Pilot Adaptation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient-Centred Medical Home Survey for Use in Patient Medical Homes in Prince Edward Island, Canada

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Research Project

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Abstract

Background: Patient experience surveys are central to evaluating quality in primary care, particularly within interdisciplinary delivery models such as Patient Medical Homes (PMHs). This study aimed to examine the contextual relevance and acceptability of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient-Centred Medical Home (PCMH) survey for use in PMHs in Prince Edward Island (PEI) and to identify stakeholder-informed adaptations.

Methods: A qualitative descriptive study was conducted at a single PMH in PEI. Five structured focus groups were held between September and November 2025, and included physicians, nursing professionals, allied health professionals, administrative staff, and patients affiliated with the PMH. Participants reviewed the CAHPS PCMH survey and provided feedback during 60 to 90-minute discussions guided by a standardized script. Audio recordings were transcribed verbatim and analyzed using deductive thematic analysis aligned with predefined CAHPS PCMH survey domains.

Results: Fifteen stakeholders participated equally across five focus groups. Participants reported that the survey was generally clear and appropriately structured but identified limitations, including provider-centred language, insufficient representation of interdisciplinary care, ambiguous terminology, and concerns regarding anonymity. Stakeholders emphasized the need for clearer definitions, inclusion of allied health services, and adaptation of demographic items to reflect the PEI context.

Interpretation: Standardized patient experience surveys require contextual adaptation to accurately reflect team-based models of primary care delivery and should be interpreted alongside complementary measures of clinical quality. Incorporating stakeholder-informed modifications may enhance the validity, acceptability, and utility of patient experience measurement for quality improvement and system-level evaluation within PMHs in PEI.

Keywords: patient medical home; patient experience; CAHPS; primary care evaluation

Introduction

Effective primary care is a cornerstone of high-performing health systems, contributing to improved population health outcomes while enhancing overall system efficiency. Strong primary care systems have been consistently associated with more equitable access to health services and lower healthcare costs. One key mechanism through which primary care exerts these benefits is the model by which care is delivered. The Patient Medical Home (PMH) represents an efficient approach to organizing and delivering comprehensive primary care (1).

The concept of PMH can be traced back to 1967, when the American Academy of Pediatrics started to describe the role of their primary care practitioners in the management of chronically ill patients (2). This concept evolved to align with the World Health Organization's articulation of primary care as a comprehensive, first-contact, and community-oriented practice domain (3). In 2007, American physician associations formalized the principles of PMH, emphasizing the physician-led care, patient-centredness, integration across the healthcare system, quality, safety, and enhanced accessibility (2).

PMHs are defined as a "*combination of the core attributes of primary care access, continuity, comprehensiveness and coordination of care with new approaches to healthcare delivery, including office innovations and reimbursement reform*" (2).

In Canada, the College of Family Physicians of Canada (CFPC) has advocated for PMHs as the future of primary care, presenting the model as one that underscores the critical role of family physicians in delivering high-quality, effective, and timely care (4). In 2021, Prince Edward Island (PEI) announced the establishment of PMHs as its

main primary care delivery model as part of a strategy to provide better care for more Islanders (5). Currently, 17 PMHs operate across PEI, offering collaborative, team-based primary care (6).

To support continuous improvement within this model, the CFPC recommends regularly monitoring patient experience as part of comprehensive quality improvement plans within PMHs (4). Since the 1990s, patient perceptions have been integral to evaluating healthcare quality and have served as a key source of information for the design and implementation of quality improvement initiatives (7). Given the growing evidence supporting PMHs and integrated care approaches, patient experience measurement represents an important area for ongoing research. Although patient experience represents a key dimension of care quality, it does not fully capture technical aspects of care delivery such as diagnostic accuracy or treatment effectiveness. Accordingly, patient experience data should be interpreted alongside complementary quality indicators that reflect clinical effectiveness and safety (8,9).

To date, no published studies have examined the contextual appropriateness of CAHPS PCMH within Canadian PMH models. Despite the widespread use of this instrument, evidence suggests that patient experience surveys developed within one health system cannot be assumed to be directly transferable to jurisdictions with different care structures, funding models, and cultural expectations, underscoring the need for context-specific adaptation (7,10).

The resulting tool and insights from this study aim to guide the development of quality improvement initiatives and future PMHs in PEI, while also informing other healthcare systems across the Atlantic provinces. This project fulfills the Dalhousie

Family Medicine Scholarly Project requirement by contributing applied, practice-relevant evidence to primary care evaluation in PEI.

