Client Experience Survey Report

2025–2026

Access Alliance
Multicultural Health and Community Services

New Beginnings for Newcomers.

Project Team

Akm Alamgir, Director, Organizational Knowledge & Learning

Ezza Jalil, Research Assistant (Project Lead)

Luca Giavedoni (Peer Researcher)

Starus Chan (Placement Student)

Data Collection Volunteers:

Ana G.
Salina G.
Ferdousi I.
Hiba C.
Sharmin I.
Esameldin B.
Mera K.
Francheska B.
Gurlal S.
Tala K.
Moharaj
Suzana P.

Disclosure:

This report is an intellectual property of Access Alliance Multicultural Health and Community Services and has been prepared by the Research & Evaluation Team of the agency. It reflects data gathered from clients of Access Alliance by a team of volunteers, with support from internal colleagues, Project Lead, Peer Researcher and Placement Student . For any questions or concerns regarding this report please contact Ezza Jalil (Project Lead) at research@accessalliance.ca.

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Access Alliance
Multicultural Health and Community Services

Background

At Access Alliance, the provision of equitable, person-centred primary care is designed upon the strategic integration of client and community perspectives. The annual Client Experience Survey serves as a critical instrument for institutional accountability, facilitating continuous quality improvement (CQI) and the refinement of culturally responsive care frameworks. By soliciting structured feedback on service accessibility, provider engagement, and navigational efficacy, this report captures essential data within a community health model defined by health equity and social inclusion. These empirical insights delineate current operational proficiencies and identify specific lacunae in service delivery, ensuring that organizational growth remains aligned with the complex socio-demographic requirements of the service population.

To support these efforts, Access Alliance collects client experience data that serves three distinct purposes:

1) **Accountability:** Generating data for reportable indicators to demonstrate accountability to stakeholders, including funders and health system authorities, the accreditation agency, and the government. We are also accountable for our clients' receiving care through our organization.

2) **Quality:** In quality improvement planning for programs and services.

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

For an effective client experience survey, we considered the following items:
(i) representativeness of the samples, (ii) adequacy of the sample size, (iii) validity of data collection and analytic process, (iv) reliability of measurements, (v) comparability of the indicators, and (vi) reusability/replicability of the overall process with scientific rigour. To ensure the quality and rigour of the process, enormous care was taken before, during, and after the collection of data, which is reflected in the Client (patient) Experience Survey (CES) 2025-2026 methodology (Appendix).

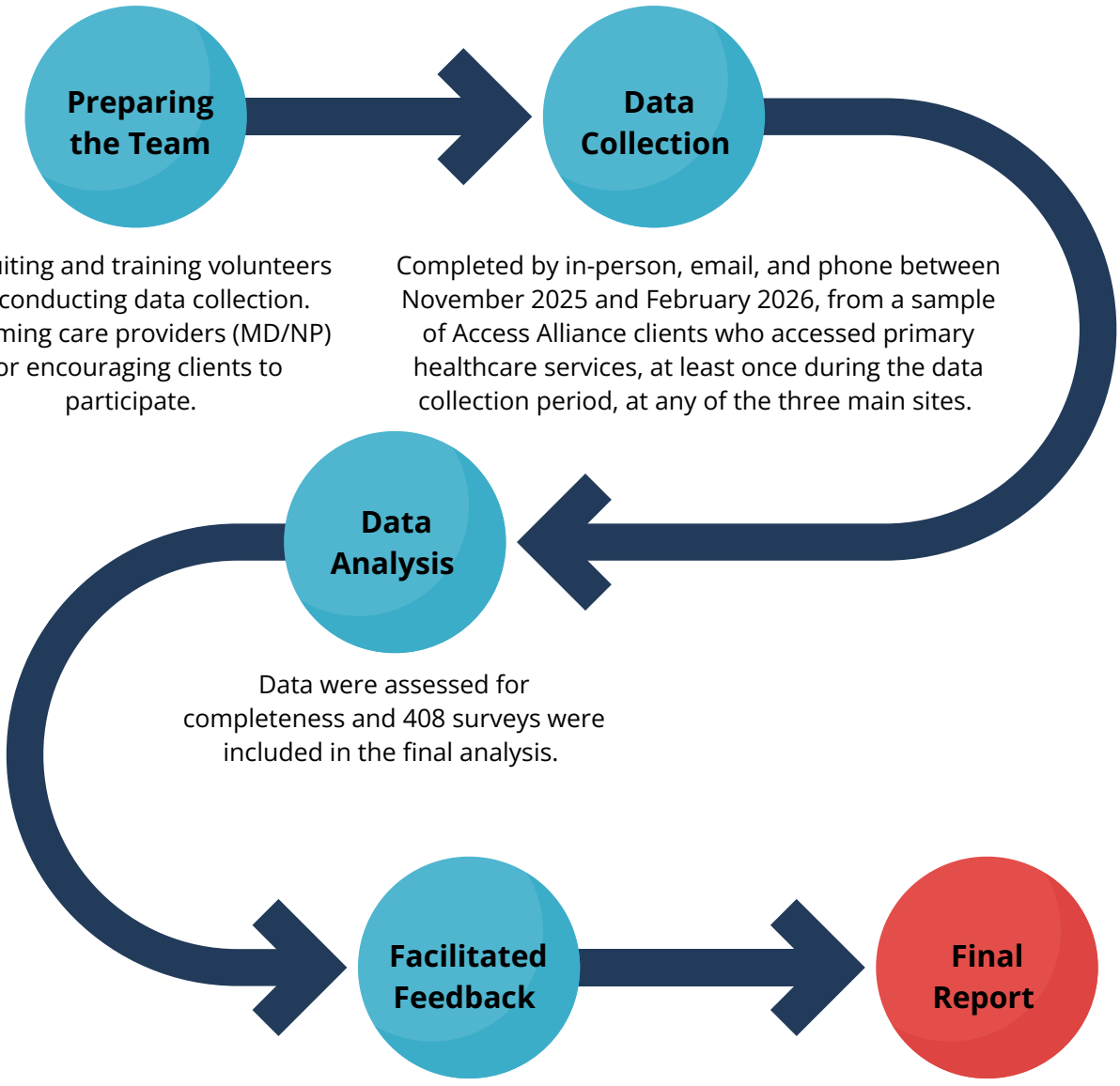
This report is a compilation of primarily quantitative data collected by a real-time or 14-day recall approach for recording experiences of clients that received primary care services**.** Data triangulation amongst the qualitative and quantitative responses is presented here to understand their expectation and experience.

This report summarizes the findings of the CES 2025-2026 from an accountability perspective focusing on priority indicators around the following quality domains:

Satisfaction	Accessibility	Equity	Client Safety	Patient-Centredness

Primary Care Client Experience Survey

Process of Implementation



Methods

Access Alliance implemented a mixed-methods data collection approach to capture real-time client experience, combining quantitative survey responses with inclusive recruitment strategies to ensure representation across diverse client groups. The survey tool was designed to assess key quality domains including satisfaction, accessibility including virtual services, equity, client safety, and patient-centeredness, and was administered to clients who had received primary healthcare services from a Doctor (MD) or Nurse Practitioner (NP) at least once between November 17, 2025, and February 5, 2026, across the Jane, College, and Danforth sites. Eligibility criteria required at least one visit during the study period, and data collection occurred either immediately after appointments or within a 14 day follow up window to balance recall accuracy with participation rates. Multiple modes of administration, including in person, email, and phone, were used to reduce barriers to participation, improve response rates, and enhance the representativeness of the sample (Figure 1).

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

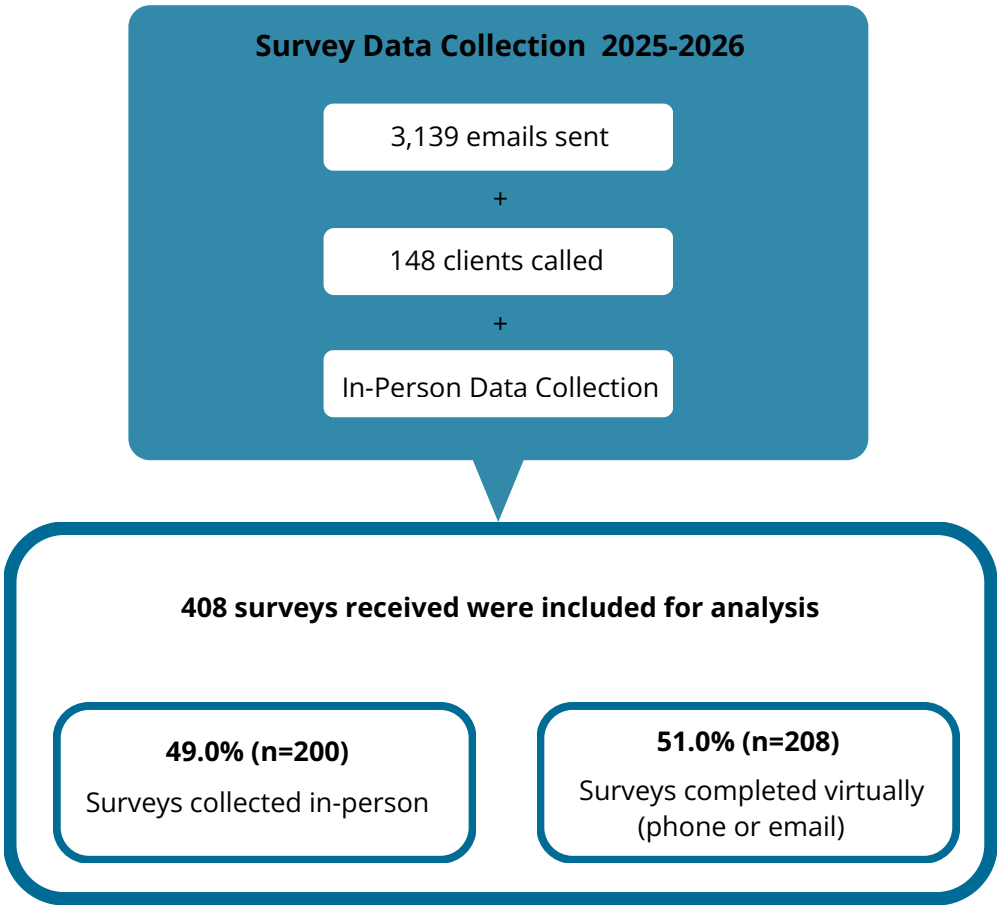


Figure 1. Overview of survey data collection and responses included in data for final analysis.

