

Collaborative Development of an Older Adult Experience Survey for Specialized Geriatric Services



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ABSTRACT

Background

While generic, site, and disease-specific patient experience surveys exist, such surveys have limited relevance to frail, medically complex older adults attending appointment-based specialized geriatric services (SGS). The study objective was to develop and evaluate a patient experience survey specific to this population.

Methods

Using established survey research methods, this study was conducted collaboratively with older adults (patients and family members/friends) at three Ontario sites offering SGS. The study was done in three phases: Phase One—literature review, evidence alignment, and operationalization of core survey items; Phase Two—cognitive interviews and refinement; and Phase Three—pilot testing, survey item analysis, and refinement.

Results

Based on an evidence-informed framework, the “Older Adult Experience Survey” includes 12 core items, two global rating items, two open-ended questions, and two demographic questions. The summed 12 core items demonstrated acceptable internal consistency (Cronbach’s alpha: 0.83), and the correlation between the summed score and a global question was 0.59, providing evidence of construct validity. The survey also demonstrated face and content validity.

Conclusion

This open access, collaboratively developed, psychometrically sound patient experience survey can be used to assess, then improve, the clinical experience and quality of care of older adults attending appointment-based SGS clinics/programs.

Key words: specialized geriatric services, frail older adults, survey, patient experience, appointment-based

INTRODUCTION

Ongoing assessment of “patient experience”⁽¹⁾ is key to improving health-care quality and reducing costs.^(2,3) While generic,⁽⁴⁾ site^(5,6,7), and disease-specific⁽⁸⁾ patient experience surveys have been developed and implemented, item wording is not specific to appointment-based specialized geriatric services (SGS) and may not have included dimensions relevant to older frail adults.⁽⁹⁾ Further, existing SGS patient satisfaction/experience surveys include various wording and rating scales that impede provincial reporting.

In Ontario, a collaborative of 11 regional programs provide SGS to the ever-increasing number of older adults⁽¹⁰⁾ living with, or at risk for, frailty⁽¹¹⁾ whose health, dignity, and independence are challenged due to multiple complex medical, functional, and psychosocial issues. This SGS collaborative works with primary care physicians, community professionals, and others, by offering a spectrum of hospital and community-based services to older adults.

The objective of this study was to develop and evaluate a minimum set of core survey items for measuring the experience of older adults in appointment-based SGS settings.

METHODS

Using established survey research methods,⁽¹²⁾ this study was conducted in three phases (see Table 1) as approved by the Health Sciences North Research Ethics Board, the Ottawa Health Science Network Research Ethics Board, and The Scarborough Hospital Research Ethics Board.

Phase One: Literature Review, Evidence Alignment, and Operationalization of Core Survey Items

The literature review was built off work done as part of the Canadian primary health-care system renewal,⁽¹³⁾ as both SGS and primary care are largely appointment-based services.

The work conducted to develop the Ontario Primary Care Performance Measurement Framework,⁽¹⁴⁾ along with Wong and Haggerty's scoping review⁽¹⁵⁾ and other publicly available articles describing patient experience frameworks and surveys, formed the basis of this non-exhaustive literature

TABLE 1.
Methods used to develop and test the Older Adult Experience Survey

<i>Phase</i>	<i>Actions</i>	<i>Details</i>
Phase 1: Framework Identification and Item Selection	Review of existing surveys used by RGPs to identify quality improvement initiatives	Performance Measurement Committee (PMC) established Review of existing surveys; Identification of common items; examination of formatting, layout, and overall design
	Literature review: Conceptualizing patient experience	Selection of a patient experience framework Collection/sharing of existing patient experience surveys and relevant literature
	Review of existing measures/frameworks	
	Framework dimension/subdimension selection and refinement Item development	Group consensus based methodology (see appendix A) used by PMC to identify dimensions and subdimensions of the selected primary care framework applicable to SGS Item refinement guided by principles of clarity, simplicity, conceptual specificity, and contextual relevance Survey face validity evaluated by the PMC
Phase Two: Survey Refinement	Review of draft survey items by target population	REB submission and approval Development of semi-structured interview guide Site selection and recruitment of patients/family Cognitive interviews (see appendix B) with consenting patients/family members: face validation; review of formatting, layout and design; item-by-item review regarding utility, relevance, and wording of each item; assessment of comprehensibility and acceptability
	Pilot survey finalized	Items revised by PMC based on de-identified notes taken during the cognitive interviews
Phase Three: Pilot Testing	Pilot testing of core items with target population	Site selection and patient recruitment Staff training in survey administration Distribution and collection of surveys
	Assessment of pilot survey psychometric properties	Data entered into SPSS v. 24 database Determination of item missingness, item frequency distributions, tests of normality Assessment of internal consistency: Cronbach's alpha Assessment of construct convergent validity: Spearman rho correlation between "Overall, I felt that the care and services I experienced were [0=poor, 10=excellent] and the 12-item summed score Assessment of construct divergent validity: item by item Mann-Whitney U or Kruskal Wallis tests by site and time of year Scores summed by domain: inter-domain Spearman rho correlations determined Responses to "What worked well?" and "What could be improved?" coded using framework's subdimensions Survey endorsement by RGPs of Ontario Executive group
	Survey review	Review of item wording, scoring and formatting by PMC Post discharge, consenting patients randomly given both the pilot survey and the post pilot version followed by cognitive interviews Score deviations examined
	Documentation	Implementation guide developed Survey (https://rgps.on.ca/resources/rgps-of-ontario-older-adult-experience-survey/) and implementation guide (https://rgps.on.ca/resources/rgps-of-ontario-older-adult-experience-survey-implementation-guide/) posted

