splitter
- Tim Hortons $5 gift cards

At each table there was a phone that could be used to call RIO for support in translating the survey tool into languages other than the six in which translations were available.

After setting up the survey station, volunteers recruited participants for the survey by:

- Approaching clients in the clinic reception area
- Introducing themselves
- Describing the purpose of the survey
- Ensuring privacy and confidentiality by explaining that their participation is voluntary, and that the information collected will remain anonymous and confidential
- Offering $5 Tim Hortons gift cards as incentive for participation
- Providing the participant with the option to fill the survey out in the language of their choice or to use RIO

After the surveys were completed, they were reviewed for completion. The site was indicated on the top-right corner of the first page, and the completed surveys were put into an envelope. To ensure privacy and confidentiality, the survey station and CES box were not left unattended at any point. At the end of the day, the box was returned to staff. Each volunteer was given two tokens at the end of the shift.

Focus group

Those participants who filled out surveys were invited to also participate in focus groups at APOD and APOJ. In order to recruit participants, volunteers:

- Provided details regarding date, time and location
- Offered the provision of healthy snacks, free childminding services and TTC tokens during the focus group as an incentive for participation

Participants for the LGBTQ focus group were recruited by Ranjith Kulatilake, Community Health Worker, LGBTQ+ Newcomer Initiatives. Those survey respondents who expressed interest in participating in the focus group were asked whether they required childcare, and if so, how many children would attend the focus group and their ages. They were also asked whether they required interpretation services, and if so, their preferred language.

The LGBTQ focus group took place May 31st from 1 to 3pm, the APOD focus group took place on Saturday June 23rd from 10am to 12pm, and the APOJ focus group took place on Thursday June 28th from 5 to 7pm. In total, twenty-five Access Alliance clients participated in the focus groups: ten at the LGBTQ focus group, fifteen at the APOD focus group, and ten at APOJ focus group. In order to be eligible to participate in these focus groups, participants had to have accessed programs or services at Access Alliance prior to April 2018 at least once and had to have filled out the paper-based survey in 2018. Any participants who had yet to complete a survey were required to complete it during the preamble, before the focus group took place. This was done in order to maintain comparability and consistency of findings between different components of the survey process. Following introductory remarks by the focus group facilitators regarding voluntary participation, audio recording, privacy and confidentiality, participants filled out informed consent forms ensuring they understood benefits, potential harms of participating in the focus group as well as that their privacy and confidentiality would be ensured to the fullest extent. They also filled out anonymous demographic forms.

The LGBTQ+ program facilitator facilitated focus group enrollment by informing program participants about the focus group, but was absent during the focus group; it was facilitated by the project coordinator and supported by a practicum student. The session was held in a location separate from the usual areas where LGBTQ+ programming is held at AccessPoint in Danforth. At APOD, the focus group was conducted by the project coordinator, and supported by a volunteer. The APOJ focus group was facilitated by one practicum student and supported by another practicum student and the project coordinator. The semi-structured focus group discussion was built around questions related to five guiding themes: accessibility, effectiveness, equity, client-centeredness, and satisfaction. With the consent of the participants, all three sessions were audio-recorded using two recorders. After the focus group, recordings were transcribed and then anonymized following standard Access Alliance procedures for handling confidential data.

Data Entry

The Project Lead revised a variables framework for analysis on SPSS analytical software. Once data collection was complete, five practicum students and volunteers were involved in the data entry process. Among the 530 surveys collected, 508 were complete (95.8%). A complete survey is defined for the purpose of this project as a survey with responses for all HQO and TC LHIN questions as well as TC LHIN recommended equity questions.

Staff helped to informally translate comments made on translated surveys.

