2020

Access Alliance
Multicultural Health and Community Services

CLIENT EXPERIENCE SURVEY

Disclosure:

This report has been prepared by the Planning & Evaluation Team of Access Alliance Multicultural Health and Community Services; it reflects data collection and analysis work carried out by an external team of two practicum students, with support from an internal Research Assistant as Project Lead. This report reflects the findings gathered from clients of Access Alliance. For any questions or concerns regarding this report please contact Akm Alamgir, PhD, Manager of Quality and Accountability Systems, at aalamgir@accessalliance.ca.

Citation: Access Alliance. (2020). Client Experience Survey Report 2020. Toronto.

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INTRODUCTION

Access Alliance Multicultural Health and Community Services (Access Alliance) works to improve health outcomes for marginalized communities which include immigrants, refugees, racialized groups, and the communities they live in. It is done by (i) facilitating access to a wide variety of programs including primary healthcare, social, settlement, youth and LGBTQ+ services; (ii) ensuring appropriate service delivery by the appropriate person at the appropriate time; and (iii) tangible improvement of the quality of health and well-being of the clients and their families. Services are delivered at four main sites across the City of Toronto- AccessPoint on Danforth (APOD), AccessPoint on Jane (APOJ), College and Barrington; and at satellite outreach locations such as COSTI, Greenwood Clinic, Paul Steinhauer Clinic, Crescent Town School, etc.

Learning from clients about their experience is essential for evaluating the quality of Access Alliance's programs and services. Client feedback is utilized to advise improvements to programs and services, ensuring their quality and that they meet client expectations and needs. Access Alliance collects client experience data which serves three distinct purposes:

1)**Accountability:** To generate data for reportable indicators to demonstrate accountability to stakeholders, including funders and health system authorities (i.e. specific indicators from the survey are reported to Health Quality Ontario (HQO) and the Toronto Central Local Health Integrated Network (TC LHIN));

2)**Quality:** For use in quality improvement planning for programs and services; and

3)**Evidence-informed Practice**: To inform internal learning by identifying opportunities for growth.

The key concerns for an effective client experience survey are (i) representativeness of the samples, (ii) adequacy of the sample size, (iii) validity of data collection and analytics, (iv) reliability of measurements, (v) comparability of the indicators, and (vi) reusability/ replicability of the overall process with scientific rigour. To ensure quality and rigour of the process, enormous care was taken before, during, and after the collection of data which is reflected in the Client Experience Survey (CES) 2020 methodology (see Appendix A).

This report summarizes the findings of the CES 2020 from an accountability perspective focusing on priority indicators around the following quality domains:

Satisfaction	Accessibility	Equity	Client Safety	Patient-Centredness

REPORT DEVELOPMENT PROCESS

Literature Review

A comprehensive review of the literature for the understanding of virtual data collection.

Data Collection

Completed by email and phone between October 5 and November 12, 2020, from a sample of Access Alliance clients who accessed programs and services, at least once, at any of the four sites during the 2019-2020 fiscal year.

Data Analysis

Data was assessed for completeness and 371 surveys were included in the final analysis.

Facilitated Feedback

Staff at Access Alliance were presented with the findings and consulted for contextual feedback.

Final Report

METHODS

In 2020, Access Alliance piloted a new, mixed-methods approach to collect client experience feedback using the Client Experience Survey (CES). Survey data collection was completed by email and phone between October 5 and November 12, 2020, from a sample of Access Alliance clients who accessed programs and services, at least once, at any of the four sites during the 2019-2020 fiscal year. The new methodology was designed in response to COVID-19, which required an alternative to the in-person collection methods used in previous years, and to pilot a less resource-intensive mode that optimizes privacy and confidentiality of individual respondents.

Email was the primary mode of data collection and telephone-based collection was the secondary mode. Web-based surveys were emailed to all the clients who had an email address in their Access Alliance record, resulting in 1300 clients being emailed to request survey completion. The telephone-based collection was completed by contacting 214 clients for whom Access Alliance had a record of a telephone number but no email. This was to ensure (i) responses were representative by including clients from this group, and (ii) to provide an accessible method for survey completion by those without a smartphone or computer, or who would not be comfortable completing a web-based survey. For telephone based survey collection, a CES data collection team of Access Alliance practicum students completed the web-based surveys on behalf of clients.

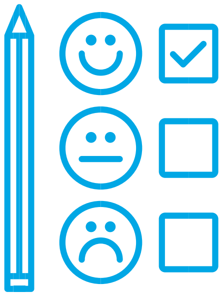
The web-based surveys were distributed and collected using the SurveyMonkey platform. SurveyMonkey templates are compliant with Web Content Accessibility Guidelines 2.0 (WCAG2) and were used to support survey accessibility for those completing it online. To reduce language barriers, the survey was translated into Spanish, Portuguese, Arabic, Farsi and Tigrinya, reflecting some of the top languages spoken by Access Alliance clients (Access Alliance, 2019). For telephone-based survey data collection, Access Alliance Language Services Remote Interpretation Network (RIO) was offered when appropriate.

The Access Alliance Client Experience Survey tool was used to collect data. Beginning with an embedded informed consent statement, the tool included questions (primarily quantitative with some open-ended, qualitative questions) consistent with the tools recommended by Health Quality Ontario (HQO) and the