review. Conventional search methods included a search of electronic databases (e.g., Google for grey literature and hand searches of key articles). Rigid inclusion/exclusion criteria were not applied, but articles that focused on older adults and appointment-based services were of prime interest. The search was limited to articles written in English between 2002 and 2016.

An evidence-informed patient experience framework was selected based on its relevancy to SGS settings, the SGS population, and alignment with other Canadian work in this area. Following this, a group consensus approach based on the Delphi methodology⁽¹⁶⁾ was used to identify SGS applicable dimensions and sub-dimensions, and to draft item wording for an SGS patient experience survey (see Appendix A).

Phase Two: Cognitive Interviews and Refinement

As informed by Willis and Artino,⁽¹⁷⁾ semi-structured cognitive interviews (see Appendix B & C) were conducted at three SGS sites (Ottawa, Scarborough, Sudbury). A convenience sample of 5–15 older adults⁽¹⁸⁾ was required. Older adults who attended SGS appointment-based services during the study period and who were able to speak and understand English were asked to provide insights into the utility, relevance, and wording of each draft item. Based on their feedback, a pilot version of the survey was finalized using the methodology described in Appendix B.

Phase Three: Pilot Testing, Survey Item Analysis and Refinement

The pilot version of the survey was tested at two sites (Ottawa, Scarborough) with another convenience sample of cognitively intact older adults. It was determined that 73 patients per site were needed, assuming a 10% margin of error and a 95% confidence interval around a sample proportion of 50%. The statistical analysis was done using SPSS statistical software (SPSS 24, IBM, Armonk, NY, USA). Item-by-item frequency distributions were generated, and Cronbach's alpha was calculated for the summed core items.

The distribution specific correlation between the global item ("Overall, I felt that the care and services I experienced were..."), and the summed core-item score was determined to provide evidence of construct validity. Correlations among the framework dimensions were then examined. Finally, framework subdimensions were used to code responses to the open-ended questions (What worked well? What could be improved?).

Subsequently, the pilot survey was revised and re-evaluated by a convenience sample of older patients who received SGS services at the Scarborough site. These patients were given both the pilot survey and the revised pilot survey in random order and then participated in cognitive interviews (see Appendix D). Item-by-item frequency distributions were compared using distribution appropriate statistics and qualitative responses were coded.

RESULTS

Phase One: Literature Review, Evidence Alignment, and Operationalization of Core Survey Items

Wong and Haggerty's⁽¹⁵⁾ primary care framework was selected and used to guide the development of the SGS patient experience survey. All six framework dimensions and 12/17 subdimensions were deemed applicable to SGS (see Table 2). This Phase One draft survey included 16 core items and two global items.

Phase Two: Cognitive Interviews and Refinement

Interviewees (n=19) indicated that the draft survey items measured all key aspects of their patient experience, thereby providing some evidence of both face and content validity. Feedback led to the rewording of eight items and the deletion of four items pertaining to three subdimensions. Based on these findings, a pilot survey was generated that included 12 items scored on a 5-point Likert scale, one global question scored on an 11-point Likert scale, a willingness to recommend item rated on a 4-point Likert scale, and two open-ended questions (see Appendix B).