The coordinator and one practicum student then reviewed a random selection of 20 surveys to for quality. Only one error was encountered. Next, the data was cleaned. This involved ensuring:

- data categories were mutually exclusive
- age appropriate services: those folks above the age of 24 who checked off the youth program option, it was ensured that they were not too old to have used it when they started coming to access. For those who checked off senior program, it was ensured they were above the age of 65.
- Folks who indicated they used only non-agency services or the CRC (i.e. computer services) were excluded

Data analysis

Quantitative analysis

SPSS software was used to conduct the following advanced statistical analysis:

- Unique indicators across sites and at each individual site
- Composite indicators

Qualitative analysis

Qualitative data analysis was conducted by the project coordinator and a practicum student. The practicum student transcribed the focus groups. The transcripts were anonymized and raw transcripts were stored in a safe location. They both used NVivo software to code the clean transcripts and the comments from the open-ended questions in the survey. Initially, they created a priori codes based on the focus group themes. Next, they collaboratively coded one transcript in order to develop a coding framework together. Then, they coded the other materials independently. Codes were added throughout the qualitative analysis process.

Risks & Mitigation Strategies

The following risks were predetermined. Mitigation strategies were developed for each risk.

Risk	Mitigation strategy
Social expectation bias	- Evaluation conducted by team of third party project coordinator, practicum students and volunteers - No Access Alliance staff present during focus group discussions - Conducting focus group discussions in spaces different from where regular programming is held
Selection bias	- Offer survey tool in various languages as well as RIO services
Data entry errors	- Volunteers perform data entry in pairs

Table 9: Risk framework for Client Experience Survey

Appendix B: Survey Respondent Demographics

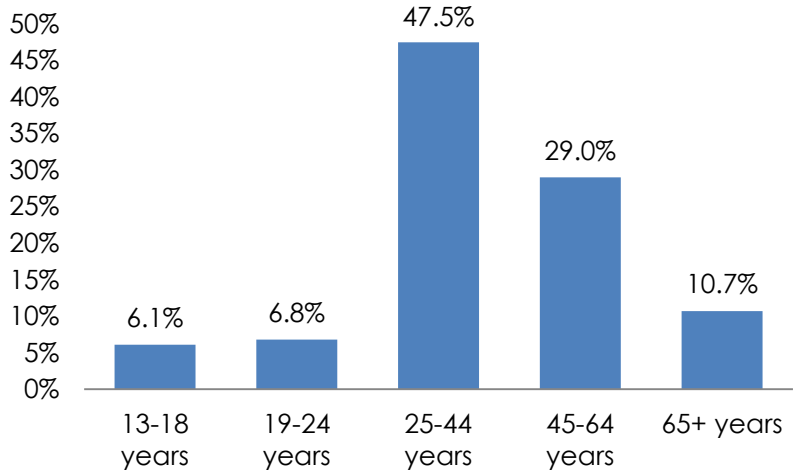


Figure 6: Percentage of clients by age (n=459)

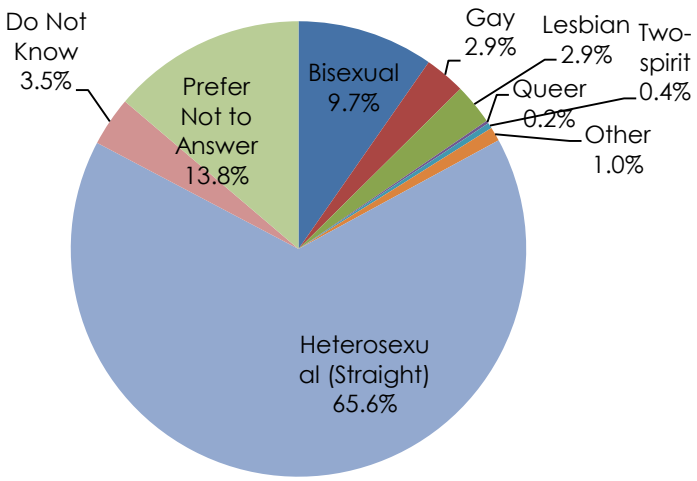


Figure 8: Percentage of clients by sexual orientation (n=487)