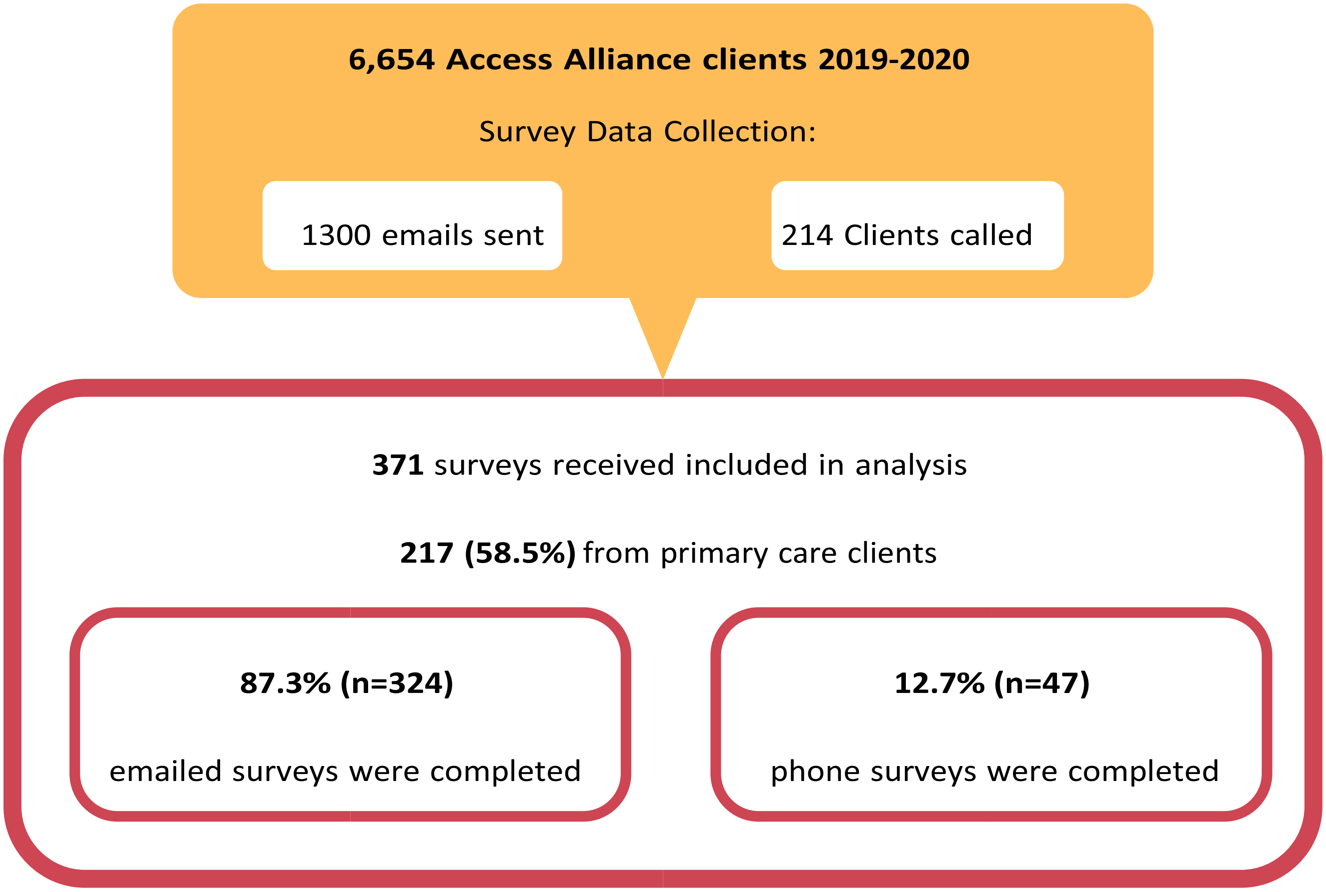
Toronto Central Local Health Integration Network (TC LHIN). Data processing and analysis was performed using Microsoft Excel.

The total number of surveys included in the final analysis is 371. The surveys included in the final analysis were those with a minimum number of questions completed, including questions for key reporting indicators. Of these surveys, 217 were completed by clients who accessed primary care services (see Figure 1). These respondents represented 58.5% of respondents, and 4.8% of the 4480 primary care clients served at Access Alliance in the 2019-2020 fiscal year.

Please see Appendix A for a more detailed version of the methodology.



OVERVIEW OF SURVEY DATA COLLECTION



6,654 Access Alliance clients 2019-2020

Survey Data Collection:

1300 emails sent

214 Clients called

371 surveys received included in analysis

217 (58.5%) from primary care clients

87.3% (n=324)

emailed surveys were completed

12.7% (n=47)

phone surveys were completed

Figure 1. Overview of survey data collection and responses included in data for final analysis.

FINDINGS

SURVEY METHODS AND ACCESSIBILITY

To understand the accessibility of using newer modes of communication or program delivery with clients, all respondents were asked ***if they were comfortable using technology***, and 76.8% (n=285, N=371) 'strongly agreed' or 'agreed', including:

- Of the **324 clients who completed the survey online, 78.9% (n=253)**, and
- Of the **47 clients who completed the survey by phone, 68.1% (n=32).**

They were also asked what their ***preferred methods to tell Access Alliance about their experience*** would be, to advise what methodologies for data collection might be most effective and accessible. The responses indicated email and phone were preferred, with **75.5% (n=280)** of clients choosing email and **42.1% (n=156)** choosing phone (see Figure 2). However, there was a difference in these responses between the groups who were emailed or contacted by phone to complete the survey. In particular, of those who were contacted by phone to complete the survey, only **23% (n=11)** responded that email was their preferred method, and **72% (n=34)** chose phone.

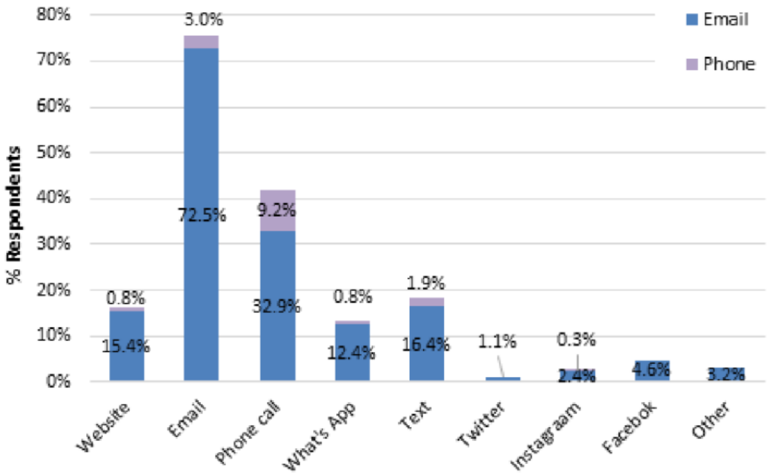


Figure 2. Respondents preferred methods to tell Access Alliance about their experiences, percentage of responses by email and phone responses.

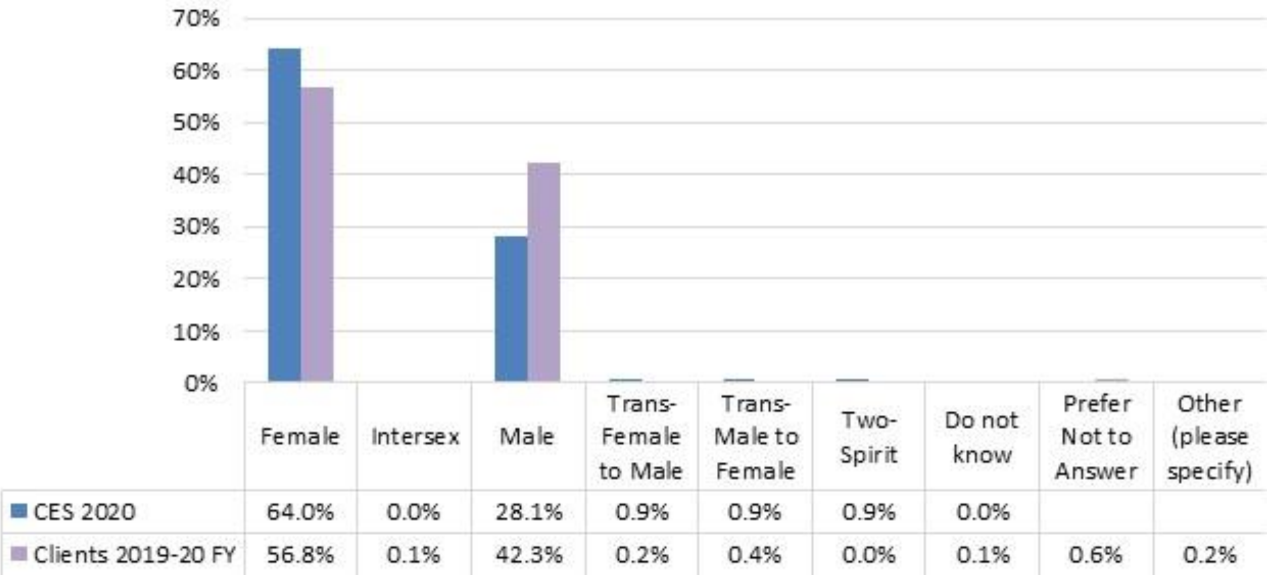
Respondents were asked to identify all methods that they would prefer and may have provided multiple responses.