Phase Three: Pilot Testing, Survey Item Analysis and Refinement

Of the estimated 257 patients who met the phase three study inclusion criteria, 145 were recruited [Ottawa: n=75/114 (65.8%); Scarborough: n=70/123 (56.9%)]. Due to missing values, summed scores for the core 12 items were generated for 131 patients. Summed scores ranged from 43 to 60. The mean of the summed core items was 56.9 (SD: 3.9) and the median was 59 (interquartile range (IQR): 6). Cronbach's alpha was 0.83, demonstrating acceptable internal consistency.⁽¹⁹⁾ As the frequency distribution associated with summed scores deviated significantly from a normal distribution (Shapiro-Wilk test: 0.80, $p < .001$; skewness: -1.180), non-parametric tests (Spearman rho correlations, Mann-Whitney U or Kruskal Wallis tests) were used to assess statistical associations and group differences. The Spearman rho correlation between the 12-item summed score and the global experience rating was 0.59, providing evidence of construct convergent validity. Although inter-domain Spearman rho correlations varied from 0.19 (trust and access) to 0.58 (comprehensiveness of services and continuity and coordination), all correlations were statistically significant ($p < .05$).

More than 60% of all patients selected the top category for any one of the 12 core survey items and 54 patients (41.2%) selected the top response for all items (see Table 3). Despite relatively little dispersion, differences were detected by time of year and/or by site/program for 6 of the 12 survey items (Mann-Whitney U or Kruskal Wallis test, $p < .5$), providing some evidence of construct divergent validity. Qualitative survey responses were mapped to nine of the ten framework subdimension and provided further information on perceived strengths and areas for improvement.

TABLE 2.
Wong and Haggerty⁽¹⁵⁾ dimensions and subdimensions retained for Older Adult Experience Survey

<i>Subdimensions</i>	<i>PHASE 1 Group Consensus Approach Rounds 1-4: modified W&H dimensions and subdimensions to better fit SGS</i>	<i>Rationale for excluding specific primary care patient experience sub-dimensions</i>	<i>PHASE 1 Group Consensus Approach Rounds 5-10: developed core item wording (draft version for cognitive interview)</i>	<i>PHASE 2 Group Consensus Approach Round 11: refinements made after cognitive interviews (pilot version)</i>	<i>PHASE 3 Group Consensus Approach Round 12: refinements made after pilot testing (final version)</i>
1. Access					
First contact accessibility	The ability to obtain patient or client initiated needed care (including advice and support) from the provider of choice within a time frame appropriate to the urgency of the problem	Currently in SGS most referrals are initiated by a patient's primary care practitioner, and therefore, care is not initiated by the client.			
Accommodation	Relationship between how resources are organized to accept patients or clients (including appointment systems, hours of operation, walk-in facilities, telephone services) & the patient's or clients' ability to accommodate factors to realize access		1. The time I had to wait for my first appointment was reasonable 2. Someone was available to talk to me if I needed it		
Economic accessibility	The extent to which direct or indirect costs related to care impeded decisions to access needed care or continue recommended care	Low priority rating. Concern that only actionable core items are included in the survey and that SGS does not have the ability to impact these costs (e.g., parking).			
2. Interpersonal Communication					
General communication	Ability of the provider to elicit and understand patient or client concerns and to explain health and health care issues		My concerns were listened to Explanations were given in a way I could understand	3. My concerns were addressed 4. Information was given in a way I could understand	
Respectfulness	Ability of practitioners to provide care that meets expectations of users about how people should be treated, such as regard for dignity & provision of adequate privacy		5. I was treated with respect I was comfortable sharing my story	(Item removed. Deemed not relevant by patients)	
Shared decision-making	Extent to which patients or clients are involved in making decisions about their treatment		I was able to contribute to decisions about my care	6. I was included in making decisions about my care, as much as I wanted to be	

TABLE 2. Continued

Subdimensions	PHASE 1 Group Consensus Approach Rounds 1-4: modified W&H dimensions and subdimensions to better fit SGS	Rationale for excluding specific primary care patient experience sub-dimensions	PHASE 1 Group Consensus Approach Rounds 5-10: developed core item wording (draft version for cognitive interview)	PHASE 2 Group Consensus Approach Round 11: refinements made after cognitive interviews (pilot version)	PHASE 3 Group Consensus Approach Round 12: refinements made after pilot testing (final version)
Whole person care	Extent to which providers address the physical, emotional and social aspects of a patient's or client's health & consider the community context in their care		7. Time was taken to learn about me as a person		
3. Continuity and Coordination					
Relational continuity	A therapeutic relationship between the patient or client and one or more identified providers that spans separate health care episodes & delivers care that is consistent with client's bio-psycho-social needs.	Low priority rating. SGS are typically of a short duration and tend not to span separate health care episodes.	I was confident that results of my visit were shared with others as needed	12. It was clear who would receive information about my care	
Information continuity	Extent to which information is used to make current care appropriate to the patient or client		I was connected to services that I needed	I was referred to other programs and/or services that I needed	11. I was referred to other programs/ services that I needed
Coordination	Provision and organization of a combination of health services and information with which to meet a patient's or client's health needs, including services available from other community health service providers				
Team functioning	Ability of SGS providers to work effectively as an inter-professional team to manage and deliver quality patient or client care	(Initially included and then excluded after cognitive interviews) Patients and caregivers accessing SGS programs don't always see the interactions between providers. And, if they do see them, they have difficulty differentiating SGS providers from other types of care providers, especially those that do home visits.	The advice I received was consistent	(Item removed. Deemed not relevant by patients)	(Item removed. Deemed not relevant by patients)