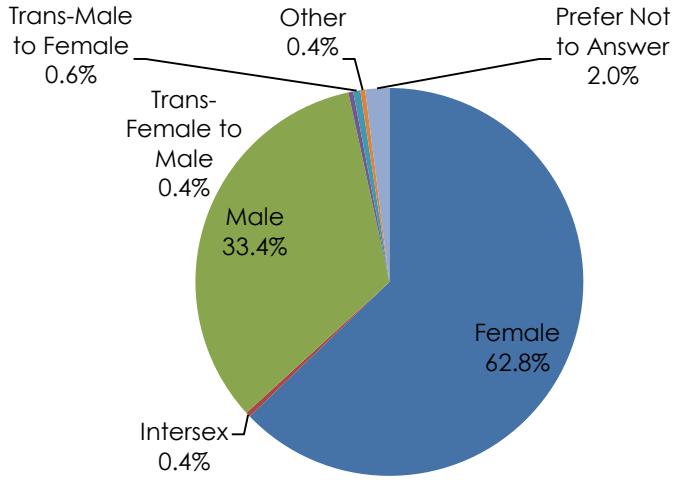


Figure 7: Percentage of clients by gender (n=506)

Language	Percentage of Clients Indicating this is their Preferred Language
Portuguese	6.0%
Spanish	4.7%
Karen/Sgaw	3.2%
Bengali	3.0%
Farsi	3.0%
Arabic	2.6%
Dari	1.1%
Vietnamese	1.1%
Somali	0.9%
Urdu	0.6%

Table 10: Percentage of clients by preferred language (n=467)

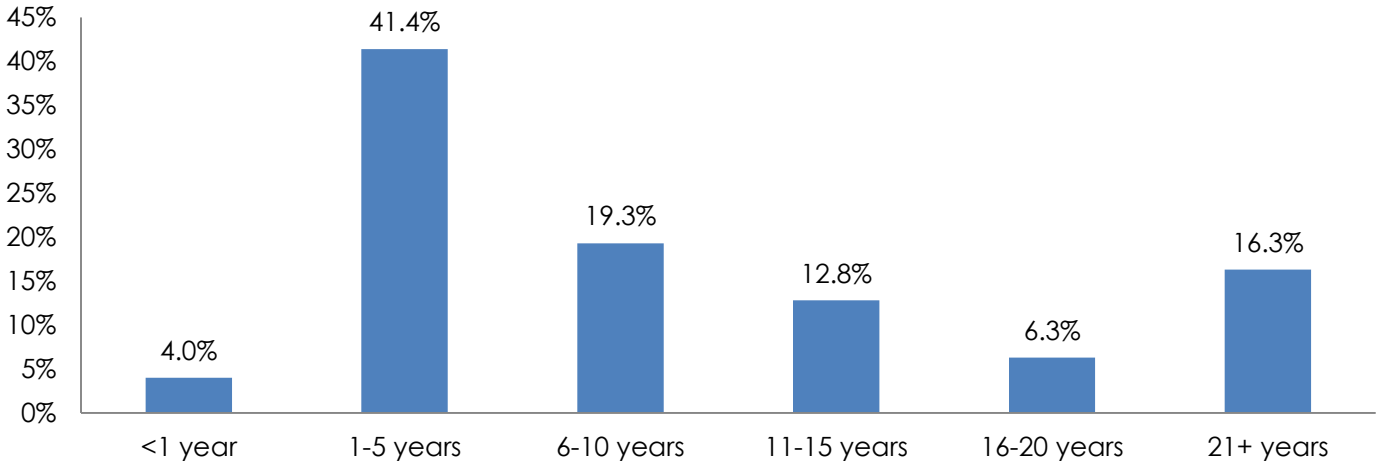


Figure 9: Percentage of clients by length of stay in Canada (n=430)