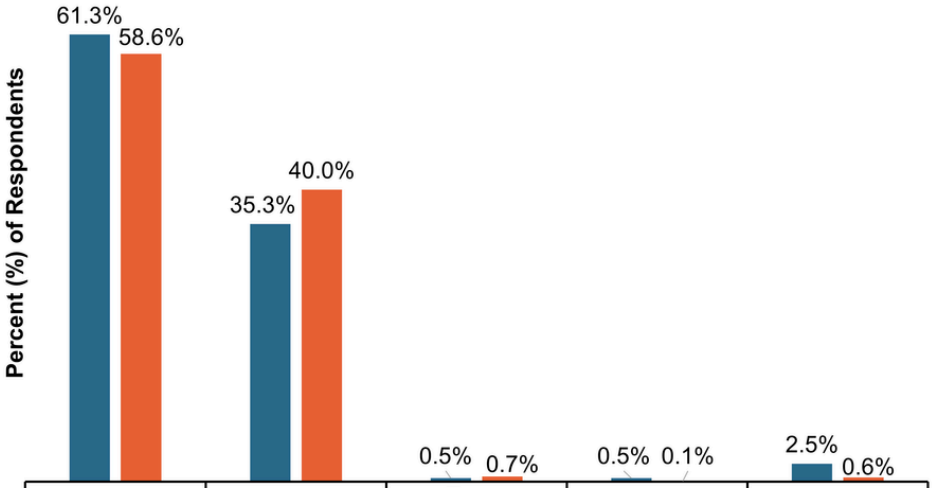
Findings

This section of the report represents a subset of the Access Alliance client population who access primary care services. In this section we referred to them as patients.

Respondent Demographics

The demographic profile of respondents is compared with the demographics of Access Alliance's clients who visited our service providers in the most recent fiscal year of 2024-2025, to assess the representativeness of the sample. For this report, patients were asked about their gender, year of birth and sexual orientation. Furthermore, an interim analysis of respondent demographics was undertaken during the data collection process to monitor and ensure the appropriate representation of the patients as the reference group.

Gender



	Female	Male	Trans (M-F; F-M)	Intersex	Other
% from CES 2025-2026 (N=408)	61.3%	35.3%	0.5%	0.5%	2.5%
% from ACAR 2024-2025 (N=6,259)	58.6%	40.0%	0.7%	0.1%	0.6%

Figure 2. Percentage of patients by gender, comparing the respondents of CES 2025-2026 (N=408) with the overall clients seen in fiscal year 2024-2025 (N=6,259). For visualization purposes, the gender categories 'Two-Spirit', 'Do not know', 'Prefer not to answer', and 'Other' gender identities are grouped as 'Other'.

Note: A more detailed figure containing Survey 2025-2026 reported gender information is located in Figure 4.

Age

Those in the age group of 25-44 years represented the highest percentage (42.4%, n=173) of respondents (Figure 3) in the CES 2025-2026, with the average age being 45.2 years.

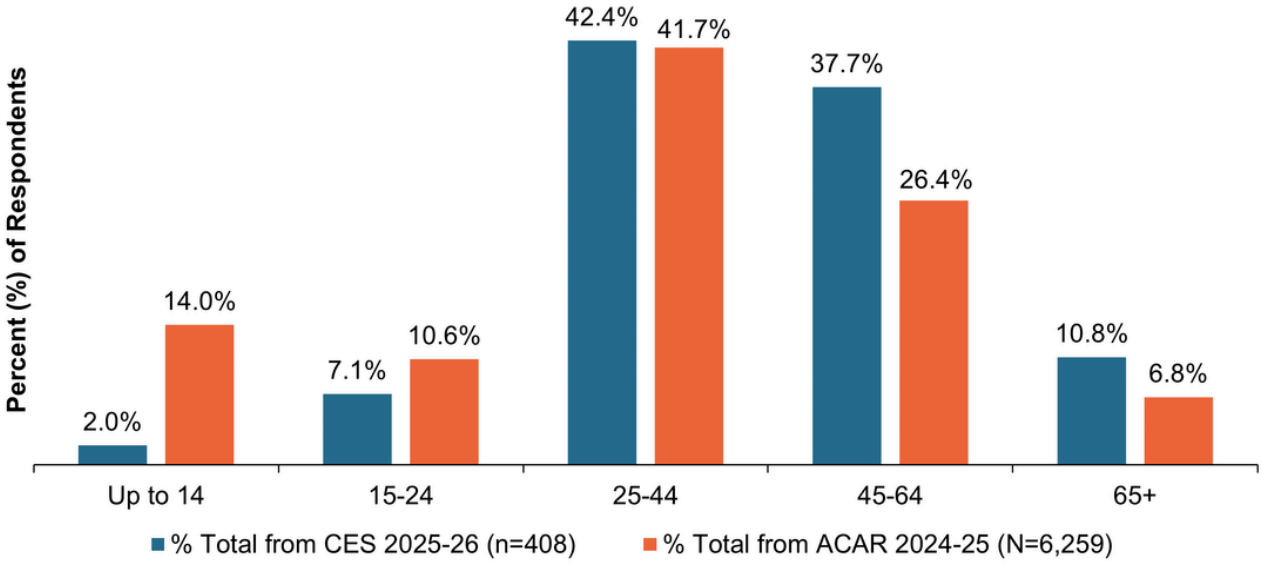


Figure 3. Percentage of patients by age, comparing the CES 2025-2026 respondents (N=408) with the clients seen in the fiscal year 2024-2025 (ACAR; N=6,259).

Sexual Orientation

Most respondents identify as heterosexual (54.2%, n=221), followed by bisexual respondents at 4.2% (n=17) (Figure 4).

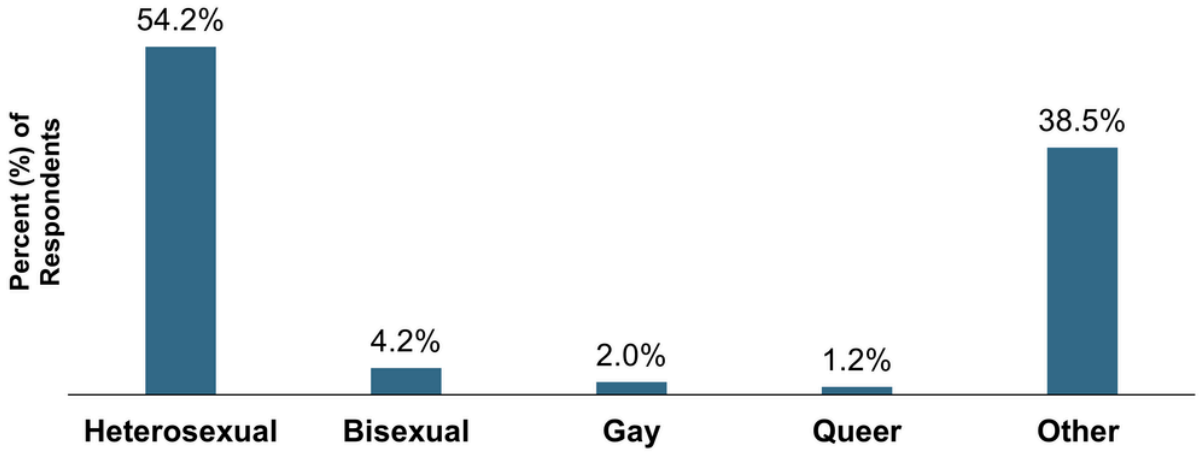


Figure 4. Percentage of patients by sexual orientation (N=408).

Note: For visualization purposes, the gender categories 'Do not know' ,'Prefer not to answer', 'Lesbian', 'Homosexual', 'Two-spirit' and 'Other' are grouped as 'Other'.

Ethnicity

Respondents provided their self-identified racial or ethnic group in response to the question "***Which of the following best describes your racial or ethnic group***?". Of all respondents, those identifying as Black (including African, Caribbean, and North American) represented the highest percentage (27.2%, n=111), followed by Latin American at 22.3% (n=91) and South Asian at 18.14% (n=43) (Figure 5).