TABLE 2. Continued

Subdimensions	PHASE 1 Group Consensus Approach Rounds 1-4: modified W&H dimensions and subdimensions to better fit SGS	Rationale for excluding specific primary care patient experience sub-dimensions	PHASE 1 Group Consensus Approach Rounds 5-10: developed core item wording (draft version for cognitive interview)	PHASE 2 Group Consensus Approach Round 11: refinements made after cognitive interviews (pilot version)	PHASE 3 Group Consensus Approach Round 12: refinements made after pilot testing (final version)
4. Comprehensiveness of Services	<p>The provision, either directly or indirectly, of a full range of services to meet patient's or clients' health care needs and caregiver information and support needs after being seen by a specialized geriatric service. This includes health promotion, prevention, diagnosis and treatment of common conditions, referral to other clinicians, management of chronic conditions, rehabilitation, palliative care and in some models, social services</p>	<p>High priority item initially, but later became low priority. It was seen to be captured in "comprehensiveness of services provided"</p>	<p>The people I saw thought about all of my needs</p>	<p>10. The (add program/ clinic name) met my needs</p>	
5. Trust	<p>Expectation that other person will behave in a way that is beneficial and that allows for risks to be taken based on this expectation. For example, patient or client trust in the SGS team provides the basis for taking the risk of sharing personal info</p>		<p>I had confidence in the care I received</p>	<p>8. I had confidence in the people I saw</p>	
6. Patient Reported Impacts of Care	<p>Patient's or client's ability or readiness to engage in health behaviours that will maintain or improve their health status</p> <p>Patient's or client's report of medication errors (given or taken the wrong drug or dose) or incorrect medical or laboratory reports and communication with their provider about not taking their prescribed medication or medication side effects</p>	<p>(Initially included, then excluded after cognitive interviews)</p> <p>Patients did not see safety as a relevant concern</p>	<p>I was able to follow the advice I was given</p>	<p>I could achieve the goals that were agreed to</p>	<p>9. I will be able to use the advice I was given</p>

TABLE 2. Continued

Subdimensions	PHASE 1 Group Consensus Approach Rounds 1-4: modified W&H dimensions and subdimensions to better fit SGS	Rationale for excluding specific primary care patient experience sub-dimensions	PHASE 1 Group Consensus Approach Rounds 5-10: developed core item wording (draft version for cognitive interview)	PHASE 2 Group Consensus Approach Round 11: refinements made after cognitive interviews (pilot version)	PHASE 3 Group Consensus Approach Round 12: refinements made after pilot testing (final version)
Confidence in the primary health care system	The perception that allows patients or clients of health care to make decisions since they assume (and expect relative certainty about providers delivering safe & technically competent care	Confidence in the primary health care system drew a low priority rating by members. Not considered very applicable to SGS.	Total: 16 core items	Total: 12 core items (4 items removed) 8 items reworded	Total: 12 core items
7. Overall Ratings					
8. Demographics					
	Overall, I felt that the care and services I received were:		13. Overall, at the (add program/clinic name) I had a:		My Age:
	14. I would recommend this program to my family or friends if they needed it		15. What could be improved? 16. What worked well?		My Gender

TABLE 3.
Pilot survey item-by-item analysis

<i>Item I felt that ...</i>	<i>Missing</i>	<i>% Picking Highest Category</i>	<i>Differed By Site (S)/By Month (M)^{AB}</i>	<i>Item-Total Correlation</i>
... the time I had to wait for my first appointment was reasonable	1 (0.7%)	70.80%	S, M	0.55
...someone was available to talk to me if I needed it	0	78.60%	M	0.38
...my concerns were addressed	2 (1.4%)	79.00%		0.48
...information was given in a way I could understand	1 (0.7%)	81.90%	S	0.48
...I was treated with respect	1 (0.7%)	92.40%	S	0.40
...I was included in making decisions about my care, as much as I wanted to be	1 (0.7%)	77.80%		0.47
...time was taken to learn about me as a person	0	73.10%		0.43
...I had confidence in the people I saw	0	83.40%		0.43
...I could achieve the goals that were agreed to	4 (2.8%)	61.70%	S	0.53
...the program met my needs	4 (2.8%)	78.70%	M	0.70
...I was referred to other programs and/or services that I needed	3 (2.1%)	76.80%		0.52
...it was clear who would receive information about my care	2 (1.4%)	81.80%		0.50

^aSignificant difference ($p < .05$), Mann-Whitney U or Kruskal Wallis test.