Respondent Demographics

Clients were asked their gender and year of birth. The demographic profile of respondents is compared with the Access Alliance client population in the 2019-2020 fiscal year, to assess the degree to which the CES findings are representative of the client population.

Gender

The percentage of respondents to the CES who identified their gender as trans-female to male, trans-male to female, two-spirit, or female is slightly higher than the percentage reported for clients in the 2019-2020 fiscal year, reflecting that, for these genders, respondents are representative of the client population. However, a lower percentage of respondents identify as male, **28.1% (n=96)**, compared to clients in the 2019-2020 fiscal year **42.3% (n=2,790)**.



	Female	Intersex	Male	Trans-Female to Male	Trans-Male to Female	Two-Spirit	Do not know	Prefer Not to Answer	Other (please specify)
🟦 CES 2020	64.0%	0.0%	28.1%	0.9%	0.9%	0.9%	0.0%		
🟪 Clients 2019-20 FY	56.8%	0.1%	42.3%	0.2%	0.4%	0.0%	0.1%	0.6%	0.2%

Figure 3. Percentage of clients by gender, by CES 2020 respondents (N=342) compared to clients seen in FY 2019-20 (N=6,599).

Age

CES 2020 respondents between **25 and 44 years** represented a higher percentage of respondents, 6**6.2% (n=219)**, compared to **51.5% (n=2,904)** percent of 2019-2020 fiscal year clients in the same age range. There was a lower percentage of **CES respondents 45-64, at 20.8% (n=69)**, compared to **25.8%, (n=1,452)** for the client population. An interim analysis of respondent demographics was undertaken during the data collection process to identify client populations that may be underrepresented among the CES respondents. This led to additional survey promotion and data collection directed towards youth and senior clients. Although the percentage of respondents aged **14-24, at 7.6% (n=25)**, remained below the client population of **15.1% (n=852)**, a representative sample of seniors was achieved, **8.5% (n=28) of CES 2020 respondents**, compared to **7.6% (n=429) among the client population**.

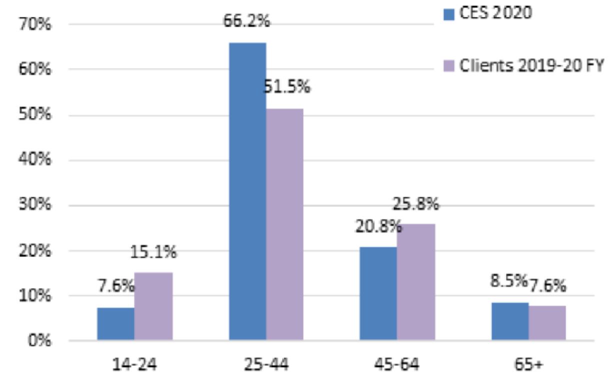


Figure 4. Percentage of clients by age range, comparing CES 2020 respondents (N=331) and clients in 2019-20 fiscal year (N=5,637).

Client Service by Site

Clients were asked ***at which Access Alliance site they had most commonly received services or attended programs***, 340 College (n=82), AccessPoint on Jane (APOJ) (n=91), AccessPoint on Danforth (APOD) (n=184), or 91 Barrington (n=14) (see Figure 5). Barrington site data was grouped with APOD data for analysis and presentation in the results.

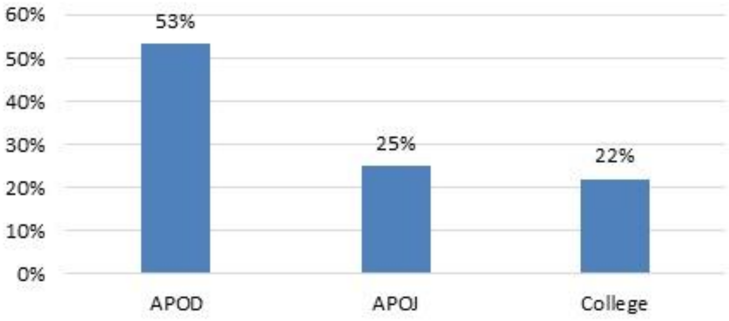


Figure 5. Percentage of clients by Access Alliance site at which they commonly received services or attended programs (N=371).

SATISFCTION

Overall satisfaction is determined by asking clients to rate the care and services they received at Access Alliance. This year, respondents reported a high level of satisfaction across all sites, with 96.2% (n=357, N=371) reporting ‘good’, ‘very good’, or ‘excellent’ (Table 1).

Total	APOD	APOJ	College
96.2% (n=357)	97% (n=192)	93.4% (n=85)	97.6% (n=80)

Table 1. Percentage of satisfied clients across sites.

As Figure 6 demonstrates, there has been some fluctuation in satisfaction ratings since 2016. However, the rating of satisfaction continues to be very strong, remaining above 90%.