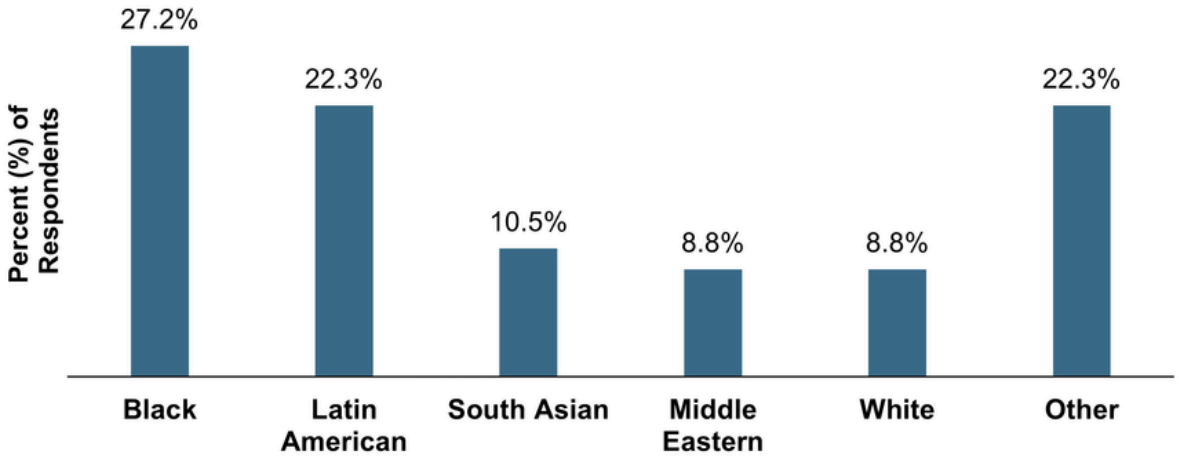


Figure 5. Percentage of respondents by ethnicity in the CES 2025-2026 survey (N=408).

Note: Percentage of respondents by ethnicity in the CES 2025-2026 survey (N=408). For clarity and visualization purposes, the race categories 'Black African', 'Black Caribbean', and 'Black North American' are grouped under 'Black'; 'White European' and 'White North American' under 'White'; and 'East Asian', 'South East Asian', 'Indian Caribbean', 'Indigenous/Aboriginal', 'Mixed heritage', "Do not know', and 'Prefer not to answer' are categorized as 'Other'.

Respondents by Location

Patients were asked, "***Which Access Alliance site did you attend for your appointment?***"

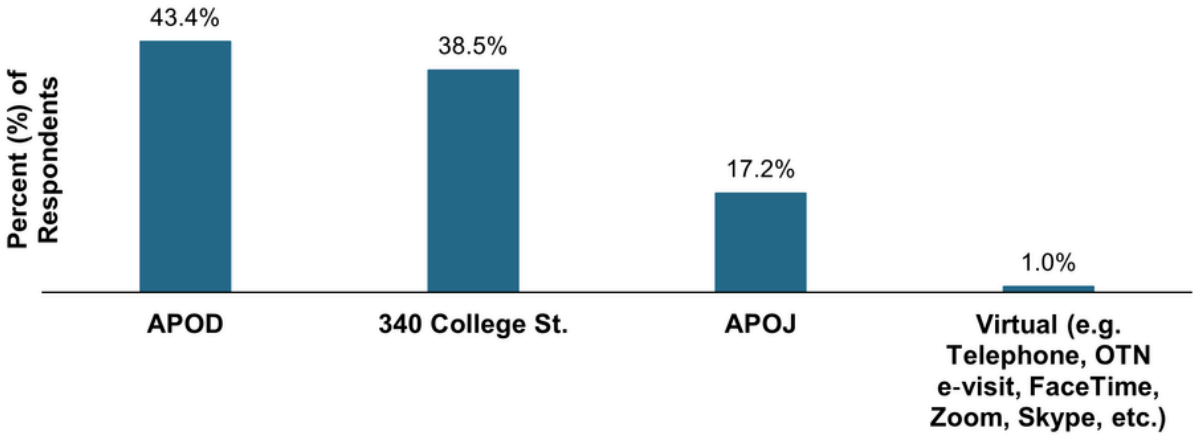


Figure 6. Percentage of patients reporting to the Access Alliance site at which they attended their appointment (N=408).

Satisfaction

Overall satisfaction is determined by asking patients (N=408) *'Overall, how would you rate the care services you received'?* The respondents reported high satisfaction (excellent/very good/good) across all sites (Table 1).

Total	College	APOD	APOJ	Other (Virtual)
98.1% (n=408)	96.2% (n=157)	97.7% (n=177)	98.6% (n=70)	100% (n=4)

Table 1. Distribution of patients' satisfaction ratings across service locations.

As demonstrated in Figure 7, there has been some fluctuation in satisfaction ratings since 2020; however, the satisfaction ratings remain above 90% across the sites.

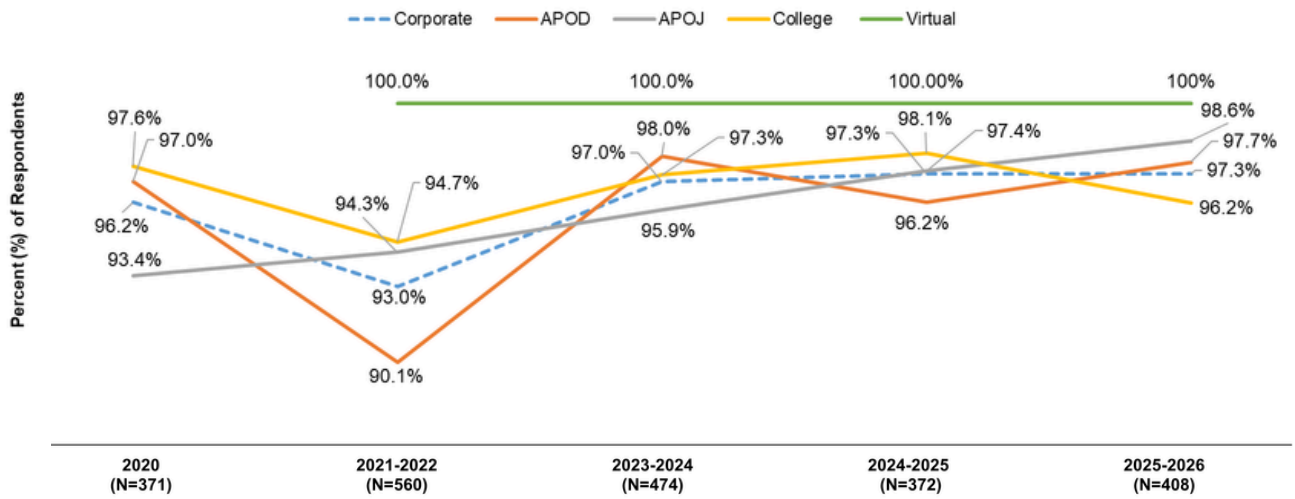
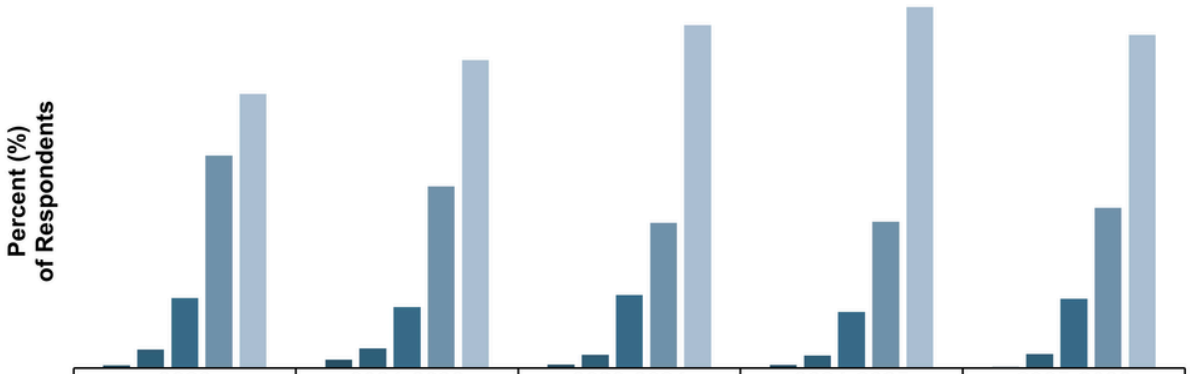


Figure 7. Trend analysis of respondents who indicated they were satisfied with overall care and services received, across sites, fiscal years 2020 to 2025-2026.

When asked '***do you have any suggestions to share with us***', patients expressed overall satisfaction with Access Alliance across key quality domains: satisfaction, accessibility, equity, patient-centeredness, and client safety. They also shared challenges and identified common themes for improvement, including:

- Increase emergency same-day appointments and provide more translated resources.
- Expand specialized services, including mental health, preventive care, and financial support for costly medications.
- Improve telephone responsiveness, voicemail, scheduling, and callbacks.
- Reduce wait times by streamlining registration and offering flexible scheduling.
- Expand clinic locations and staff, and increase provider availability. Add on-site pharmacies and diagnostic services, and expand social supports such as food and housing assistance.
- Enhance communication about programs, send reminders, provide online tools, and ensure interpretation services.