Study Design and Methods

This pilot study used a qualitative descriptive design to explore how the CAHPS PCMH survey can be adapted to the PMH model in PEI. The goal was to evaluate the clarity, relevance, and contextual fit of the survey items and generate a locally appropriate draft survey for use across PMHs in PEI. A qualitative descriptive approach was selected to obtain rich, practice-informed feedback on survey clarity, relevance, and acceptability while remaining close to participants' accounts and without imposing an interpretive theory-generating framework, consistent with the exploratory and pilot nature of the study. Reporting followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Appendix G).

Research Question:

How can the CAHPS Patient-Centred Medical Home survey be adapted to reflect the context, language, and care delivery model of Patient Medical Homes in Prince Edward Island, as informed by stakeholder feedback?

Primary Objective:

- To assess the clarity, contextual relevance, and acceptability of the CAHPS PCMH survey items for use in Patient Medical Homes in Prince Edward Island.

Secondary Objectives:

- To explore stakeholders' perceptions of the adequacy and completeness of the CAHPS PCMH domains in capturing meaningful aspects of patient experience
- To identify survey items that require modification to reflect the PEI PMH context

- To produce a locally adapted draft version of the CAHPS PCMH survey for future use in PMHs across PEI (Appendix H)

Research Team and Reflexivity

The study was led by the principal investigator, a postgraduate medical trainee with clinical experience in primary care settings in PEI. The research supervisor is an academic family physician with expertise in primary care and quality improvement. The principal investigator facilitated all focus group discussions. Participants were informed of the investigator's role and the study's academic purpose. No prior supervisory or evaluative relationships existed between the investigator and participants. Some professional familiarity with participants was acknowledged and addressed by emphasizing voluntary participation, confidentiality, and the absence of any impact on employment or clinical care.

Setting

The study was conducted at the Sherwood PMH in Charlottetown, PEI, a provincially designated PMH delivering team-based primary care through physicians, nursing professionals, allied health providers, and administrative staff. Focus groups were held in private areas within the clinic to ensure confidentiality and participant comfort.

Participants and Sampling

A purposive, non-probability quota sampling strategy was used to ensure representation from key stakeholder groups within the PMH model. A total of 15 participants were recruited across five focus groups, representing physicians, nursing professionals, allied health professionals, administrative staff and adult patients.

Inclusion criteria were adults aged 18 years or older, affiliation with the Sherwood PMH as a healthcare provider, staff member, or patient, ability to provide informed consent, fluency in English, and willingness to participate voluntarily.

Recruitment and Consent

Participants were recruited through posters displayed in clinic waiting areas and rooms, as well as through in-person invitations facilitated by clinic administration (Appendix D). Interested individuals contacted the principal investigator directly. Eligibility screening was conducted prior to enrollment.

All participants attended an information session during which the study purpose, procedures, potential risks, and participant rights were explained. Written informed consent (Appendix E) was obtained prior to participation. Participants were informed that they could withdraw at any time without consequences to their care or employment. No incentives were provided.

Data Collection

Focus groups were chosen to facilitate discussion among participants and allow shared and contrasting perspectives on survey applicability to emerge through group interaction. Data were collected through structured discussions conducted between September and November 2025. Each session lasted approximately 60 to 90 minutes. Participants were provided with the CAHPS PCMH survey in advance of the discussion (Appendix B) and given time to review the instrument independently. Focus groups were conducted using a standardized discussion guide aligned with CAHPS PCMH domains (Appendix C). The guide explored the survey's overall impression, clarity, provider representation, relevance, length, format, and perceived gaps.

The sessions were audio-recorded with participant consent. Field notes were taken by the facilitator to capture contextual observations.

Data Analysis

Audio recordings were transcribed verbatim and anonymized using Heidi AI as an assistive transcription tool. All transcripts were reviewed against audio recordings by the principal investigator to ensure accuracy. Data were analyzed using a deductive thematic analysis to systematically organize participant feedback according to the predefined CAHPS PCMH survey domains, consistent with the study's instrument-evaluation and adaptation objectives. Initial coding was conducted by the principal investigator, with codes grouped into themes reflecting survey clarity, contextual relevance, provider representation, continuity and coordination of care, and survey administration considerations. Although guided by predefined domains, analytic flexibility allowed identification of unanticipated insights.