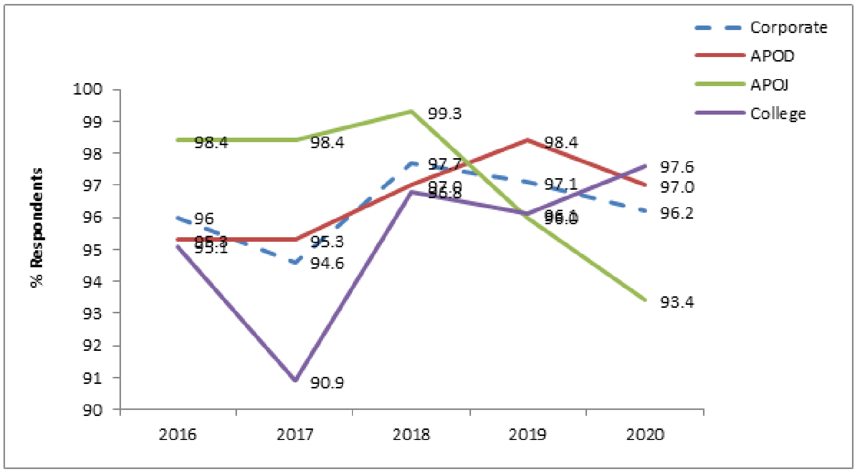
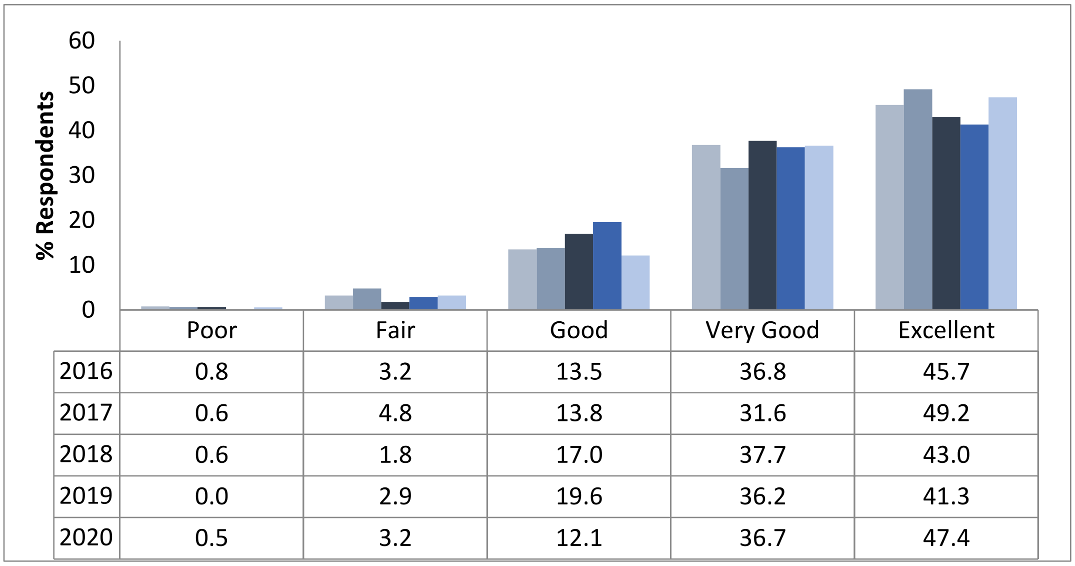


Figure 6. Trend analysis of respondents who indicated they were satisfied with overall care and services received, across sites, 2016-2020.

Regardless, compared to previous years, a high percentage of respondents identified their level of satisfaction as 'excellent' or 'very good', and overall satisfaction was impacted by an increase over previous years in the respondents who chose 'fair', combined with a decrease in those who chose 'good' (see Figure 7).



	Poor	Fair	Good	Very Good	Excellent
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
2019	0.0	2.9	19.6	36.2	41.3
2020	0.5	3.2	12.1	36.7	47.4

Figure 7. Trend analysis of overall satisfaction, 2016-2020.

Clients' responses regarding ***whether they would recommend Access Alliance to friends or family*** also reflect satisfaction with Access Alliance services. Of the respondents, **97.8% (n=348)** said they probably or definitely would recommend Access Alliance to friends or family.

Through their qualitative feedback, clients expressed a high level of overall satisfaction with Access Alliance, across all the quality domains of satisfaction, accessibility, equity, patient-centeredness and client safety. Challenges and issues that were experienced at Access Alliance were also shared, and themes that arose related to each of the quality domains will be discussed below

ACCESSIBILITY

Accessibility can be defined as programs and services which are available, accessible and welcoming to all.

Facilitators and Barriers to Access

To understand overall accessibility and the barriers to accessing programs and services that clients may experience, an open-ended, qualitative question asked about ***any barriers that prevented clients from using Access Alliance programs and services***, and **83.1% (n=236, N=284)** of clients did not report any barriers. Table 2 provides an overview of the percentage of clients at each site that reported that they did not experience any barriers.

Location	Percentage who reported accessible
APOD	84.5% (n=131)
APOJ	77.5% (n=55)
College	86.2% (n=50)
Total	83.1% (n=236)

Table 2. Percentage of clients that did not report barriers to access.

Throughout the survey, clients reported different ways in which Access Alliance programs provided accessible programs and services, including:

- wide range of programs and services;
- programs and services meeting the needs of specific groups, including newcomers, and LGBTQ+ communities; and
- providing access to primary care that would not otherwise have been available.

At the same time, some clients reported barriers to accessing programs and services, such as:

- being unable to reach or not receiving return calls from Access Alliance; difficulty obtaining appointments or long wait times;
- administration processes impacting access to care, or change in site, doctor or nurse practitioner;
- scheduling conflicts;
- Transportation challenges; and
- Requests for more information about programs and services

Language

Providing equitable and accessible, programs and services includes reducing language barriers for clients. **74.9% (n=278)** of clients reported that they were ***able to get services in a language of their choice*** 'always' or 'often'.

Clients were also asked ***what language they would be most comfortable speaking in with their healthcare provider***. Respondent's answers included 23 different languages. Table 3 includes the top ten languages identified by 2019-2020 fiscal year clients when first registering with Access Alliance, and the percentage of CES respondents who chose one of these languages.

Preferred Language	**Percentage Respondents (N=342)**
English	77.2% (n=264)
Portuguese	4.7% (n=16)
Spanish	3.5% (n=12)
Arabic	1.2% (n=4)
Tigrinya	0.0% (n=0)
Bengali	2.9% (n=10)
Persian/Farsi	1.8% (n=6)
Karen/Sgaw	0.6% (n=2)
Amharic	0.6% (n=2)
Hungarian	0.0% (n=0)

Table 3. Percentage of clients by language in which they are most comfortable speaking with their provider, based on top ten languages identified by 2019-2020 FY clients at registration.

Timely Access

From a Primary Care (PC) perspective, accessibility also requires people getting the right care at the right time, in the right setting, and by the right healthcare provider. Many clients shared positive qualitative feedback regarding the availability and speed with which they could receive an appointment, while some reported difficulty obtaining appointments or long wait times.

To assess whether patients (PC clients) received timely access to PC Service Providers, they were asked ***'Did you get an appointment on the date you wanted?'*** and **77% (n=167, N=217)** responded 'yes'. Timely access is also evaluated based on clients being able ***to see their MD or NP on the same or next day,*** and **32.7% (n=71)** reported that this was the case, while **52.5% (n=114)** of clients indicated that they were able to see their MD or NP within 7 days (see Table 4).

Same or next day	2 –3 days	4 –5 days	6-7 days	Total between same day and 7 days
32.7% (n=71)	6.5% (n=14)	4.6% (n=10)	8.8% (n=19)	**52.5% (n=114)**

Table 4. Number of days in which respondents where able to see or speak with their MD or NP.

These indicators are lower than previous years (see Figures 8 and 9), which may be due to COVID-19 impacting the timeliness with which clients received appointments. In light of COVID-19, there was an initial need for Access Alliance to reschedule or delay programs and services to implement new safety protocols and transition to new service delivery methods. Throughout 2020, the need for social distancing and other COVID-19 safety protocols may have contributed to longer wait times. In the qualitative feedback, clients did identify COVID-19 as affecting their access to and experience of programs and services.