^bDifference by site (S): Ottawa or Scarborough site or by month (M): Jan-March, April-May, June-July.

Item-total Correlation = correlation between the item score and the summed framework-based items excluding that item.

The pilot survey was then revised. Two of the core items were reworded, two demographic items were added, instructions were shortened, anchors for the 12 core survey items and one global assessment question were changed, the survey name was modified, and minor changes were made to formatting.

Testing of the revised pilot survey was conducted with additional patients ($n=5$). No one expressed concerns regarding the above revisions. Four patients found the revised survey easier to complete. Response selections were identical for four of the 12 core items and only once did a response switch by two points. Further, there were no significant differences in mean summed core-item scores (pilot version vs. revised pilot version: 55.4 [SD: 4.8] and 55.2 [SD: 4.9], respectively) and median scores did not differ significantly by version (56 [IQR: 8.5] vs. 57 [13], respectively; Mann-Whitney U: $p = 1.00$).

DISCUSSION

A framework-based patient experience survey specific to frail, medically complex older adults attending appointment-based SGS was developed and tested by incorporating input from older adults, their family members/friends, and experts in geriatrics and research. When taken together, the 12 core items of the Older Adult Experience Survey demonstrated acceptable internal consistency (Cronbach's alpha: 0.83). Slightly more than 40% of patients had the maximum score, perhaps accurately reflecting perceived patient experience or perhaps indicating a ceiling effect. Despite this finding, the survey

was able to identify meaningful group differences. Users are encouraged to use a mixed methods approach to triangulate qualitative and quantitative information.⁽²⁰⁾

Testing was conducted on an English language, paper-based version of the survey at three sites providing appointment-based SGS. Further examination of interrater and test/retest reliability, structure, discriminant validity and response rates is warranted. Psychometric properties will need to be re-evaluated if the survey is translated to another language or to an electronic version.

Future studies may provide evidence of the survey's clinical utility and ability to identify areas for quality improvement that will lead to improved quality of patient care. Findings may also provide insights for system planners at the local, regional, and provincial levels.

CONCLUSIONS

Based on an evidence-informed framework, the collaboratively developed Older Adult Experience Survey demonstrates acceptable internal consistency, as well as face, content, construct convergent and construct divergent validity.

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CONFLICT OF INTEREST DISCLOSURES

The authors declare that no conflicts of interest exist.

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APPENDIX A. The Group Consensus Approach (GCA): Details (Delphi Informed)