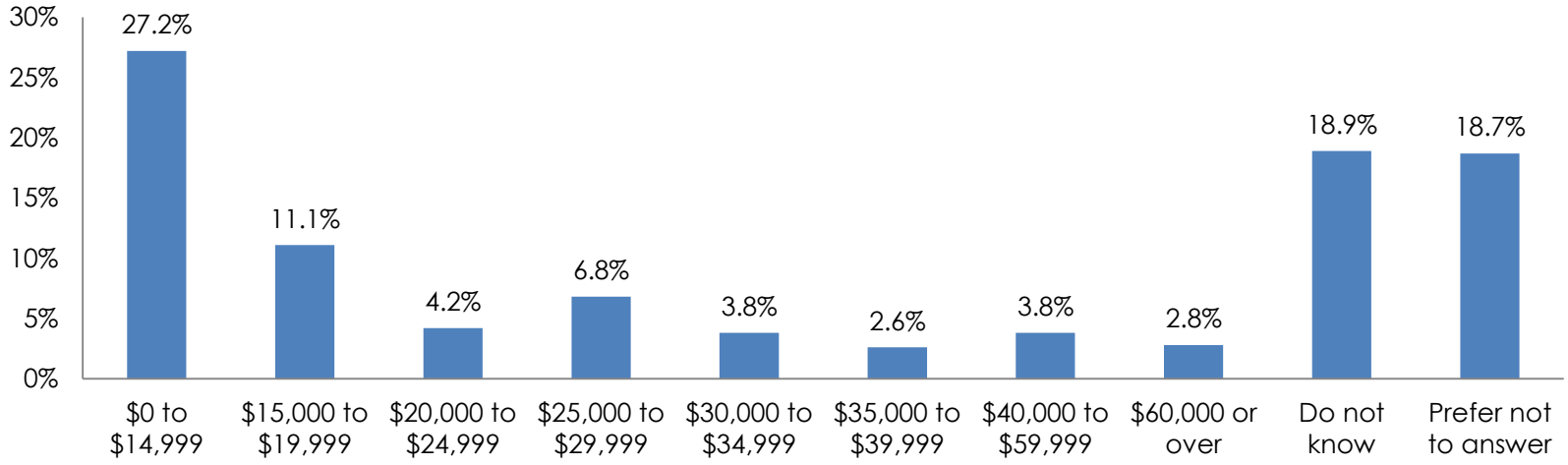


Figure 60: Percentage of clients by total annual family income before taxes (n=497)

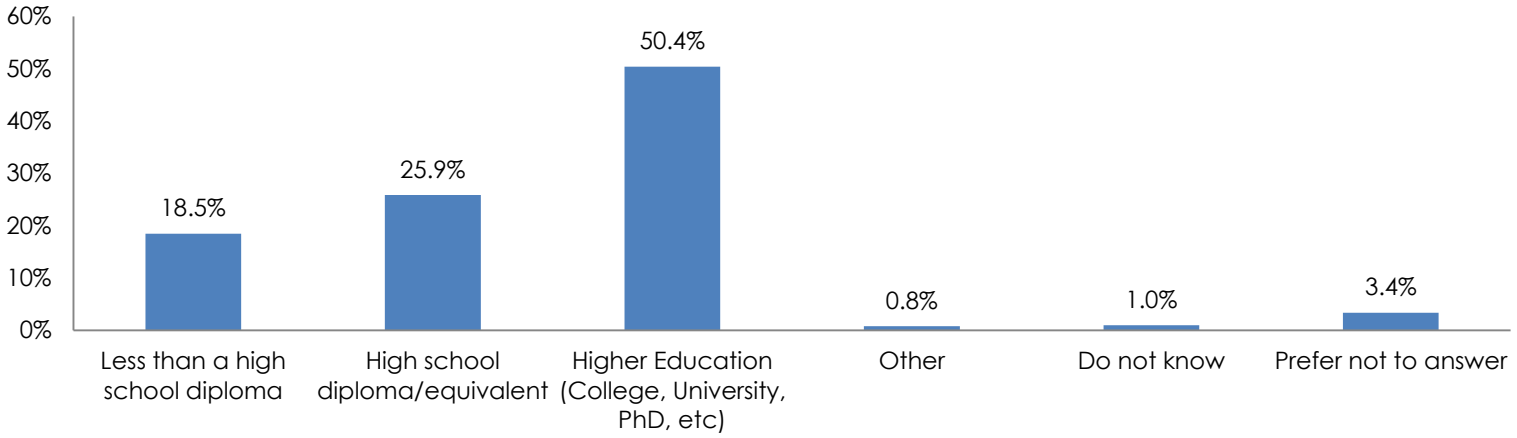


Figure 7: Percentage of clients by highest level of education completed (n=502)

Appendix C: APOD & APOJ Focus Group Report

Introduction

Three focus groups were conducted in order to contextualize survey findings. One was conducted with LGBTQ+ clients at AccessPoint on Danforth (APOD) on May 31st, 2018 and two were conducted with generic audiences at APOD and AccessPoint on Jane (APOJ). This report summarizes the findings of these two generic focus groups.