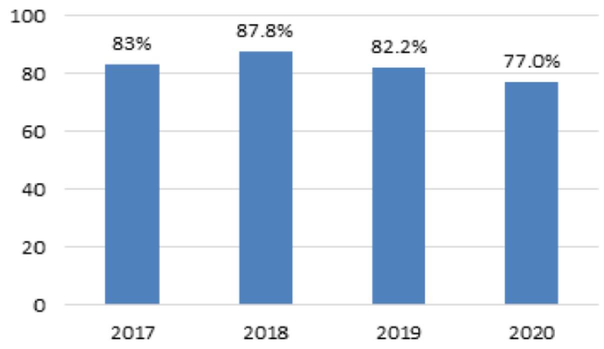


Figure 8. Trend analysis of respondents who indicated they got an appointment on the date that they wanted, 2017-2020.

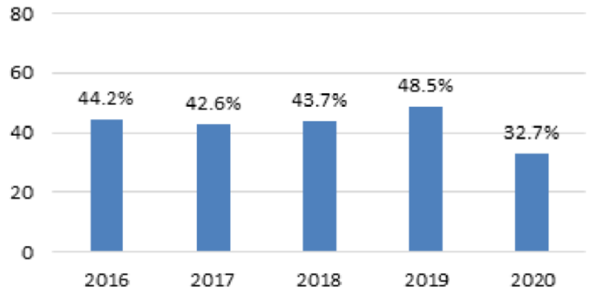


Figure 9. Trend analysis of respondents who indicated they got an appointment on the same or next day, 2016-2020.

EQUITY

Access Alliance is committed to providing equitable access to programs and services for their clients. This includes the elimination of all forms of barriers that prevent clients from accessing programs and services, and creating and maintaining a safe environment that facilitates open and respectful participation of staff, clients, volunteers, students, community and board members alike.

To measure equity, all clients who completed the survey were asked ***whether they always feel comfortable and welcome at Access Alliance, and 97.3% (n=361, N=371)*** responded 'yes', which reflects that Access Alliance is succeeding in providing equitable access through welcoming clients and providing a safe and respectful experience, although it is a slight decrease in comparison to previous years (see Figure 10).

Numerous clients described through qualitative feedback feeling welcome and at home when they accessed programs and services. Clients note the value of this experience for them as newcomers to Canada or being a part of LGBTQ+ communities. There is also feedback from some clients of staff or service providers not being welcoming or being unfriendly.

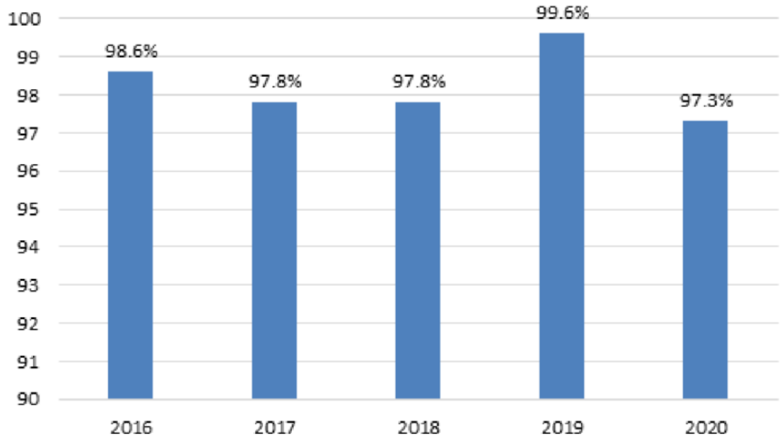


Figure 10. Trend analysis of respondents who agreed with the statement "*I always feel comfortable & welcome at Access Alliance*", across sites, from 2016-2020.

CLIENT SAFETY

Ensuring patient safety includes avoiding any negligence or mistakes that may cause clients harm when they access programs or services. This also includes ensuring privacy of client information, and 93.5% (n=347) of clients 'strongly agreed' or 'agreed' that ***they trust that their personal information is being kept confidential*** (Table 5).

Client awareness of how they can provide complaints or suggestions regarding their care and experience empowers them to do so. It allows them to feel safe knowing they can communicate any issues they may have, and that an avenue for clients to provide feedback prevents, or allows any harm or abuse that may occur, to be addressed. Clients were asked about their familiarity with ***how they might provide a suggestion or complaint, and 77.1% (n=286)*** responded that they do know how to do so (Table 5), suggesting that there is a need to increase awareness of ways in which clients can provide feedback to Access Alliance.

Indicator of Client Safety	**2020 (N=371)**	**2020 (N=276)**
Trust personal information is kept confidential	93.5% (n=347)	97.1% (n=268)
Know how to make a suggestion or complaint	77.1% (n=286)	78.3% (n=216)

Table 5. Indicators of Client Safety, 2020 and 2019. % who responded 'strongly agree'/'agree'.

As noted above, throughout the qualitative feedback, clients described Access Alliance as welcoming and comfortable. Many also described it as safe environment, and that the care, treatment and support that they received improved their health and wellbeing. There were a few instances of clients expressing concerns related to client safety, including reporting incidences when treatment was delayed, not effective or resulted in negative outcomes.

PATIENT-CENTEREDNESS

Access Alliance strives to deliver programs and services in a way that puts 'patients at the centre of care to ensure they are treated and cared for in ways that are sensitive to their needs and preferences. When asked if ***staff treat them with dignity and respect 94.4% (n=350)*** of respondents 'agreed' or 'strongly agreed', indicating that staff are engaging with clients in ways that are 'patient-centred'.

Clients were asked about aspects of their experiences that reflect whether patient-centered care is being delivered by Access Alliance staff (see Tables 6 and 7). Across these indicators, there is a range in scores, with some remaining strong, with a small decrease since 2019 (see Table 6), and others showing a greater decrease (see Table 7). Figures 11, 12 and 13 also provide a five-year trend analysis (2016-2020) for three of these indicators. **Scores for the following indicators have remained strong:**

Indicator of Client Safety	Respondent Group	2020	2019
Have the opportunity to ask questions about treatment	PC Clients Only	87.6% (n=190, N=217)	91.1% (n=164, N=180)
MD/NP spends enough time with them	PC Clients Only	84.3% (n=183, N=217)	89.4% (n=161, N=180)

Table 6. Indicators of Patient/Client Centeredness 2020 and 2019. % who responded ‘always’/’often’.