To enhance rigor, emerging themes were reviewed with the research supervisor, and discrepancies were resolved through discussion. An audit trail documenting coding decisions and theme development was maintained. Findings were synthesized into thematic tables stratified by stakeholder group. Data collection continued until thematic sufficiency was achieved, defined as the point at which no substantively new insights emerged across stakeholder groups.

Ethical Considerations

Ethics approval was obtained from the PEI Research Ethics Board (Appendix A). The study posed minimal risk, primarily related to potential discomfort during the discussion of healthcare experiences. Participants were free to decline answering any

question. No personal health information was collected. All data were anonymized, securely stored, and accessible only to the research team.

Data Storage and Retention

Physical documents were stored in locked cabinets at the Dalhousie Family Medicine PEI Site. Electronic data were stored on password-protected institutional servers. Data will be retained for a minimum of five years following study completion, in accordance with PEI REB policy, after which they will be securely destroyed.

Results

Five structured focus groups were conducted with key stakeholders from the Sherwood PMH, including physicians, nursing professionals, allied health professionals, medical office administrative staff, and patients. Thematic analysis was guided deductively by the focus group discussion guide and CAHPS PCMH domains, with allowance for emergent insights within predefined domains. Findings are presented across major domains related to survey clarity, relevance, content coverage, format, and contextual fit. A summary of themes and corresponding codes is provided in Appendix F.

Overall Perceptions of the CAHPS PCMH Survey

The CAHPS PCMH survey was perceived as well-structured and comprehensive across stakeholder groups. Participants consistently described the questions as clear and methodical. However, multiple groups noted that the survey appeared to be oriented toward evaluating a single primary care provider rather than the PMH as an integrated, team-based model of care. A physician participant described the survey as "*very organized and easy to follow"*, while noting that it "*still feels like it's mostly about the doctor, not about the whole clinic*".

Clarity of Purpose and Relevance

While most participants understood the survey as a measure of patient experience, there was a consistent feeling of ambiguity regarding its purpose. Physicians and allied health professionals indicated that this ambiguity could influence how patients interpret and respond to the questions, potentially biasing the results.

Allied health professionals and nursing staff explicitly stated that they did not feel represented or evaluated with the current survey structure. Patients and administrative staff suggested that without explicit explanation, respondents may default to evaluating only their physician or nurse practitioner. As one allied health participant noted: *“patients often see me more than their doctor, but none of the questions seem to reflect that part of their care”.* A physician commented, *“Without explaining that this is about the whole medical home, patients will answer it like a provider report card”.*

Language, Terminology, and Cultural Fit

The survey language was widely regarded as simple and accessible. However, several terms were identified as problematic in the PEI context. The term “provider” was consistently cited as ambiguous, with participants noting that patients are unlikely to associate this term with allied health professionals or nursing staff.

Participants across all groups raised concerns regarding demographic questions, particularly those related to ethnicity and gender, which were perceived as not reflective of Canadian norms. Allied health and nursing participants emphasized the need to Canadianize demographic categories and provide inclusive gender options. A nursing participant stated, *“Some of the demographic questions don’t really match how we talk about identity in Canada, and I worry patients might feel uncomfortable or confused”.* An

allied health professional added, *“The wording feels very American, especially around ethnicity, and that could affect how honestly people respond.”*

Certain clinical terms, such as “check-up,” “routine care,” and “care needed right away,” were viewed as subjective and insufficiently defined, potentially leading to inconsistent interpretation among respondents. A patient participant remarked: “*When it says, ‘care needed right away’, I wasn’t sure if that meant same-day, urgent, or emergency care”*.

Coverage of PMH Services and Team-Based Care

A dominant theme across all focus groups was the insufficient representation of interdisciplinary and team-based care. Physicians highlighted that many patients receive substantial care from nursing staff, pharmacists, and other allied health professionals without seeing their primary provider frequently. Nursing and allied health participants noted that the survey does not capture the frequency, accessibility, or perceived value of their services. A nursing participant explained, “A lot of patient care happens with nurses and pharmacists, but the survey doesn’t really ask about those interactions at all”. A physician echoed this concern, stating, “*Patients may go months without seeing me but still receive excellent care from the team, and that isn’t captured here”*.

Several stakeholders suggested incorporating a preliminary section asking patients which services or provider types they had accessed within the PMH over a defined period. This approach was viewed as more feasible than duplicating survey sections for each provider type and more aligned with the realities of PMH care delivery.