Methodology

Twenty-five Access Alliance clients participated in the focus groups conducted at APOD and APOJ; fifteen at APOD and 10 at APOJ. The former was conducted on Saturday June 23rd from 10am to 12pm and the latter on Thursday June 28th from 5 to 7pm. In order to be eligible to participate in these focus groups, participants had to have accessed programs or services at Access Alliance prior to April 2018 at least once and had to have filled the paper-based survey in 2018. Childminding services were made available to enable clients with young children to participate. Refreshments were provided to both participants and children. Two TTC tokens were also provided to each participant.
Following introductory remarks by the focus group facilitators, participants filled out informed consent forms ensuring they understood benefits, potential harms of participating in the focus group as well as that their privacy and confidentiality would be ensured to the fullest extent. They also filled out anonymous demographic forms. At APOD, the focus group was conducted by the project coordinator, supported by a volunteer. The APOJ focus group was facilitated by one practicum student and supported by another practicum student and the project coordinator.
Both sessions were audio-recorded using two recorders and recordings were later transcribed and anonymized to ensure identifying information was omitted.

Findings

Demographics

The participants ranged in age between 17 and 69, and the average age was 48.8. Among the participants, 70% identified as female, 24% identified as male, and 4% preferred not to answer. Seventy-five percent were heterosexual, 4.2% were 4.2%, 12.% preferred not to answer and 8.3% did not know. Twelve percent were born in Canada, 84% were born outside of Canada and 4% preferred not to respond to whether they were born in Canada. Among the 22

participants who were born outside Canada, the year of arrival ranged between 1994 and 2017. One participant indicated both English and Bengali as preferred languages, while all other participants indicated English. With respect to total annual family income before taxes in 2017, 34.8% belonged to the lowest bracket ($0 - $14,999), 4.3% belonged to the $15,000 - $19,999 bracket, 4.3% to the $20,000 - $24,999 bracket, 13% to the $25,000 and $29,999 bracket, 4.3% to the $30,000 and $34,999 bracket, 13% preferred not to answer and 26.1% did not know. The average number of people supported by this income was 2.9 and ranged between one and seven. Among the 24 participants who responded to the question around immigration status, 62.5% were Canadian citizens, 4.2% were non-status, 4.2% responded "Other", 20.8% were permanent residents, 4.2% preferred not to answer and 4.2% were refugee claimants. With respect to highest education level, 16% of respondents indicated they had "College certificate or diploma, trade, vocational or technical school, CEGEP", 4% did not know, 24% had a high school diploma or equivalent, 20% had less than a high school diploma, 4% responded "Other", 8% preferred not to answer, and 24% had a university degree.

Client Satisfaction

Clients at both focus groups expressed great satisfaction with Access Alliance programs and services. Satisfaction was higher at APOJ than APOD. APOJ focus group participants expressed more uncritical satisfaction, while APOD focus group participants shared more insight around opportunities for improvement. They offered some suggestions around improvement in staff behavior protocol; while the experience with frontline staff was positive overall, they recommended more cooperation, patience, supportiveness and friendliness on their part. They also mentioned that logistical issues led to mishaps and long wait times in the clinic reception area.

Accessibility

With respect to accessibility, clients felt it was convenient to travel to APOD and APOJ sites and expressed satisfaction with interpretation services. Many preferred a decrease in wait times for appointments and an increase in hours of operation during weeknights and weekends. Participants with young children also mentioned availability of a stroller parking and childminding for all programs (e.g. cooking program) would make it easier for them to participate in programming. They also recommended seating in the CRC be made more comfortable.

Equity

Overall, focus group participants expressed that Access Alliance is a space where they feel welcome and comfortable. They felt that its provision of services to some of the most marginalized members of society make it an equitable space. They also felt visuals around client rights and responsibilities emphasized the values underpinning Access Alliance. They did, however, suggest more volunteer appreciation as well as improved training for frontline staff around working with

individuals with limited English proficiency as well as individuals who are deaf or hard of hearing. They also recommended an increase in consideration around privacy and confidentiality concerns at the CRC. Lastly, they felt the lack of a space for caregivers to park strollers indicated a lack of respect for the young.