Details	<p>Delphi: A group-based consensus research method with structured voting where a panel of ‘experts’ complete a series of questionnaires interspersed with controlled feedback and their voting is anonymous (McKenna, 1994).</p> <p>Group Consensus Approach: Participants attended “real time” teleconference calls and had in-depth discussions regarding potential survey wording prior to voting.</p> <p>Recruitment: 8 participants were recruited who had expertise in geriatrics and research.</p> <p>Documentation: GCA worksheets were sent to participants prior to each teleconference. The worksheet included proposed survey wording to be voted on, a space to vote “Yes” or “No” and space to present concerns and rewording suggestions. A summary of the group discussion and the voting on survey wording revisions were forwarded to members after each round.</p> <p>Facilitation: The proposed wording (e.g., framework wording or core item wording) were presented by the facilitator, who then facilitated a group discussion (regarding the principles for inclusion).</p> <p>Item Evaluation for Inclusion: Each item was evaluated based on cognitive interview feedback and discussion amongst GCA participants regarding key principles for inclusion:</p> <ul style="list-style-type: none"> Clarity – clear definitions of each dimension and subdimension that apply to SGS Simplicity – short and common words, short sentences and simple concepts Contextual specificity – applicable wording for SGS programs in different settings and by different providers Contextual relevance – relevant questions that solicit feedback to support the implementation of QI initiatives within SGS <p>Voting: Voting was conducted during structured meetings. If participants were unable to attend, they could submit their vote in advance via the GCA worksheet.</p> <p>Level of agreement: 100% level of agreement was needed. If this was not reached, a discussion regarding rationale for non-agreement occurred, additional wording options were generated, and participants voted on the revised wording options.</p>
Implementation Phase 1	<p>GCA Rounds 1-4 (framework development)</p> <p>Reviewed and minimally modified the dimensions and subdimensions of the Wong and Haggerty 2013 primary care patient experience framework to better fit specialized geriatric services 6/6 dimensions included. 12/17 subdimensions included in SGS version Participants: 8</p> <p>GCA Rounds 5-10 (core item development)</p> <p>16 core items developed that aligned with 12 subdimensions Participants: 8</p>
Phase 2	<p>GCA Round 11 (core survey item development POST cognitive interviews)</p> <p>4/16 core items removed and resulted in 2/12 sub-dimensions being removed. 8/16 core items reworded</p> <p>a 5-point Likert scale was selected for the 12 core items (1=strongly disagree, 3=neutral, 5=strongly agree), an 11-point Likert scale (0=poor, 10=excellent) was selected for the one global question, a 4-point Likert scale was chosen for the willingness to recommend item (1=definitely no; 4=definitely yes), and two open-ended questions were added to gather details about what worked well and what could be improved. Participants: 8</p>
Phase 3	<p>GCA Round 12 (survey development, core items and formatting POST pilot testing)</p> <p>2/12 core items re-worded 2 demographic items added</p> <p>Anchors for 12 core survey items and one global assessment question were changed to 1= no, definitely not; 5= yes definitely and 0=poor experience, 10=excellent experience, respectively</p> <p>Survey name was changed to The Older Adult Experience Survey (OAES) and minor changes to survey formatting (1 legal size page to two letter size pages)</p> <p>SMOG Readability Test conducted (Flesch-Kincaid grade level: 6.2) Participants: 6</p>

APPENDIX B. Cognitive Interview Details

Details	<p>Definition: Cognitive interviewing is an evidenced based, qualitative method designed to investigate participant thought processes while answering survey questions.⁽¹⁷⁾</p> <p>Format: Involves (1) “think-aloud interviewing where respondents actively verbalize their thoughts as they attempt to answer the survey questions” and (2) “verbal probing where interviewer administers a series of probe questions specifically designed to elicit detailed information” (p. 354⁽¹⁷⁾).</p> <p>Semi-structured: Potential probing questions are developed in advance of the interview, while additional probing questions may be developed during the interview based on the participants’ responses.</p> <p># to be recruited: 5-15 participants⁽¹⁸⁾</p>
Phase 2	<p>Implementation</p> <p>12 cognitive interviews conducted with 19 participants at three SGS sites (The Ottawa Hospital Geriatric Day Hospital, The Scarborough Hospital GAIN Clinic and the North East Specialized Geriatric Centre)</p> <p>Survey probes were developed in advance (e.g., I noticed that you were hesitating, tell me what you were thinking?). Specific survey wording was identified for additional clarification (e.g., what does the term “reasonable” mean to you?). Participants were asked if each survey item was useful and relevant to their experience of SGS care and whether any items should be reworded/added/removed</p> <p>See Appendix C for the Phase 2 cognitive interview guide</p> <p>Analysis</p> <p>One analyst amalgamated and analyzed the data from all sites</p> <p>Quantitative analysis: Percent agreement with the relevance of each core item</p> <p>Qualitative analysis: Core survey item feedback was themed according to the conceptual framework (e.g., dimensions, subdimensions). Feedback from participants regarding specific item wording was grouped (e.g., “2 mentioned...”) and feedback detailed as to why wording was confusing, or how it could be improved</p>
Phase 3	<p>Implementation</p> <p>5 cognitive interviews with 5 patients at one site (The Scarborough Hospital GAIN Clinic)</p> <p>Participants reviewed the pre-pilot and post-pilot versions of the survey.</p> <p>Three patients completed the post-pilot survey first while two patients completed the pilot-tested version first.</p> <p>Specific changes to the format of the survey were provided to participants along with the rationale for those changes and participants were asked “do you have any concerns with this change?” and “if yes, please tell us about your concerns”.</p> <p>See Appendix D for the Phase 3 cognitive interview guide</p> <p>Analysis</p> <p>One analyst analyzed the data from the one site</p> <p>Quantitative analysis: percent who (1) noticed differences between the two surveys, (2) had concerns about specific format changes, (3) stated which version was easier to complete, (4) stated that changes impacted how they responded to the question</p> <p>Qualitative analysis: aligned thematic analysis with quantitative categories to provide specific examples about their experience completing the different versions of the survey</p>

APPENDIX C. Cognitive Interview Guide: Phase 2

Examples of possible probing questions

- What does the term “_” mean to you?
- Can you repeat the question I just asked in your own words?
- How did you come up with your answer?
- Was that easy or hard to answer?
- I noticed that you hesitated. Tell me what you were thinking.