A patient participant noted, *“I see the nurse and pharmacist much more often than my doctor, but I wasn’t sure how to reflect that in the survey”.*

Survey Length, Structure, and Administration

Opinions regarding survey length varied. Physicians, allied health professionals, and patients generally felt the current length was appropriate, whereas nursing staff expressed concern that the survey may be too long for elderly or low-literacy populations. A nursing participant commented, “*For some of our older patients, even a few extra questions can feel overwhelming, especially if there’s a lot of reading”*. Participants agreed that any expansion to include allied health content would require streamlining existing items.

Most stakeholders preferred survey administration after a clinic visit rather than before, citing concerns about response bias and patient anxiety. Strong consensus emerged regarding the importance of anonymity, with participants emphasizing that responses should not be perceived as linked to individual providers or patient records. An administrative staff member commented: *“If patients think their provider can see their answers, they may not be fully honest”.*

Local Adaptation and Acceptability

Participants identified several areas requiring local adaptation, including removal of dental care items, clarification of specialist-related questions given limited access on PEI, and consideration of emerging tools such as the MyHealth PEI portal. Allied health professionals highlighted the importance of capturing whether services accessed within the PMH would otherwise be unavailable due to financial or system barriers.

Across groups, participants indicated that they would be more likely to complete the survey if it was explicitly framed as a tool for quality improvement rather than provider performance evaluation. As one administrative staff member stated, "*If patients know this is about improving the clinic and not judging their provider, they're much more likely to take the time to fill it out.*"

Discussion

This qualitative pilot study explored the contextual relevance, clarity, and acceptability of the CAHPS PCMH survey within the setting of a PMH in Prince Edward Island, informed by structured stakeholder feedback. Overall, participants perceived the survey as clear and well-organized, but identified limitations underscoring the need the need for local adaptation. These findings reinforce literature emphasizing the need for contextual tailoring of standardized patient experience instruments (10,11).

Clarity, language, and interpretability of survey items

Participants consistently highlighted areas where survey language was perceived as ambiguous or overly subjective, particularly regarding terms such as "urgent care," "check-up," and "routine care." These concerns are well described in the literature on patient-reported measures, which notes that unclear terminology may lead to variability in interpretation and compromise the validity of responses (12). The subjectivity surrounding the perceived urgency of care was especially salient, as participants described discrepancies between patient expectations and clinical triage processes.

The importance of testing survey language through stakeholder engagement is well established. Cognitive interviewing and qualitative review, as described by Willis in 2005 (13), are critical tools for identifying problematic wording and improving survey

comprehension prior to large-scale deployment. The present study aligns with this methodological approach by using focus group discussions to elicit detailed feedback on item clarity and meaning, thereby strengthening the content validity of the adapted instrument.

Provider identification and representation of team-based care

A prominent theme across focus groups was the perception that the CAHPS PCMH survey is heavily physician-centred and insufficiently reflective of the interdisciplinary nature of PMHs in PEI. Allied health professionals and administrative staff reported that their roles were not adequately captured, limiting the survey's ability to evaluate care delivery comprehensively. This finding is consistent with broader critiques of traditional patient experience surveys, which have historically focused on physician encounters rather than team-based models of care (14).

Given that PMHs are explicitly designed to deliver care through interprofessional teams, failure to reflect the contributions of nursing staff, allied health professionals, and administrative personnel may underestimate key determinants of patient experience. Participants suggested that either distinct sections for different provider groups or branching logic based on services accessed could improve the survey's relevance without substantially increasing respondent burden. These recommendations align with evidence that patient experience is shaped by multiple points of contact within the healthcare system, not solely by physician interactions (15).

Patient participants echoed these concerns, reinforcing the need for survey adaptation from a patient perspective.

Continuity, coordination, and local care context

Stakeholder feedback emphasized the importance of continuity and coordination of care, core attributes of high-quality primary care, yet noted that some survey items did not fully reflect how these domains are operationalized in PEI. For example, participants discussed evolving practices related to test result follow-up in the context of patient portals, such as MyHealth PEI, and questioned whether existing items adequately captured shared responsibility between patients and providers.

Haggerty and colleagues' conceptual framework for continuity of care, encompassing relational, informational, and management continuity, provides a useful lens through which to interpret these findings (15,16). Participants' concerns suggest that while the CAHPS PCMH survey addresses elements of continuity, adaptation is required to reflect provincial workflows, access constraints, and the realities of specialist availability in PEI. Without such contextualization, survey responses may conflate system-level limitations with perceived quality deficits.