Effectiveness

Focus group participants reported participation in health education, physical exercise, language and cooking classes contributed to improvement in mental, social and physical wellbeing as well as nutritional behaviour. They also noted Access Alliance's provision of opportunities to participate in community programs led to an increase in proficiency, comfort and confidence around speaking English.

Client-Centeredness

Overall, clients felt Access Alliance's programs and services were catered to their unique needs. They did, however, suggest new programs or expansion of existing programs in the following realms:

- child and family
- computer and technology education
- cultural education (e.g. indigenous cultural education)
- gardening
- health and wellness education
- language (English, French, Arabic)
- social services
- trips and outdoor experiences
- unspecified child, adult and senior programs

They noted that additional resources (e.g. staff, funding, etc.) are necessary for program functioning. They also suggested increased outreach and publicity around existing programming would improve client participation, which would lead to further aforementioned benefits in wellbeing. Lastly, they mentioned a need for primary care providers to spend more time with them.

Appendix D: LGBTQ Focus Group Report

Introduction

In order to understand the unique needs and experiences of LGBTQ+ clients at Access Alliance, a focus group was conducted at AccessPoint on Danforth with clients who access LGBTQ+ programming at Access Alliance. This focus group was conducted on May 31st 2018, and had 10 participants. It explored the same questions and themes as the two other general focus groups which were conducted as part of the 2018 Client Experience Survey.

Methodology

Participants were recruited by Ranjith Kulatilake, Community Health Worker, LGBTQ+ Newcomer Initiatives. All focus group participants were required to also complete the Client Experience Survey if they had not already done so by the time the focus group took place. This was done in order to maintain comparability and consistency of findings between different components of the survey process. The LGBTQ+ program facilitator facilitated focus group enrollment by informing program participants about the focus group, but were not involved in any component of the focus group process.

All participants were informed that participation in the focus group was voluntary, and all provided written informed consent. All participants completed a demographic questionnaire when they arrived, in order to provide greater context for focus group analysis. The semi-structured discussion was built around questions related to five guiding themes: accessibility, effectiveness, equity, client-centeredness, and satisfaction.

With participants' consent, the focus group discussion was audio recorded. The session lasted two hours, from 1 to 3 pm. Participants received two TTC tokens, and light refreshments were provided. Childcare and interpreter services were also available upon request. The session was held in a location separate from the usual areas where LGBTQ+ programming is held at AccessPoint in Danforth. After the focus group, recording were transcribed and then anonymized following standard Access Alliance procedures for handling confidential data.

Findings

Demographics

The average age of participants was 31 years, and ages ranged from 21 to 44 years. In terms of gender, 50% were male, 30% female, and 20% trans (one participant indicated "Trans-Male to Female" and one "Trans-Female to Male"). In terms

of sexual orientation, the majority of participants identified as either gay (50%) or lesbian (30%), with one participant identifying as queer, and one as heterosexual.

All participants were born outside of Canada. The majority (70%) had arrived in Canada in 2017. All identified as refugees, with 80% identifying as refugee claimants and two others writing in refugee-related statuses in the "Other" field. All participants indicated English was their preferred language at Access Alliance.

The majority of participants had a university degree, and all had at least a high school diploma or equivalent. Of the six participants who disclosed their annual family income, all had incomes between $0 and $14,999. Of the six participants who disclosed the number of people supported by this income, all indicated that they supported solely themselves.

Client Satisfaction

Participants in this focus group expressed a high level of satisfaction with LGBTQ+ programming at Access Alliance, and with the LGBTQ+ program coordinator. Many participants were also satisfied with the quality of healthcare services Access Alliance provides. Main drivers of dissatisfaction included wait times, administrative issues, and a perceived lack of support for LGBTQ+ programming in the organization as a whole, all of which are detailed below.