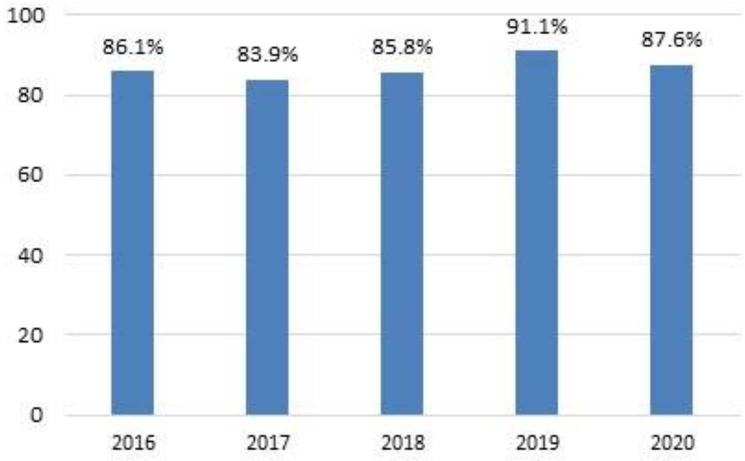
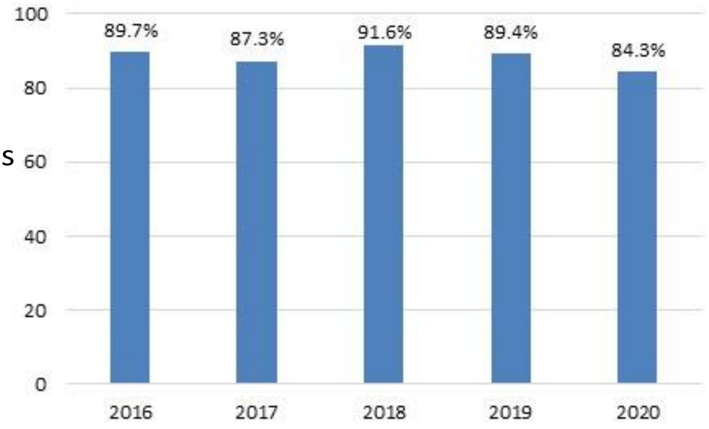


Figure 11. Trend analysis of respondents who agreed they are provided with opportunities to ask questions about recommended treatments.

Figure 12. Trend analysis of respondents who felt their PC provider spent enough time with them.



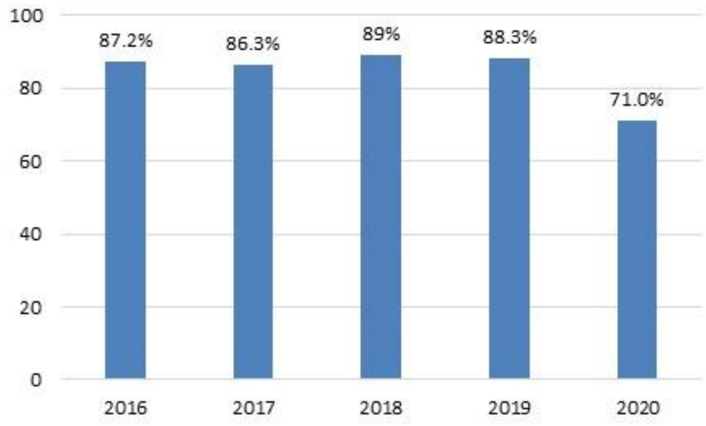


Figure 13. Trend analysis of respondents who agreed they are involved in decisions about their care and treatment.

Indicator of Patient/Client Centeredness	**Respondent Group**	**2020**	**2019**
Are involved in decisions about care/treatment	PC Clients Only	71% (n=154, N=217)	88.3% (n=159, N=180)
Programs/services meet needs	All Clients	79.8% (n=296, N=371)	96.0% (n=265, N=276)

Table 7. Indicators of Patient/Client Centeredness 2020 and 2019. % who responded ‘always’/’often’.

In addition to the quantitative indicators, descriptions from the qualitative feedback reflect clients’ experiences of being ‘at the centre of care’ at Access Alliance. Feedback indicated that client needs are being met, staff are friendly and welcoming, listen and respond to clients, always take care of them, and treat them with respect. As noted previously, clients also shared feedback regarding staff not being welcoming or helpful and some examples of needs not being met.

FEEDBACK FROM TEAMS

As a part of the reporting process, the survey methodology and key findings were presented separately to relevant stakeholders of Access Alliance, which includes all staff members, Primary Care Team, Community Program staff, the Quality Governance Committee, and the clients or members of the community who are apart of the Community Reference Group (CRG). Such a report-back practice provides the opportunity for contextualization of the findings and gathering their opinion for future process improvement efforts. Feedback received from the teams is summarized below:

- Community Reference Group Meeting (clients and members of the community)
  - Reported levels of satisfaction are in line with the experiences of community members.
  - However, the number of emails registered in the database appears to be low. There can be proactive efforts by Access Alliance to collect all emails from onboarding new clients and recording them in the database.
- Quality Governance Committee
  - CES data is reflective of the Access Alliance population, client satisfaction is good, some decrease in indicators requiring qualitative follow-up with service provider teams to provide contextual insights.
  - The following analysis of indicators can be identified in next years' report:
    - A cross-tabulation of equity with program satisfaction and validation of client reporting for same day/next day data with Electronic Medical Records
- All Staff
  - Promote client awareness of the availability of interpretation services while accessing programs and services by increasing signage to support requests for interpretation, continued reminders by staff and including Peer Outreach workers in programming who can interpret in real-time.

- All Staff (Continued)
    - Clients provide verbal feedback to staff but when prompted, do not want to provide written complaints. To reduce reservations around providing complaints or feedback:
        - Change the terminology from ‘complaint’ to ‘feedback’, provide information on how feedback is processed, reinforce confidentially of the process and develop a more accessible link on the website. Additionally, include the feedback link in staff email signatures which will bring clients to the standardized feedback page.
- Primary Care Staff
    - Due to low health literacy, clients may not know what to ask regarding their health while in appointments with primary care providers.
    - Virtual appointments in combination with virtual interpretation are time-consuming which may contribute to clients feeling rushed or that the provider is unable to spend enough time with them. Also, in-person appointments may allow clients to express their health needs more easily.
- Community Program Staff
    - Support client awareness of programs and services through simpler calendar descriptions, a centralized community board at each location
    - Similarly, utilize Peer Outreach Workers to communicate with clients to promote programs.
    - Utilize computer text messaging software to connect clients with staff for programming to allow messages to be relayed to the intended program staff.

CONCLUSION

The 2020 Client Experience Survey utilized a new approach, with the implementation of email and telephone-based survey data collection. The survey and sampling methodologies were designed to ensure accessibility and a representative sample of the Access Alliance client population, which includes the general and primary care service populations as recommended by industry standards (Canadian Centre for Accreditation, 2016).

Overall, the 2020 scores continue to be strong across the various indicators of satisfaction, accessibility, equity, and client safety, and qualitative feedback highlights clients' positive experiences in these areas. The 2019 CES scores, reflected an increase that had been occurring over recent years (Access Alliance, 2019), and there has been some decrease in scores for 2020, however, numbers remain higher than industry standards. Indicators and qualitative feedback are also positive for timely access and patient centeredness, although there is a greater decrease for some of these indicators.

Two factors may be affecting the CES 2020 outcomes. The first is the impact of COVID-19 on the delivery of programs and services, including delays and adjustments to providing new delivery methods to ensure the safety of clients. Similar patterns of lower indicators may emerge across the sector in 2020 as a result of COVID-19, which will be relevant to understanding and further analyzing the Access Alliance CES.