Survey administration, anonymity, and response burden

Participants expressed strong views regarding survey administration timing and modality. There was broad consensus that administering the survey after a clinical encounter is preferable to pre-visit distribution, as pre-encounter surveys may influence patient perceptions or raise concerns about potential impacts on care. Concerns about anonymity, particularly with electronic distribution, were also prominent, with participants recommending clear, explicit assurances that responses would not be identifiable by providers. These findings are consistent with evidence demonstrating that perceived confidentiality and ease of completion significantly influence survey participation and response quality (17,18). Offering both paper-based and digital options, as suggested

by participants, aligns with best practices for maximizing response rates across diverse demographic groups. Importantly, these considerations are not merely logistical but directly affect the validity and acceptability of patient experience data.

Implications for patient experience measurement in PMHs

In 2014, Friedberg et al. (19) demonstrated that participation in PCMH models is associated with changes in patient experience, utilization, and care processes; however, accurately capturing these changes requires measurement tools that reflect local care delivery structures. The present study contributes to this evidence by demonstrating that direct stakeholder engagement is essential to ensure that standardized tools remain meaningful and actionable in specific contexts.

By identifying concrete areas for adaptation such as provider identification, inclusion of allied health services, clarification of terminology, and contextualization of care processes, this study provides a pragmatic foundation for developing a PEI-specific version of the CAHPS PCMH survey. Importantly, this study represents a formative phase in the development of a contextually appropriate patient experience instrument, rather than a psychometric evaluation.

It is important to acknowledge that patient experience and satisfaction measures capture only one dimension of healthcare quality. While patient-reported experience is a critical component of high-quality primary care and has intrinsic value, including its potential therapeutic or “healing” effect, patients may not be well positioned to assess technical dimensions of care such as diagnostic accuracy, clinical appropriateness, or treatment effectiveness. These elements require complementary quality assurance approaches, including clinical performance metrics, audit and feedback mechanisms,

and outcome-based evaluations. Accordingly, patient experience surveys such as the CAHPS PCMH should be viewed as part of a broader quality measurement ecosystem rather than as stand-alone indicators of system effectiveness (9,20).

Strengths and Limitations

This study has several notable strengths. First, it employed a qualitative, stakeholder-engaged approach that allowed for in-depth exploration of the contextual appropriateness of an established patient experience instrument within a real-world PMH setting. By including participants from multiple roles, clinical, allied health, administrative staff, and patients, the study captured a broad range of perspectives reflective of the interdisciplinary nature of PMHs. This diversity enhanced the credibility of the findings and ensured that survey adaptation considerations extended beyond physician-centred care.

Second, the use of a structured focus group guide aligned with the survey domains facilitated systematic data collection while still allowing participants to raise unanticipated but highly relevant issues, such as concerns around anonymity and response bias. Finally, the study provides pragmatic, actionable insights that can directly inform survey refinement and local quality-improvement initiatives.

Several limitations must also be acknowledged. The study was conducted within a single PMH, which may limit the transferability of findings to other PMHs in Prince Edward Island or other jurisdictions with differing organizational structures. The sample size was small and purposive, consistent with exploratory qualitative research, but it may not fully capture the perspectives of all provider groups or patients themselves.

However, the study did not include formal psychometric testing of the survey instrument; as such, conclusions regarding validity and reliability are inferential and intended to guide subsequent quantitative validation. Despite these limitations, the study offers valuable formative evidence to support contextually appropriate survey adaptation.

Conclusion

This qualitative study highlights the importance of contextual adaptation when applying standardized patient experience surveys within interdisciplinary primary care models. While the CAHPS PCMH survey was generally perceived as clear, well-structured, and relevant, stakeholders identified critical gaps related to its provider-centric framing, limited representation of allied health services, and insufficient alignment with the operational realities of PMHs in PEI. These findings underscore that patient experience measurement tools must evolve alongside care delivery models to remain meaningful and valid.

The results suggest that modest but deliberate modifications, such as clarifying terminology, incorporating interdisciplinary care domains, adapting demographic items to the local context, and explicitly addressing anonymity, could substantially enhance the survey's relevance and acceptability. Importantly, stakeholders did not view standardization and local adaptation as mutually exclusive; rather, they emphasized the need for a balanced approach that preserves comparability while ensuring contextual fit.