Compared to previous years, there is an increase in percentage of respondents who identified their level of satisfaction as 'good' and 'very good' in fiscal year 2025-2026. Whereas responses for 'poor' decreased to a 5-year low, while 'fair' and 'good', remain similar to the 5-year average (Figure 8).



	2020	2021-2022	2023-2024	2024-2025	2025-2026
Poor	0.5%	1.4%	0.6%	0.54%	0.25%
Fair	3.2%	3.4%	2.3%	2.15%	2.45%
Good	12.1%	10.5%	12.7%	9.68%	12.01%
Very Good	36.7%	31.4%	25.1%	25.27%	27.70%
Excellent	47.4%	53.2%	59.3%	62.37%	57.60%

Figure 8. Trend analysis of overall satisfaction in fiscal years 2020 to 2025-2026.

Satisfaction: In-Person vs. Virtual Appointments

For overall appointments (N=408), most respondents rated their experience as excellent (57.6%) or very good (27.7%) and consistent for both in-person and virtual appointments.

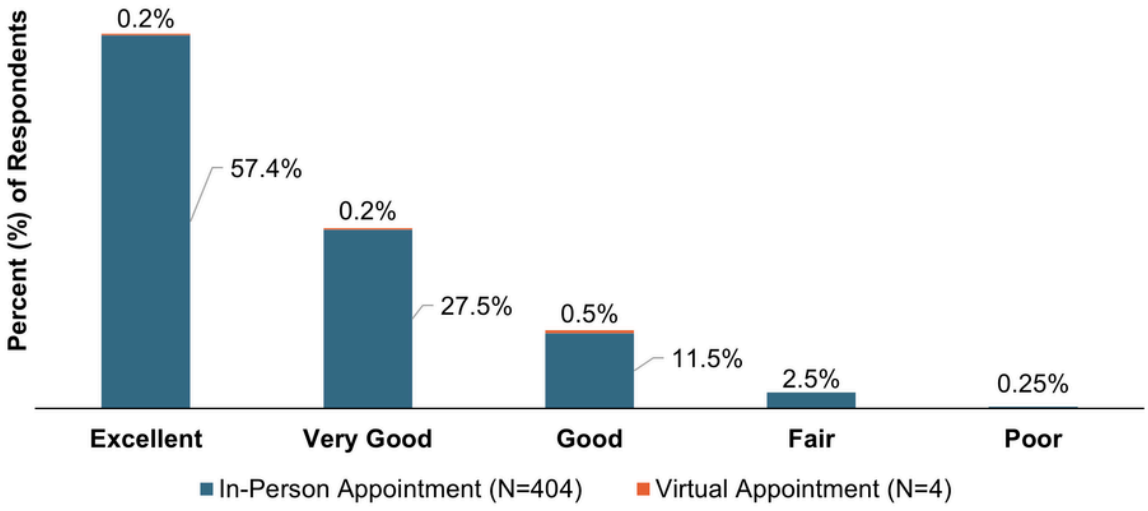


Figure 9. Overall satisfaction in patients receiving in-person and virtual appointments (N=408).

Satisfaction by Age Group

Satisfaction levels were highest among the 25 to 44 years (41.7%, n=170) and 45 to 64 years (37.0%, n=151) age groups (see Figure 10). Dissatisfaction was minimal across all age groups. The Chi-Square test results (Pearson Chi-Square = 5.498, p = 0.24) indicate that age did not significantly impact satisfaction levels.

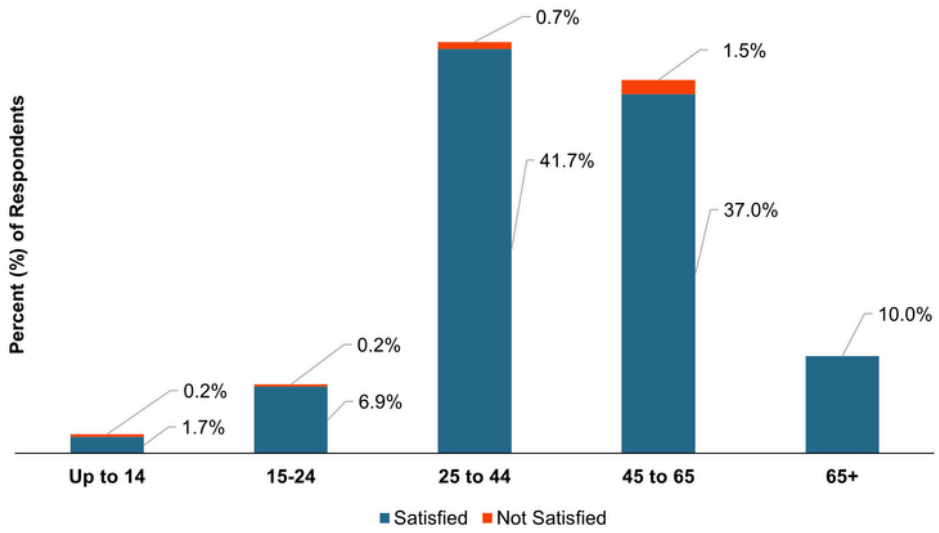


Figure 10. Satisfaction levels by age group for the CES 2025-2026 (N=408).

Satisfaction Levels by Gender

Figure 11 indicates satisfaction ratings by gender identity. Dissatisfaction was minimal, with only small percentages reporting dissatisfaction. Chi-Square test results (Pearson Chi-Square=33.142, p=0.00) suggest that gender did significantly influence satisfaction levels.

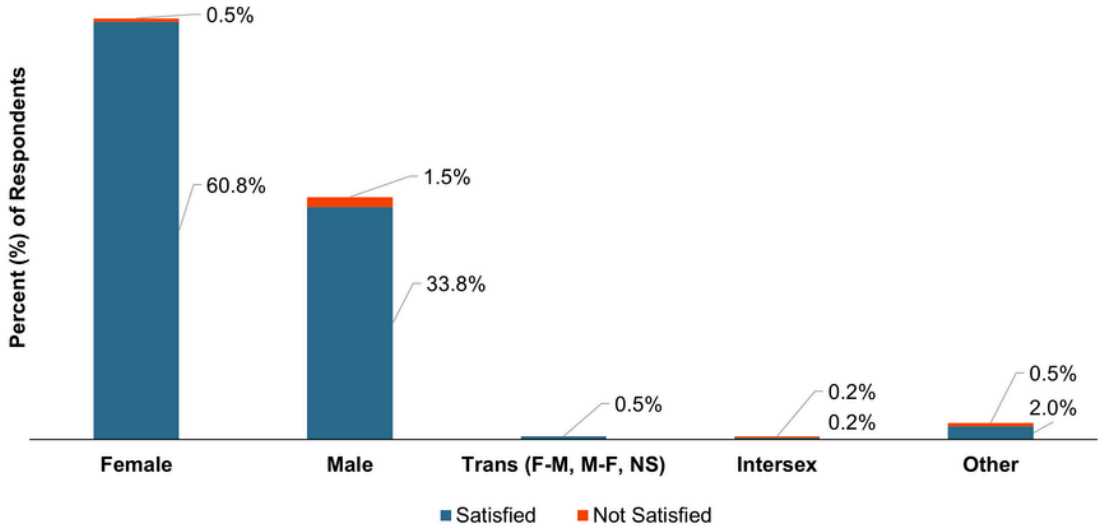
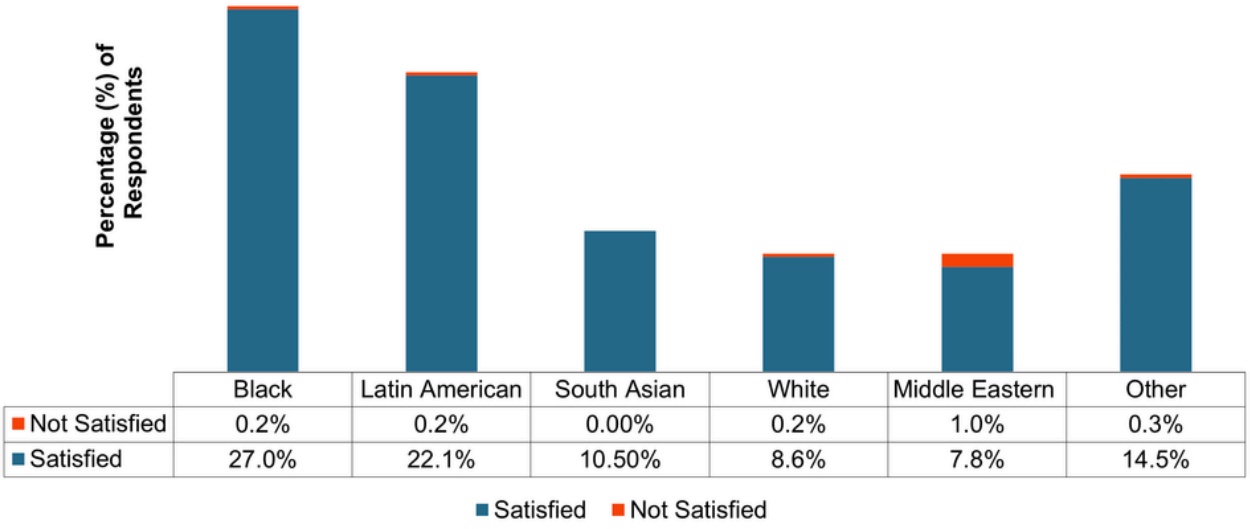


Figure 11. Satisfaction levels by gender (N=408).