The second is the implementation of the new methodology for CES 2020. In previous years, convenience sampling was used, by collecting survey data during in-person client visits to Access Alliance programs or services. For the CES 2020, sampled clients were those who accessed programs or services in the previous fiscal year (ending in March), and were contacted by email or telephone in the fall of 2020. Email- and telephone-based collection may have also resulted in feedback being received from a broader sample of clients, with a wider range of experiences. If this is the case, the lower scores may reflect that the new methodology is more effective in gathering a wider range of client feedback and experiences. However, due to the difference in methodologies, the 2020 findings may not be directly comparable with CES outcomes from previous years, presenting a limitation for interpreting the findings.

The CES 2020 process is to be evaluated by an external team of students from the University of Toronto Institute for Health Care Improvement. The evaluation's focus on the CES 2020 methodology, implementation and findings will support assessment of the quality of the findings and advise future CES planning. Once completed it will be openly available and shared with the sector.

Access Alliance will maintain and sustain current practices to ensure the quality of programs and services and, through consultation with relevant departments and teams, utilize the findings from the CES 2020 as a learning opportunity that will contribute to Access Alliance's continuous service and program improvement goals.

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APPENDIX A

CES 2020 Methodology

Situation Statement: COVID-19 Context

Because of the current COVID-19 situation, Access Alliance decided to shift from an inperson (high-touch) collection of client experience data towards a virtual (low-touch) approach. This will maintain the Continuous Quality Improvement (CQI) commitment of the agency as well as ensure the health and safety of clients, staff, and volunteers. This survey process and tools will be designed to capture objective information on clients' experiences with programs and services.

Implementation

The following describes our implementation of the pilot of the virtual approach for CES data collection to use our experience to provide a sustainable low touch practice for the sector.

Survey content: The survey tool includes reportable indicators consistent with other CHCs and OHTs (satisfaction, accessibility, client centeredness, equity, anti-oppression, and effectiveness). It also contains an embedded informed consent statement that mentions provisions around voluntary participation, anonymity, confidentiality, and intended use of aggregated data.

Accessibility: To address language barriers, the English survey tool was translated into Portuguese, Spanish, Arabic, Farsi, and Tigrinya, which reflect some of the top languages spoken by Access Alliance clients (Access Alliance, 2019). There was limited usage of the surveys translated into languages other than English. In some cases, the surveys were sent to clients who expressed concern about completing the English language survey by phone, and who preferred to receive a survey by email in a language with which they were comfortable. To also respond to language barriers, when undertaking data collection using the telephone-based survey, the Access Alliance Language Services Remote Interpretation Network (RIO) was offered when appropriate. Although it took longer to complete the survey using an interpreter, clients did request, and agree to complete the survey, using RIO.

Web-based surveys can enable the use of accessibility features for those with visual, physical, and/or motor skill impairments, making web-based surveys more accessible than the traditional paper-based format. Survey Monkey was used for survey data collection because it offers survey templates that are compliant with global technical guidelines for web accessibility, and that can be used in conjunction with screen magnifiers, screen readers, and voice command and control software (Survey Monkey).

- **Project team:** The CES process was led by the Access Alliance Research Assistant (RA), supported by two placement students. Although efforts were undertaken to recruit volunteers for the data collection team, volunteers were not available to support telephone-based data collection. The Manager of Quality and Accountability oversaw the activities to monitor data flow and quality.
- **Data collection timeline:** Survey data collection was scheduled to be over a two-month period, from the first week of October to the end of November 2020. Due to the response to the emailed survey surpassing the target sample size within a week, and telephone-based data collection being completed within approximately six weeks, data collection was complete by the middle of November.
- **Survey mode:** A mixed-method approach was adopted, meaning more than one outreach mode (in combination) was used to collect data (a sustainability strategy approach).

Mode-1 - Email-based survey: We used the list of clients (a ‘sampling frame’) that have email addresses recorded in Access Alliance’s database, and sent each a unique SurveyMonkey link as a personalized email, which they could access to complete the survey at home on their own time.

It was planned that targeted data collection would be undertaken if respondents were not representative of the Access Alliance client population. In response to an initial analysis indicating that the proportions of Access Alliance clients who are youth and seniors were not represented among the survey respondents, seniors and youth program staff at Access Alliance promoted and distributed the survey with their clients.

Although not included in the original methodology, links were shared with staff to distribute the survey with their clients, and it is estimated that the survey was sent directly to clients by one staff member.

Mode-2 - Telephone-based survey: We contacted clients directly via telephone to make the CES more accessible for clients, especially those who do not have the technology or skills to complete the survey online. Using the list of telephone numbers in the client registration records, the CES data collection team phoned a random sample of clients, as well as clients who were emailed the survey and requested to complete it by phone. During the survey collection phone calls, the CES data collection team filled out the surveys on SurveyMonkey on behalf of clients.

Mode-3 - Tech-based group discussion: We will be scheduling a pilot of a tech-based (e.g., Zoom) arrangement for qualitative data collection (e.g., Focus Groups or Facilitated Discussions, or Interviews), which will supplement the quantitative data that has been collected.

Sample size: The target sample size was to achieve, via the email- and telephone-based surveys, a total of 250 respondents, with 90 (2% of Access Alliance's primary care clients in the previous 2019-2020 fiscal year) of responses being from primary care patients. A high response rate to the email-based survey resulted in the target sample size being achieved, and the target for primary care clients was also reached. Clients were reached using each mode, as follows:

Email-based survey

- We sent the CES by email to approximately 1300 clients for whom Access Alliance had an email address. A 10% response rate was expected, which would have equalled 130 responses, however, the responses surpassed the expected sample size within one week.
- As noted above, the initial analysis indicated that the proportions of Access Alliance clients who are youth and seniors were not represented among the survey respondents. To increase responses from these groups, seniors and youth program staff at Access Alliance promoted and distributed the survey among their clients, which resulted in some additional responses.
- Some respondents to the emailed survey exited the survey before finishing it. Only surveys with a minimum number of questions completed, including questions for key reporting indicators, were included in the final analysis.

Telephone-based survey

- The goal was to collect telephone-based responses from 140 clients. Responses were collected by phoning an initial list of 140 clients with phone numbers, and who were not included in the email sample. Initial survey respondents were not representative of the proportion of senior clients at Access Alliance, and a random sample from registration records of clients 55 years and over was used for targeted phone calls to senior clients.
- We included telephone-based survey collection to collect responses from clients for whom Access Alliance did not have an email address, or for whom a web-based survey was not accessible. Calls were made to all clients on the phone lists, however, the target sample size for telephone-based responses was not reached. Due to the total response rate, and the number of email-based responses, surpassing the expected sample sizes, it was determined that it was not necessary to collect as many surveys by phone as planned.

Follow-up: To improve the response rate, we planned to remind clients two to three times by email, text or phone, with each reminder being approximately 10 days apart. Telephone-based survey: Follow-up occurred one time after either leaving a message, in response to requests that we call back or if we were not able to reach someone or unable to leave a message. Unless a specific time frame was suggested, we called back approximately 10 days following the initial call. **Email-based survey:** One reminder was sent by email to clients who had not yet responded to the survey. Planning was in process to send a second reminder by text message 10 days following the email reminder to the remaining clients who had not responded. However, a longer than expected turnaround for the software provider to set up a department account to use MessageHopper, text message software, resulting in the text reminder not being sent. Although this was a lost opportunity to test the use of text messages to increase response rates, the already surpassed response rates to the emailed survey had eliminated the need for a second reminder.