Survey Core Items being Tested	Probe Question
The time I had to wait for my first appointment was reasonable <i>ACCOMMODATION: Relationship between how resources are organized to accept patients</i>	“first appointment” “reasonable”
Someone was available to talk to me if I needed it <i>ACCOMMODATION: Relationship between how resources are organized to accept patients & the patient’s ability to accommodate factors to realize access</i>	“available”
My concerns were listened to <i>COMMUNICATIION: Ability of provider to elicit and understand patient concerns</i>	“concerns”
Explanations were given in a way I could understand <i>COMMUNICATION: Ability of the provider to explain health and health care issues</i>	“explanations”
I was comfortable sharing my story <i>RESPECTFULNESS: Ability of practitioners to provide care that meets expectations about how people should be treated, such as regard for dignity & provision of adequate privacy</i>	“sharing my story”
I was treated with respect <i>RESPECTFULNESS: Ability of practitioners to provide care that meets expectations about how people should be treated, such as regard for dignity & provision of adequate privacy</i>	“respect”
I was able to contribute to decisions about my care <i>SHARED DECISION MAKING: Extent patients are involved in making decisions about their treatment</i>	“contribute”
Time was taken to learn about me as a person <i>WHOLE PERSON CARE: Extent providers address the physical, emotional and social aspects of a patient’s health & consider the community context in their care</i>	What does this statement mean to you? Could you paraphrase this?
I had confidence in the care I received <i>TRUST: Expectation that other person will behave in a way that is beneficial and that allows for risks to be taken based on this expectation</i>	“confidence” “care”
The care I received was safe <i>SAFE: Patient’s report of medication errors or incorrect medical or laboratory reports and communication with their provider about not taking their prescribed medication or medication side effects</i>	“safe”
The advice I received was consistent <i>TEAM FUNCTIONING: Ability of SGS providers to work effectively as an inter-professional team to manage and deliver quality patient or client care</i>	“advice” “consistent”
I could follow the advice I was given <i>PATIENT ACTIVATION: Patient’s ability or readiness to engage in health behaviours that will maintain or improve their health status</i>	“advice”
The people I saw worked together well <i>TEAM FUNCTIONING: Ability of SGS providers to work effectively as an inter-professional team to manage and deliver quality patient or client care</i>	What does this statement mean to you? Could you paraphrase this?
The people I saw thought about all of my needs <i>COMPREHENSIVENESS OF SERVICES PROVIDED: The provision, either directly or indirectly, of a full range of services to meet patient’s health care needs and caregiver information and support needs after being seen by a specialized geriatric service</i>	“people I saw” “all”
I was connected to other services that I needed <i>COORDINATION: Provision and organization of a combination of health services and information with which to meet a patient’s health needs, including services available from other community health service providers</i>	“connected”
16. I was confident that results of my visit were shared with others as needed <i>INFORMATION CONTINUITY: Extent to which information is used to make current care appropriate to the patient or client</i>	“results” “with others as needed”
Overall, I felt that the care and services I received were:	“care and services”
I would recommend this program to family or friends if they needed it	“if they needed it”

APPENDIX D. Cognitive Interview Guide: Phase 3

Introduction

- Hand out the Letter of Information and consent form and a pen? Collect signed informed consent forms.
- Hand out the first survey. Write Participant code (A, B, C, D or E) PLUS write “1st” on the back of the first survey given out. Hand out the first survey and a pencil. Gather up the survey.
- Hand out the second survey. Write Participant code (A, B, C, D or E) PLUS write “2nd” on the back of the second survey given out. Hand out the second survey. Gather up the survey.

Circle the Participant ID: A B C D E

Order survey given	Pilot version (PES)	Revised version (OAES)	Time
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1st survey given

2nd survey given

Changes made to:	Probe Questions	Changes made to:	Probe Questions
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Experience of completing surveys

Did you notice any difference between the two surveys? Yes No
If yes, can you give me a quick list of the differences you noticed?

Experience of completing surveys

Did you notice any difference between the two surveys?
 Yes No
If yes, can you give me a quick list of the differences you noticed?

I'd like to ask you specific questions about the changes we made.

NOTE: Have a laminated copy of the PES and the OAES available in case the participant needs additional visual information when answering the questions below.