Note: 'Prefer not to answer' , 'Do not know', and 'Other' are categorized as 'Other'.

Satisfaction Levels Across Ethnicities

Satisfaction was highest among Black (n=110), Latin American (n=90), and Asian (n=71) respondents. Dissatisfaction was minimal, with Middle Eastern and Asian groups showing the highest dissatisfaction at 0.98% and 0.74%, respectively (see Figure 12). Furthermore Black respondents (e.g. Ghanian, Kenyan, Somali) reported the highest satisfaction (27.0%, n=110) while Middle Eastern respondents had the lowest satisfaction (7.84%, n=32).



	Black	Latin American	South Asian	White	Middle Eastern	Other
Not Satisfied	0.2%	0.2%	0.00%	0.2%	1.0%	0.3%
Satisfied	27.0%	22.1%	10.50%	8.6%	7.8%	14.5%

Figure 12. Satisfaction levels by age group for the CES 2025-2026 (N=408).

Note: 'East Asian', 'South East Asian', 'Indian Caribbean', 'Indigenous/Aboriginal', 'Mixed heritage', "Do not know', and 'Prefer not to answer' are categorized as 'Other'.

Satisfied Access Alliance Clients who Agreed to Recommend Services

Patient responses regarding ***'whether they would recommend Access Alliance to friends or family'*** also reflect satisfaction with Access Alliance services. Of the respondents, 96.3% (n=393) said they are satisfied and probably or definitely would recommend Access Alliance to friends or family. Overall, the findings reflect a high level of satisfaction and a strong likelihood of recommendation among most customers. Pearson Chi-Square test (χ^2 = 98.020, df=1, p = 0.000) indicates that customer satisfaction significantly influences the likelihood of recommending the service.

	Satisfied	Not Satisfied
Would Recommend Services	96.3% (n=393)	1.5% (n=6)
Would not Recommend Services	1.0% (n=4)	1.2% (n=5)

Table 2. Crosstabulation of patient satisfaction and patients who would recommend our services (N=408).

Access - Virtual Appointments

In response to the question, ***'how did you connect with your provider for this virtual visit'***, 4 patients, out of 408, reported connecting virtually by telephone (Figure 13).

A few patients experienced issues while accessing services virtually. These included difficulty explaining health issues virtually as effectively as in person (n=1) and expressed concerns regarding issues of privacy and security (n=1). Despite these challenges, patients reported greater benefits from having their appointments virtually compared to in-person (See Figure 14).

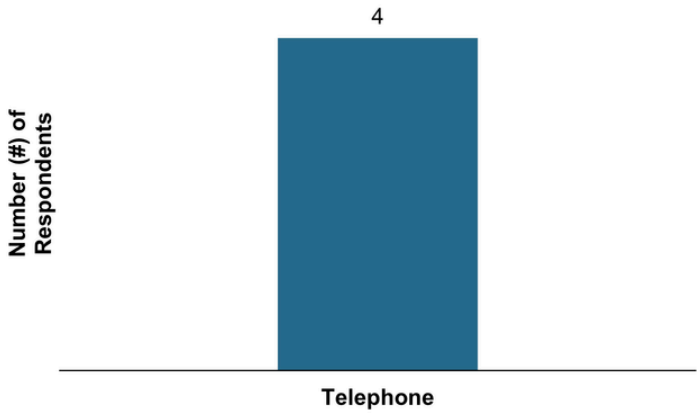


Figure 13. Mode of virtual appointments (n=4).

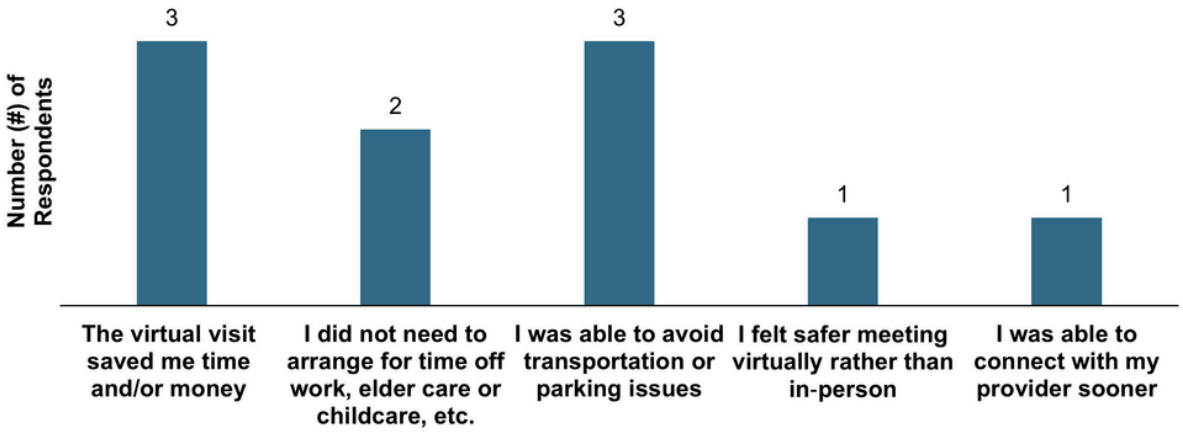


Figure 14. Patient reported benefits of virtual appointments.

Overall satisfaction with virtual appointments was determined by asking ***'How likely are you to choose to receive care virtually again (where appropriate) when in-person visits are more available'***.

- **50%** (n=2) indicated they do not have a preference for or against virtual visits.
- **25%** (n=1) indicated they are 'very likely' to choose virtual care in the future.
- **25%** (n=1) indicated they are 'very unlikely' to choose virtual care in the future.

These findings suggest that while open to the idea of virtual care, there is still a portion of respondents who prefer in-person visits.

Access - In-Person and Virtual Appointments

Among the patients surveyed, several methods to book appointments were identified (Figure 15). When asked ***'On a scale of poor to excellent, how would you rate your overall experience while getting this appointment':***

- **94.6%** (n=386) of clients rate the experience as 'excellent', 'very good', and 'good'.

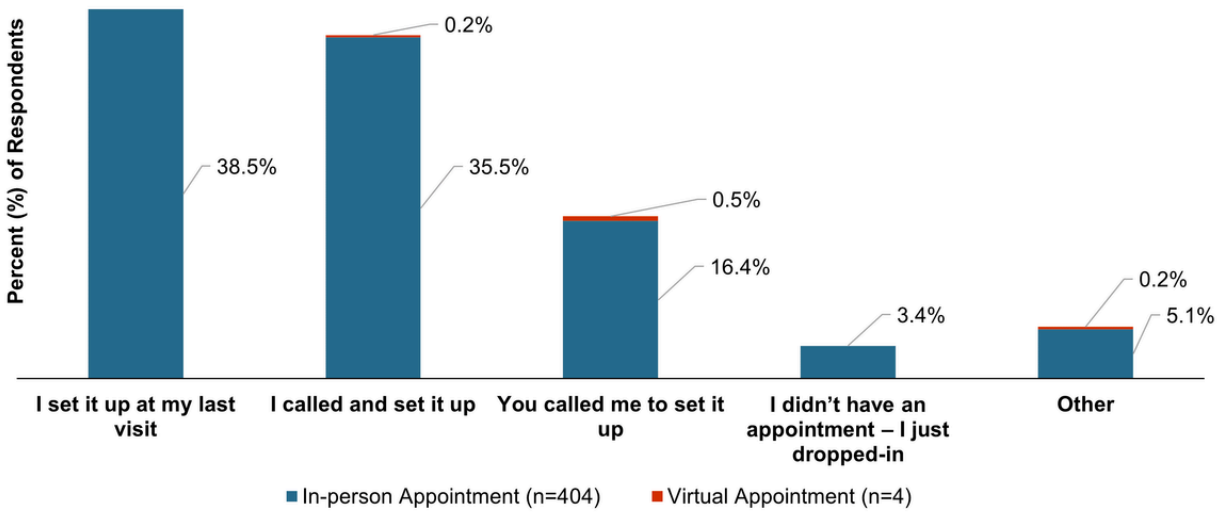


Figure 15. Percent of patient-reported methods of booking appointments.

Note: Drop-in appointments are only available in-person not by virtual modes. Other means of appointment booking methods including 'Other, please specify' are grouped under 'Other'.

Access - Timeliness

We asked patients, ***'Did you get an appointment on the date you wanted?'***

- **87.8%** (N=358) responded 'yes'.
- Timely access is also evaluated based on patients being able ***to see their MD or NP the same or the next day,*** where 29.9% (n=122) reported being able to (Table 3).

Same or Next Day	2-3 Days	4-5 Days	6-7 Days	Total between same day and 7 Days
29.91% (n=122)	11.27% (n=46)	9.56% (n=39)	12.0% (n=49)	62.74% (n=256)

Table 3. Number of days in which patients were able to see or speak with their MD/NP.