Accessibility

Some participants expressed satisfaction with hours of operation, but others expressed a desire for more evening and weekend hours. There was a consensus among participants that the Access Alliance locations met their needs. Many participants identified the lack of TTC tokens provided by programs as a financial barrier making it more difficult to access programming at Access Alliance. Wait times were also identified by many participants as a source of frustration, with multiple participants detailing stories of months-long waits for appointments.

Equity

A recurring theme in this focus group was that Access Alliance's LGBTQ+ programming was a space where LGBTQ+ clients felt a strong sense of belonging and comfort. However, many participants also raised concerns that the LGBTQ+ programming was not adequately supported by other staff members or by the organization in general. There was a perception among some participants that the program may be treated as a side note or singled out for budget cuts, and that some frontline staff members may harbour homophobic or especially transphobic attitudes that impact interpersonal interaction and quality of service for LGBTQ+ clients.

Effectiveness

In terms of physical health, focus group participants discussed feeling happy to have a family doctor with Access Alliance, and an appreciation of diabetes education programming. Participants reported that counselling services helped them improve their mental well-being, but there was a discussion around the need to balance respect for appointment duration with respect for clients opening up about difficult topics during appointments. Participants also appreciated volunteer opportunities but felt that a lack of recognition for volunteers led to a decreased sense of belonging at Access Alliance.

Client-Centeredness

Focus group participants said that they used Access Alliance's primary care services because they felt healthcare staff at Access Alliance would understand their needs as LGBTQ+ newcomers. They also reported an appreciation of staff giving clients the chance to discuss issues via phone or email when clients were unable to attend in-person appointments. Participants did express frustrations around administrative procedures at Access Alliance, with discussions of not being correctly checked in for appointments, or not having forms submitted in a timely manner to labs or other agencies. They also had a variety of suggestions for new or expanded programs for LGBTQ+ clients, including:

- A trans-focused group
- More frequent LGBTQ+ programming, especially at APOJ
- An urgent triage system or hotline for mental health concerns
- Integrating other programs, such as the Scarborough Cycles bike program, into LGBTQ+ programming
- More social events, such themed food nights, in the LGBTQ+ program
- Expanded social services including career planning and opportunities, financial literacy workshops, and a housing worker familiar with the housing discrimination faced by refugees

There were repeated requests for staff training on supporting LGBTQ+ clients, as well as other clients with diverse needs. Participants noted that additional resources, including both staff and funding, were required to implement such programming changes. They also had suggestions for new avenues for outreach, including an orientation on Access Alliance programs for LGBTQ+ newcomers, and mechanisms for informing LGBTQ+ individuals about programs before they immigrate to Canada.

Appendix E: Knowledge Mobilization Plan

Categories	Description	Where to Present	Objectives
Introductory	1) What it is? 2) Frequency, time line 3) Why we do it? 4) How many surveys we collected? 5) How it was representative and valid?	All Teams	Background and icebreaking
Methodology	Additional info (materials already discussed in the introductory Groups) 1) Who did it and why? 2) How we did it?	External Teams	
	Limitations 1) Anticipated impact (e.g. small group may be excluded, seasonal bias, etc.) 2) Mitigation strategies planned (e.g. include clients from group programs, planning a real-time survey, etc.	External Teams	
Findings	Satisfaction 1) Trend of categories for last four years 2) Refer to Access Alliance 3) Satisfied client who will refer 4) Drivers for satisfaction 5) Missed opportunities to make clients satisfied	All Teams	
	Explanatory Indicators (Primary care services) 1) % of patients who could to see a MD/NP on the same day or next day 2) % of patients who got appointment to MD/NP when they wanted 3) Among patients who got appointment when wanted, % of patients who got on the same say/ next day 4) % of patients who were satisfied with the decision	PC Team	

	making process for their care 5) % of patients whose service providers spent enough time to care 6) % of patients who could ask questions to their service providers	
	Explanatory for all clients (TC LHIN Framework) 1) Accessibility – location, work hours 2) Accessibility – additional 3) Population Focused 4) Client centred 5) Equity 6) Anti-oppression 7) Effectiveness	All Staff & Governance
	Background indicators 1) Demographic trend analysis 2) AODA 3) Others	Back Office
Conclusion	1) Conclusion 2) Take home message	All Teams