Changes made to:	Probe Questions
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Survey Name

The name of the survey was changed from Patient Experience Survey to Older Adult Experience Survey based on feedback from patients.

Do you have any concerns with this change? Yes No
If yes, please tell me about your concerns.

Who completed the survey

For “who completed the survey”, the number of response options was decreased, and the word “patient” was removed:
Patient only
Patient with a family member/friend
Patient with other: _____
to:
I am completing this survey on my own
Someone is helping me to complete this survey

Do you have any concerns with this change? Yes No
If yes, please tell me about your concerns.

Changes made to:	Probe Questions
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Instructions

There were no specific instructions on how to fill in the survey. The preamble was changed from:
Please think about your experience as a patient when responding to the questions below
to:

Please read the items below and circle the number to the right that best describes your experience

Do you have any concerns with this change? Yes No
If yes, please tell me about your concerns.

In the first version, those completing the survey were asked to respond to items that were introduced with the words “I felt that...”. We’ve now taken those words out.

Did this change the way you responded? Yes No If so, how?

Rating scale anchors (items 1-12)

The words at the end of the rating scale (for items 1-12) were changed from:

“Strongly disagree”
“Strongly agree”

to:
“1, No definitely not”
“5, Yes, definitely?”

Did this change the way you responded? Yes No If so, how?

APPENDIX D. Cognitive Interview Guide: Phase 3 (continued)

Changes made to:	Probe Questions
Core item wording (item 9)	<p>This survey is provided to patients at some point after the results of the tests and assessments have been received and the results, goals, advice, and next steps have been discussed. We needed a survey item to understand a patient’s readiness to be involved in maintaining or improving their health moving forward.</p> <p>Item #9 was changed from: “I felt that I could achieve the goals that were agreed to” to: “I will be able to use the advice I was given”</p> <p>This item was changed because some people may not know at that particular time if they could achieve the goals that were discussed, but they would know if they were ready to work on the goals discussed.</p> <p>Do both of these items mean that you would be ready to be involved in maintaining or improving your health? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Which one of these items would be easier to respond to? <input type="checkbox"/> old <input type="checkbox"/> new Why?</p> <p>Which one of these items could you more confidently answer? <input type="checkbox"/> old <input type="checkbox"/> new Why?</p> <p>Do you have any concerns with this change? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please tell me about your concerns.</p>
Core item wording (item 11)	<p>Item #11 was changed from: “I was referred to other programs and/or services that I needed” to “I was referred to other program/ services that I needed”</p> <p>Did this change the way you responded? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how?</p>
Rating scale anchors (Item 13)	<p>Item #13 was changed from: “Overall, the care and services I experienced were” to “Overall, at the GAIN Clinic I had a”</p> <p>Did this change the way you responded? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how? The words at the end of the rating scale for item #13 were changed from: “Poor” and “Excellent” to: “Poor Experience” and “Excellent Experience”</p> <p>Did this change the way you responded? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how?</p>
Rating Scale (Item 14)	<p>For survey item # 14 “I would recommend this program to family or friends, if they need it” we modified the rating scale to align with items 1-12.</p> <p>We changed the rating scales from: Definitely no somewhat no somewhat yes definitely yes to: 1 2 3 4 5 where: “1= No definitely not” and “5= Yes, definitely?”</p> <p>Did this change your answer to this question? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, why?</p>
# pages (1-2 pager)	<p>We changed the survey from 1 page to 2 pages to allow for more room in the comment section for those who want to provide detailed feedback.</p> <p>Did the number of pages influence your completion of the survey in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Would you say you are more likely, less likely or equally likely to fill out a 2 page survey? <input type="checkbox"/> Yes <input type="checkbox"/> No At the bottom of the first page we state: “Please turn the page over for remaining questions” and put an arrow at the bottom. Both are there to help people realize that there is a second page to complete.</p> <p>Do you think that people will realize that they need to complete 2 pages? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What else could we do to make sure that people complete both pages?</p>

APPENDIX D. Cognitive Interview Guide: Phase 3 (continued)

Changes made to:	Probe Questions
Demographic info	<p>We now ask respondents to provide age and gender information.</p> <p>Did you feel comfortable providing this information? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you think most people will provide us with this info? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you think that these questions will impact answers to any other questions? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how?</p>
Overall preference	<p>Overall, which version was easier to complete?</p> <p><input type="checkbox"/> 1 page survey <input type="checkbox"/> 2 page survey Why?</p>
Other feedback	<p>What other thoughts did you have about the survey that you haven't had a chance to share yet?</p>