The trend analysis shows a similar percentage of respondents receiving appointments on their preferred date from 2020 to 2025-2026 (during and after the COVID-19 pandemic) (Figure 16). Figure 16 shows that, in the current year, the proportion of patients who received appointments on their preferred date has remained above 85%, continuing to exceed both pre- and post-pandemic levels. Furthermore, there was an approximate 4% increase from the previous year, rising from 26.1% to 29.9% in patients reporting that they received an appointment on the same or next day (Figure 17).

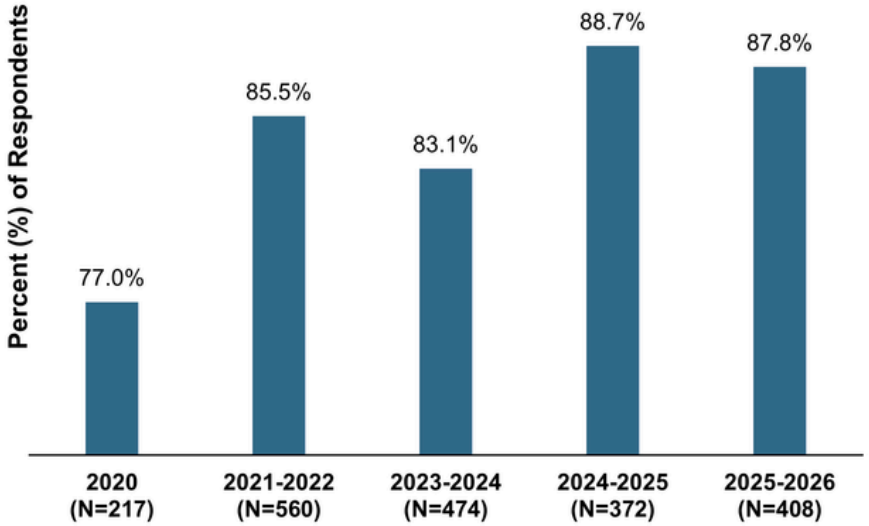


Figure 16. Trend analysis of patients who indicated they got an appointment on the date that they wanted, fiscal years 2020 to 2025-2026.

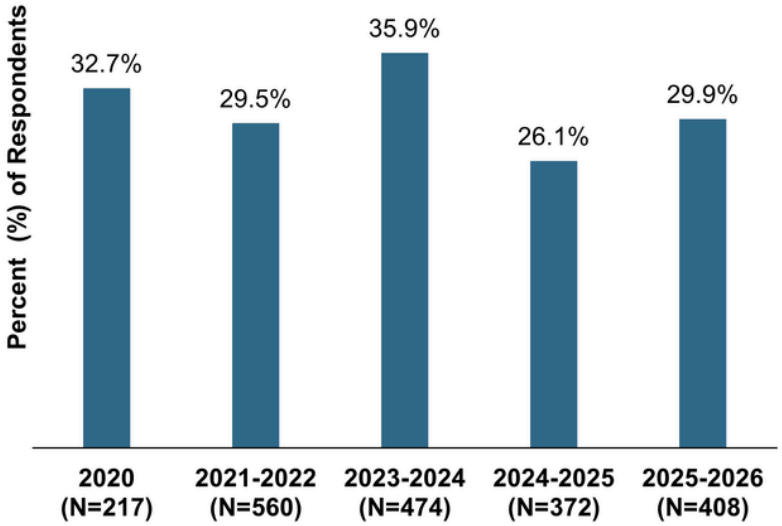


Figure 17. Trend analysis of patients who indicated they got an appointment on the same or next day, fiscal years 2020 to 2025-2026.

Equity

Access Alliance is committed to providing equitable access to programs and services for its patients. To measure equity, we look at a combination of indicators. One indicator is whether patients ***'always feel comfortable and welcome at Access Alliance'*** of which over 95% of respondents since 2020 indicate 'yes'.

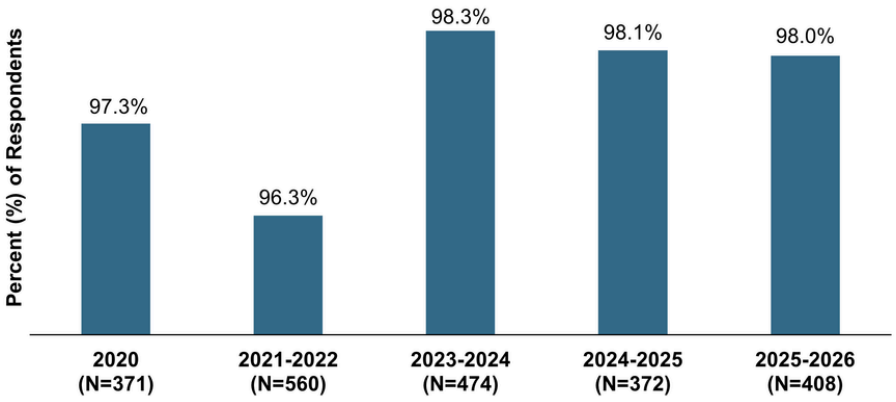


Figure 18. Trend analysis of patients who agreed with the statement '*I always feel comfortable and welcome at Access Alliance*', from fiscal years 2020 to 2025-2026.

Respondents who answered "no" and were asked "***the reasons why they do not always feel comfortable and welcome at our centre***" reported unfriendly staff interactions, challenges with appointment and follow-up availability, and difficulty contacting the centre by phone.

Level of agreement to other indicators related to client equity are identified in Figure 19. Generally this feedback is strong and positive with all indicators above 90%. These findings suggest that Access Alliance is achieving its goal of equitable and welcoming service provision.

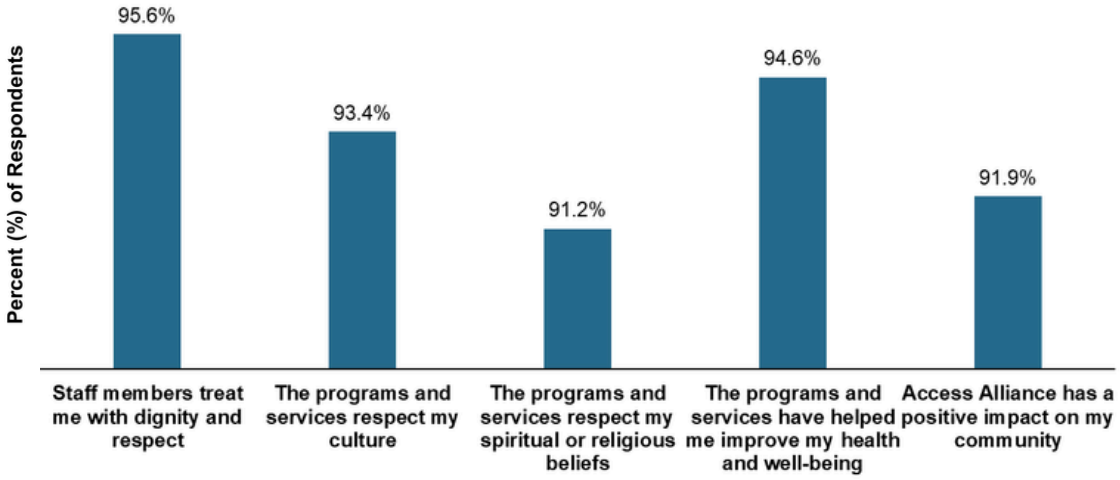


Figure 19. Respondents who agreed or strongly agreed with the above statements (N=408).

Use of Assistive Devices, Technologies, and Supports

Patients were asked to report if they utilize mobility or assistive devices in everyday life (Figure 20). Results demonstrated 14.5% (n=69) use mobility or assistive devices. Of these the most commonly reported was mobility aids (e.g. canes, wheelchair) (n=19), followed by hearing aids or assistive listening devices (n=11) and accessible transportation services (n=11) (Figure 20). A large proportion of respondents (n=306) selected "none of the above," indicating no current use of assistive devices or supports, while a small number (n=43) chose not to disclose this information.

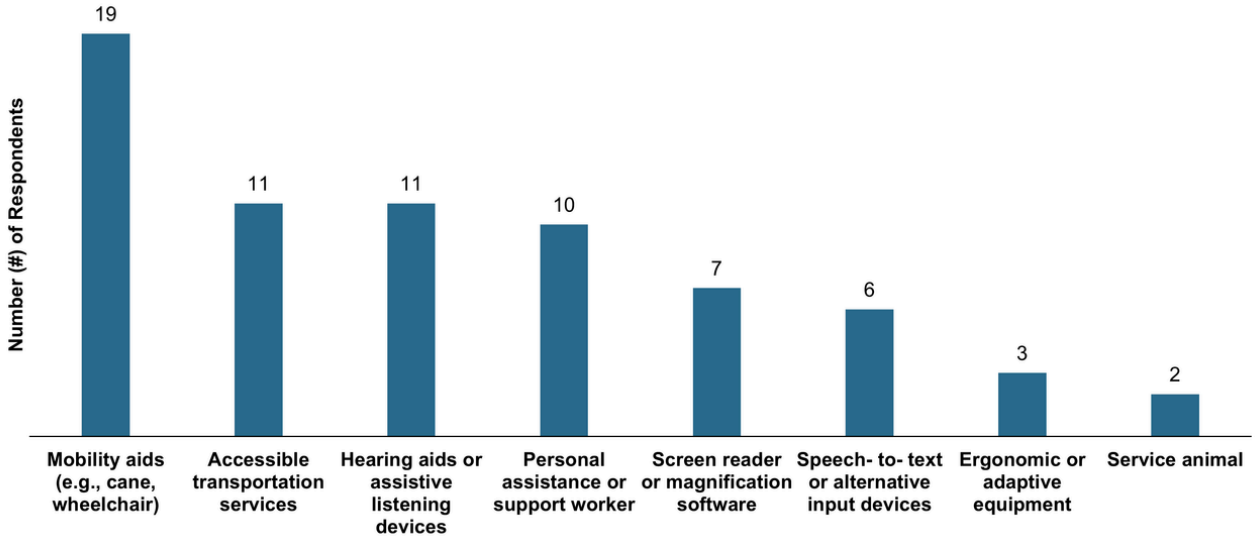


Figure 20. Respondents who reported regular usage of mobility or assistive devices (N=69).