Quality assurance: We monitored quality continuously over the course of data collection with regard to response rate, and to ensure data collected was proportionate to our overall client population (i.e., primary care vs. non-primary care clients, etc.). As discussed above, an interim analysis of respondent demographics identified client groups that were underrepresented and targeted data collection was undertaken to increase their representation. Final preparation of the survey data included translation of responses from the non-English language surveys, and the data from all the language surveys were compiled and prepared in Microsoft Excel to provide a complete and accurate data set for analysis.

Respondent incentive: To improve the response rate, a chance to enter into a draw to win a $25 grocery gift card, by one of every 20 participants, was offered upon completion of the survey. Participating respondents provided either their email address (via online survey) or phone number (via phone survey) to be entered in the draw. The entries were only used for the purpose of the draw and to track survey completion, and were in no way used to identify individual’s responses or feedback.

Survey promotion: To increase client awareness of the CES and improve the response rate, Facebook and Instagram posts notifying clients that they may receive emails or phone calls requesting that they complete the survey were shared via the Access Alliance accounts. Staff also promoted the survey among their clients.

Data storage and security: All personal client and survey data were stored in secure, password-protected electronic files on Access Alliances devices, only accessible to the CES 2020 project team. Survey data will be kept for a minimum of two years before being destroyed.

APPENDIX A

Anticipated Risks & Corresponding Planned Mitigation Strategies

The planning of the virtual approach to the CES included anticipation of potential risks and planned mitigation strategies, outlined below.

A. The primary risk associated with the email-based survey method pertains to the response rate, for which the following characteristics should be considered:

1. Generic web-based surveys are typically associated with the lowest response rates, as compared to postal (generic and personalized) and telephone surveys (Leeuw et al., 2007; Sinclair et al., 2012).
2. Approximately 18% of Access Alliance clients have their email addresses in the agency database, which represents a limited sample pool. Related to this, there is a secondary risk of polarity bias, in that the analyzed data may not be representative of the broader client population (a risk that comes with small sample surveys).
3. Web-based surveys have become very popular in recent years due to their low cost and significant reach capabilities. However, the resulting survey fatigue from an excess of online content may increase resistance to new survey requests (Cook et al., 2016).

To mitigate the aforementioned risks, the following strategies were adopted:

- Personalization of the email-based survey invitation and reminders to improve response rates (Leeuw et al., 2007; Sinclair, et al. 2012).
- Follow-up reminders will be utilized to improve responses, as follows:
    - First reminder: An email reminder will be sent out after the initial (email) survey mail-out. Cook et al. (2016) found that six reminder emails at 10-day intervals resulted in a meaningful response and reminders following the survey mail-out will be approximately 10 days apart.
    - Second reminder: Text messaging will be used to send a second reminder approximately 10 days after the email reminder is sent. Research shows that changing the mode of reminders may mitigate decreasing response rates (Funkhouser et al., 2017).

        Options for sending bulk texts that have been considered include the use of the PushBullet application with an Access Alliance smartphone, and Message Hopper, software for managing text communication with clients via computer. Access Alliance's Language Services department has a pre-existing Message Hopper account. As a result, it will be possible to use it to send the-reminder text. Otherwise, the use of Message Hopper would not have been feasible due to its cost and installation needs. When texting via Message Hopper, a hyperlink to the survey can be included in the text, and text recipients can send return texts, which allows the CES data collection team to use Message Hopper to respond to client questions or requests.

  - Third reminder: If following the second text reminder, the response rate is still low, a third and final reminder will be sent by email, also 10 days following the second reminder by text. Sending multiple reminders to recipients to encourage survey completion may not always enhance response rates (Toledo et al., 2015). Alternately, or in combination with this strategy, if survey respondents are not representative of Access Alliance clients, Access Alliance staff will be consulted to identify clients in target groups to inform them of the survey and request survey completion.
- The data collection team will phone clients without email addresses in the Access Alliance database and those who might not have the technology or skills to complete the survey online. If it is assessed that completing the survey by phone may be a barrier for a client, the option to email the English, or one of the other language surveys, will be offered.

B. Web-based surveys require some basic computer skills, which may limit certain populations from accessing them (e.g. seniors, individuals with motor/visual impairments, etc.) (Cook et al., 2016).

To mitigate the aforementioned risk, we are adopting the following strategies: • ·To address accessibility issues, we will use Survey Monkey software to deliver the survey because it offers survey templates which are compliant with the Web Content Accessibility Guidelines 2.0 (WCAG2) - global technical guidelines for web accessibility. Accessible electronic survey tools should work with devices that are used by people with varying challenges; for example, they should work well with screen magnifiers, screen readers, and voice command and control software (Survey Monkey, n.d.). Depending on which device clients are using to complete the survey, this format may be more accessible than the traditional paper-based format (e.g., iPads have accessibility features for those with visual, physical, and/or motor skill impairments).

- Considering the self-directed nature of the survey, the client email invitation will include the offer to contact a member of the project team, should the respondent need more support to complete the survey.
- In addition, the data collection team will phone clients without email addresses in the agency database and those who might not have the technology or skills to complete the survey online.

C. SurveyMonkey is a US-based online software, which brings about some debate aroundthe privacy of clients' information (Note: SurveyMonkey, as a default, offers end-to-end encryption of data and other security features which implies highly secure data collection and storage as long as PHI is not being gathered).

To mitigate the aforementioned risk, we are adopting the following strategies:

- The CES data collection tool is designed to be completely anonymous for respondents;
- No personal health information (PHI) data is collected through the survey. Moreover, the CES data is not connected to clients' profiles nor any other database. As such, there is no risk of either cross-pollution of the data or linkage of the data with clients' personal profiles.

D. Clients may not answer the survey questions truthfully over the phone due to social desirability bias.

To mitigate the aforementioned risk, we are adopting the following strategies:

- A cross-team data collection approach will be used, including students and volunteers, so that the program staff will not be collecting client experience data from their own clients.

E.Survey data collection process may result in incomplete data and lack of data accuracy

To mitigate the aforementioned risk, we are adopting the following strategies:

- The Survey Monkey platform provides tools to program the survey to require responses and validate response types or formats, increasing the potential for high-quality data. The automatic capture of data in the Survey Monkey database improves the efficiency of the data collection process and removes data entry errors.

F. Due to the combination of methods used to administer the CES, clients may fill out the CES multiple times through the different channels, leading to duplications.

To mitigate the aforementioned risk, we are adopting the following strategies:

- We will remove the clients that have email addresses in their chart from the list of clients that we will be sampling from to contact via telephone. This way we will not be contacting the clients through both email and telephone methods.
- We will also discourage clients to fill out the survey multiple times by letting them know that they should not fill it out again if they have already completed it.