Note: "None of the above" and "Prefer not to answer" were excluded from the figure to improve visual clarity and data interpretation.

Barriers to Accessing Services, Offices, and Digital Platforms

When asked ***"Did you encounter any barriers in accessing or navigating our services, offices or digital platforms related to your disability?"*** 97.1% (n=396) reported no barriers (Figure 21) . Among the 2.9% (n=12) who did report barriers, challenges included difficulties using the telephone system, navigating online services, and travelling to in-person appointments.

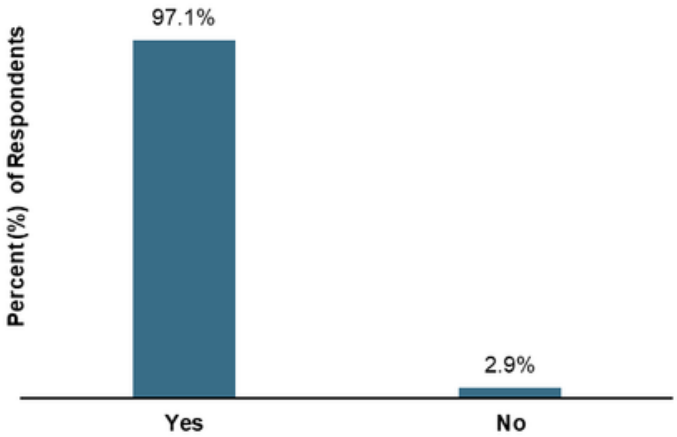


Figure 21. Patient-reported disability-related barriers to accessing services (N=408)

Client Safety

To inform on client safety, patients were asked whether they ***'trust that their personal information is being kept confidential'*** and ***'if they know how to make a suggestion or complaint'.*** Patients generally 'agreed' or 'strongly agreed' with these statements (Table 4).

Indicators of Client Safety	2024-2025 (N=372)	2025-2026 (N=408)
Trust personal information is kept confidential	97.6% (n=363)	94.1% (n=384)
Know how to make a suggestion or complaint	84.7% (n=315)	81.37% (n=332)

Table 4. Indicators of Client Safety, fiscal years 2025-2026 and 2024-2025, of patients who responded 'agree' or 'strongly agree'.

Through qualitative feedback, many also described Access Alliance as a safe and welcoming environment, where they received quality care, treatment, and support which improved their health and well-being. There were few instances of patients expressing concerns related to communicating with reception staff and a few patients reported they felt providers were not listening to their concerns, or experienced delays in care as they were not able to get through the phone to make an appointment, and issues with the continuity of care and seeing different service providers. Multiple patients also reported difficulties affording expensive prescription medications.

Patient Centeredness

When asked if ***'staff treat them (patients) with dignity and respect'***, 95.59% of respondents (n=390, N=408) agreed or strongly agreed.

Patients were asked about aspects of their experiences that reflect whether patient-centered care is being delivered by Access Alliance staff (Table 5). Here we understand that there is a decrease in these indicators. The number of patients reporting proper involvement in their care decisions and healthcare staff spending enough time with them decreased by ~3% from the previous year's reporting. Importantly, there is a ~5% decreases in patients reporting the opportunity to ask questions about treatments.

Indicator of Patient Centeredness	2023-2024 (N=372)	2024-2025 (N=474)	2025-2026 (N=408)
Have the opportunity to ask questions about treatment	86.9% (n=412)	87.9% (n=327)	82.84% (n=338)
Involved you as much as you want to be in decisions about your care and treatment	90.3% (n=428)	91.4% (n=340)	87.5% (n=357)
MD/NP spends enough time with them	92.4% (n=438)	92.7% (n=345)	89.22% (n=364)

Table 5. Indicators of Patient Centeredness fiscal years 2025-2026, 2024-2025, and 2023-2024. Percent (%) who responded 'always'/'often'.

Conclusion

The current report findings synthesize the longitudinal strengths of existing primary care programming while identifying emerging trajectories in community health requirements. The data synthesized in the Annual Primary Care Client Experience Survey Report underscores a critical nexus between client-reported outcomes and institutional evolution. By transitioning from subjective service delivery to an evidence-informed model of community health, Access Alliance effectively bridges the gap between theoretical health equity and clinical practice.

The integration of these findings into long-term strategic planning not only addresses current systemic barriers but also establishes a reproducible framework for high-quality, culturally responsive primary care. Ultimately, this rigorous commitment to continuous quality improvement ensures that the organization remains an adaptive and vital instrument in fostering longitudinal health outcomes and community resilience. Utilizing a participatory framework, this data collection effort relies on the lived experiences of service users to drive evidence-informed service planning. The qualitative and quantitative metrics captured herein are instrumental in bolstering client-centred clinical practices and developing targeted interventions to mitigate systemic barriers to care. Consequently, Access Alliance continues to advance a high-quality primary care paradigm designed to optimize health outcomes and foster community resilience through rigorous, data-driven advocacy

Recommendations

Based on the responses, feedback, and suggestions collected in the Client Experience Survey 2025-2026, the following recommendations are presented.

- Maintain and sustain effective practices of service provision to ensure continued positive client experiences, consistent quality of care, and responsiveness to community needs.
- Strengthen staff training in trauma-informed care to support inclusive, patient-centered care and ensure clients are meaningfully engaged in treatment planning and decision-making.
- Improve patient communication by developing clear, easy-to-understand materials on Access Alliance resources (including virtual care, community programs, and translation supports) and providing guidance to strengthen use of the Oceans (online booking platform) for appointment scheduling.
- Increase responsiveness to phone inquiries by implementing call response standards and tracking wait times, ensuring culturally responsive communication, and strengthening follow-up processes for appointment updates and test results.
- Improve timely access to care by expanding same-day appointment capacity, optimizing scheduling processes, and strengthening triage pathways for urgent needs.
- Enhance inclusiveness in service delivery by consistently offering language interpretation services across all patient touchpoints, including intake, booking, and clinical encounters, and ensuring staff actively document and use preferred languages.
- Expand patient support by proactively providing tailored health information and navigation assistance, helping clients connect to relevant community resources and services in a more coordinated and holistic way.

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Appendix

Implementation

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

Real-Time Data Collection: To gather client feedback immediately after receiving care without any recall bias, in-person data collection allowed for clients to provide their feedback without delay. With the email and phone-based modes, the ability to ensure the 'real-time' (immediately after a client has received care from the medical team) aspect of data collection is limited. Therefore in 2021-2022, for the email and phone modes, we have implemented the[1] 'Seven-day recall' method for data collection. This methodology has been revised during CES 2023-2024 due to the challenges we encountered in our previous iterations of the project implementation based on experience and feedback from staff and clients. Feedback received from respondents indicated that they were overwhelmed by the survey communication when delivered weekly as they had already responded to the survey previously. Additionally, the 'Seven-day recall' method via email or phone-based modes was labor-intensive for the project team to conduct with limited available resources. Therefore, the data collection methodology was adjusted by extending the recall duration to 14 days instead of the 7-day recall.

[1] The seven-day recall method is commonly used in patient self-reporting such as dietary or physical activity tracking, disease or illness symptom tracking, and outcome measures. Studies validating various tools at varying recall durations demonstrate that the 7-day recall method produces information comparable to shorter recall periods or daily real-time tracking with limited recall bias (Bennett et al., 2011, Cella et al., 2010, Hernández-Cordero et al., 2016, Waller et al., 2016).

Appendix

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, 2025). To respond to language barriers during in-person and telephone data collection, Access Alliance Language Services Remote Interpretation Network (RIO) was offered when appropriate.

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, n.d.)

Project team: The process is led by the Access Alliance Research Assistant and the Peer Researcher, with support from a placement student and volunteers. The Director of Organizational Knowledge & Learning oversees the activities to monitor data flow and quality.

Survey Approach and Sampling

In the previous fiscal year (April 1, 2024 to March 31, 2025) primary care providers (MD/NP) have seen 4,187 clients (Access Alliance, 2024). The Canadian Centre for Accreditation standards require over 2% of these clients to be surveyed. Our focus, however, is not on the minimum sample size but also on the representation of clients and the power of data is of paramount importance. As such, we implemented convenience sampling to collect a target of 400 (minimum target of 65) completed surveys from clients who have accessed primary care (MD/NP) services at Access Alliance.

Appendix

Methodology

Access Alliance implemented a mixed-methods data collection approach to collect real-time client experience. The survey tool was designed to assess quality domains of satisfaction, accessibility (including virtual services), equity, client safety, and patient-centeredness. Survey data collection was completed in-person, by email, and by phone with clients who received primary healthcare services with a Doctor (MD) or Nurse Practitioner (NP) from Access Alliance between November 17, 2025, and February 5, 2026, at least once, at any of the three (Jane, College, and Danforth) sites. Data collection occurred immediately after an appointment or within 14 days after.

The primary mode of data collection was an in-person invitation after clients had finished their visit with their MD or NP. Clients completed the survey via a secure link to the online survey platform with support by trained volunteers on-site. The secondary mode of data collection was through virtual low-touch modalities which included email and phone calls. Web-based surveys were emailed to all clients who had an email address in their Access Alliance record and attended an appointment with a provider within the previous 14 days. This 14-day recall methodology is indeed a modification of the one previously implemented for CES 2021-2022. The change was made from 7 days to 14 as a result of the feedback from clients and our staff team (refer to the Appendix for more details). As such, 3,139 email requests were sent to clients for survey completion. The telephone-based collection was completed by randomly contacting 148 clients for whom Access Alliance had record of a telephone number, but no email. This was to ensure (i) responses were representative by including clients without emails, 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. Furthermore, clients who were emailed or met with in person could request a telephone call for scheduling and language accessibility purposes. For telephone-based survey collection, the project coordinator completed the web-based surveys on behalf of patients.

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 (Survey Monkey, n.d.). The survey was translated into Arabic, Farsi, Spanish, Portuguese, and Tigrinya to reduce language barriers, reflecting some of the top languages that Access Alliance clients speak (Access Alliance, 2025). For in-person and telephone-based survey data collection, interpretation was available as required and provided by Access Alliance Language Services, Remote Interpretation Ontario.

Appendix

Modes of Continuous Data Collection

The tool is formatted using secure Survey Monkey software and administered using electronic tablets (iPads), email-based or phone-based collection. Volunteers were recruited to support in-person survey data collection.

Mode-1: In-person virtual data collection: Clients will be provided iPads after their visit with a Primary Care Provider (MD/NP). Each location has its own designated iPad for CES data collection only. The survey will be pre-set on the iPad for the client to complete. Alternatively, clients can have access to the survey using their mobile devices via a designated QR code. Neither the iPads nor the survey platform are connected to our electronic medical record system.

Mode-2a: Email-based survey: For clients who attend services in-person or virtually, a follow-up email is sent to the client asking them to complete the survey through the provided SurveyMonkey link. The sampling frame will include clients who attended services and have an email address recorded in Access Alliance's database. Each are sent a personalized email with the survey link, which they could access to complete the survey at home on their own time.

Note for both modes: SurveyMonkey software has some associated pros and cons:

- Pros: (i) SurveyMonkey is web accessibility compliant; (ii) the survey can be programmed to require responses and response types, increasing the potential for high-quality data; (iii) the automatic capture of data in the Survey Monkey database improves the efficiency of the data collection process, and removes data entry error.
- Cons: As a US-based software, there are associated privacy concerns with using SurveyMonkey; however, we are not collecting any personal health information.

Mode-2b: Phone-based survey: For clients who attend services in-person or virtually and do not have an email address, they will receive the CES request by phone.

To avoid duplication of responses whether in-person or by virtual modes, those who have completed the CES previously in the data collection period should not complete the CES again. Due to anonymous responses, determining duplicates is difficult. In anticipation of this issue:

- For clients in-person or by phone, they were screened by being asked if they have previously completed this feedback survey.
- In the email to clients, there is a note to only complete the survey once.

Appendix

Methods for Modes 2a and 2b

On a bi-weekly basis, the Data Management Coordinator conducted a data pull of clients who attended appointments (in-person or virtually) with Primary Care Providers (MD/NP) in the previous two-week period. An excel file serving as the database was used to track the email blasts and phone calls made to clients.

- **Email:** Clients with email addresses were sent a standardized email asking them to complete the CES for their most recent visit within the last two weeks.
  - The email will be sent from the SurveyMonkey collector of the CES English version. It has a brief message outlining why we are emailing and asking them to reply to research@accessalliance.ca or call 416-324-8677 x3232 if they would like a phone call instead. The same message is also shown in the translated languages where they are directed to click the associated link for completing the survey in their preferred language.
  - The links in the email will be updated for each email blast to allow for the collectors to close automatically after one week from the initial invitation.

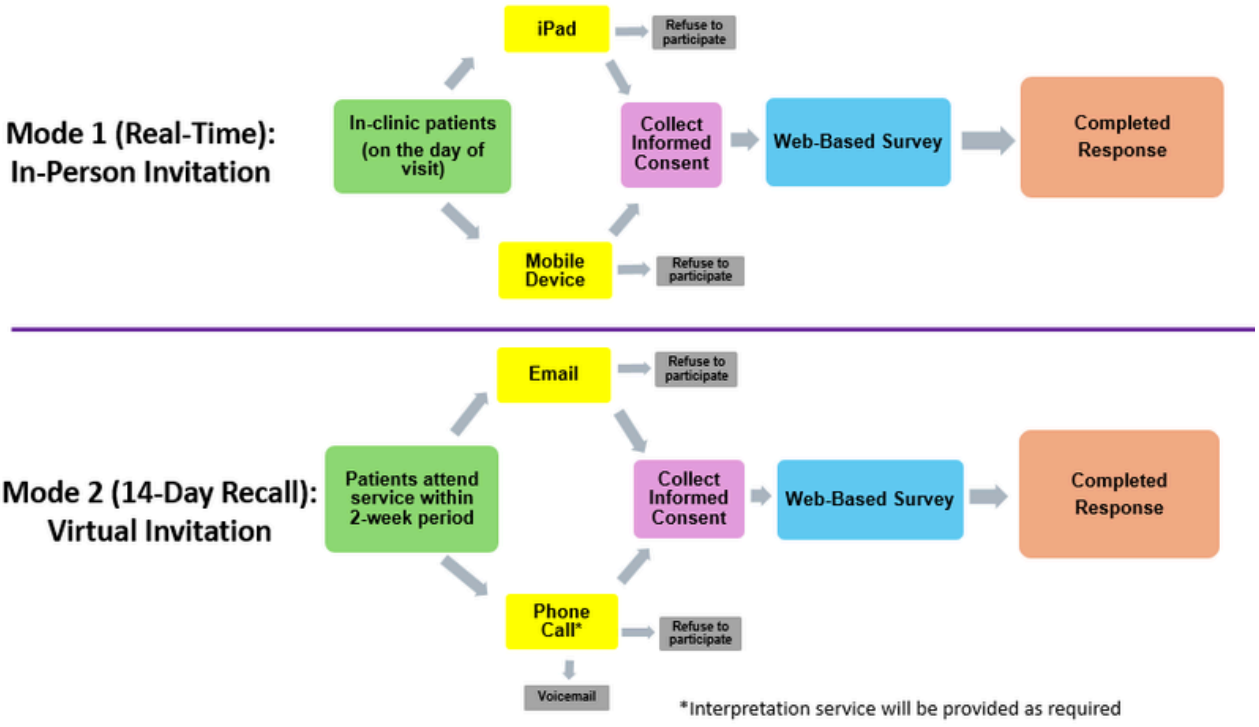
- **Phone:** Clients who only have phone numbers and no listed email, will be contacted by phone and offered verbal administration of the informed consent and CES over the phone or to be emailed the CES. The number of clients phoned was dependent on project team availability.
  - Clients requesting a phone call from the Survey Monkey email blast will receive a call back to be verbally administered the survey.
  - For phone calls, the trained project coordinator will make an initial call to collect data. A callback can be arranged with the client. A maximum of two contact attempts were conducted, one initial call and one follow-up call to clients who did not answer the first call (if time permits or if the client requests a call back).

Appendix

Selection Criteria for CES:

1. Patients who have attend on-going primary care service at Access Alliance with an MD/NP.
2. Patients who attend appointments at clinic sites at College, AccessPoint on Danforth (APOD), AccessPoint on Jane (APOJ), or by virtual or remote methods.
3. Patients who give consent to take the survey.
    a. Patients 13 years of age or older. For those under, 13 parental/guardian consent is required or the parent/guardian can complete it on behalf or with the child.

Data Collection Process



Appendix

Quality Assurance: We monitored quality continuously over the course of data collection with regards to response rate, and to ensure data collected is proportionate to our overall primary care client population. An interim analysis of respondent demographics and location was conducted to identify client groups that are underrepresented. Targeted data collection occurred to increase the representation of particular client groups as required.

Volunteers were Trained on: (i) how to approach clients, including how to explain confidentiality and privacy (within an anti-oppressive framework), (ii) how to ask difficult and sensitive questions (e.g. gender), and (iii) how to offer language interpretation support over the phone through Remote-Interpretation-Ontario (RIO). TC LHIN Measuring Health Equity Initiative resources around asking difficult questions were used as part of the training. Volunteers also receive guidance on how to avoid introducing bias. On-going support was provided to volunteers throughout data collection.

Respondent incentive: To improve the response rate, a chance to enter into a draw to win one of 10, $25 grocery gift cards, was offered upon completion of the survey. Participating respondents were asked to provide either their email address or phone number to be entered in the draw. The entries are only used for the purpose of the draw and to track survey completion and are in no way used to identify individual responses or feedback.