This study provides a foundation for subsequent phases of survey refinement, including patient engagement, cognitive testing, and psychometric validation. When used in conjunction with complementary clinical quality measures, a contextually

adapted patient experience survey can meaningfully contribute to comprehensive quality improvement within team-based primary care. This project also supported resident development in qualitative research and applied quality improvement within primary care.

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Appendix A

Research Ethics Board (REB) Approval Letter

Health PEI
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June 26, 2025

Dr. Guillermo Villegas Molero
Dalhousie Family Medicine
Program – QEH
60 Riverside Drive
PO Box 6600
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Dear Dr. Molero,

RE: ***Pilot Adaptation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient-Centered Medical Home Survey for Use in Patient Medical Homes in Prince Edward Island, Canada***
Principal Investigator: Dr. Guillermo Villegas Molero

The above noted study qualified for expedited review by the PEI Research Ethics Board which was conducted by the Chair and one other member. The following documents were reviewed.

Documents included for review:
- Synto Application #94
- Consent Form (Not Dated)
- Poster
- CAHPS Clinician & Group Adult Survey with PCMH Questions
- Supervisor Agreement Forms
- TCPS2 CORE Certificate for Dr. Villegas Molero

I am pleased to advise you that full approval has been granted for the above noted study.

While the REB is not requesting changes based on ethical acceptability, the REB notes the consent form lists inclusion and exclusion criteria which are merely the opposite of each other. The REB recommends removing the exclusion criteria. The REB also notes in the protocol that the word "anonymous" is misused. It should be

that responses will be anonymized . If you decide to make any of these changes, send a copy of the final versions, dated, for our records.

This study was reviewed according to ICH GCP guidelines and will require an annual report and request for reapproval to be in place prior to June 26, 2026.

Notification of closure is required once the study is completed or terminates early. The Continuing Review Reporting Requirements ; the Reporting Study Closure and/or Early Termination ; and the Request for Annual Approval forms can be found on the Health PEI website under the PEI Research Ethics Board link.

ATTESTATION: This Research Ethics Board complies with Division 5 of the Food and Drug Regulations, the ICH Harmonized Tripartite Guidelines: Good Clinical Practice, and the Tri-Council Policy Statement.

Sincerely,

Name: Kathryn Bigsby, MD, FRCPC
Title: Chair, PEI Research Ethics Board

Appendix B

CAHPS Patient-Centred Medical Home Survey (Original Version)

CAHPS Clinician & Group Adult Survey 3.0 with PCMH Questions

Survey Instructions

Answer each question by marking the box to the left of your answer.

You are sometimes told to skip over some questions in this survey. When this happens, you will see an arrow with a note that tells you what question to answer next, like this:

☒ Yes → **If Yes, go to #1 on page 1**
☐ No

Your Provider

1. Our records show that you got care from the provider named below in the last 6 months.

Name of provider label goes here

Is that right?

[1] ☐ Yes
[2] ☐ No → **If No, go to #29 on page 4**

The questions in this survey will refer to the provider named in Question 1 as "this provider." Please think of that person as you answer the survey.

2. Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?

[1] ☐ Yes
[2] ☐ No

3. How long have you been going to this provider?

[1] ☐ Less than 6 months
[2] ☐ At least 6 months but less than 1 year
[3] ☐ At least 1 year but less than 3 years
[4] ☐ At least 3 years but less than 5 years
[5] ☐ 5 years or more

Your Care From This Provider in the Last 6 Months

These questions ask about **your own** health care. Do **not** include care you got when you stayed overnight in a hospital. Do **not** include the times you went for dental care visits.

4. In the last 6 months, how many times did you visit this provider to get care for yourself?

☐ None → **If None, go to #29 on page 4**
☐ 1 time
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10 or more times

5. In the last 6 months, did you contact this provider's office to get an appointment for an illness, injury, or condition that **needed care right away**?

[1] ☐ Yes
[2] ☐ No → **If No, go to #7 on page 2**

6. In the last 6 months, when you contacted this provider's office to get an appointment for **care you needed right away**, how often did you get an appointment as soon as you needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

7. In the last 6 months, did you make any appointments for a **check-up or routine care** with this provider?

[1] ☐ Yes
[2] ☐ No → **If No, go to #9**

8. In the last 6 months, when you made an appointment for a **check-up or routine care** with this provider, how often did you get an appointment as soon as you needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

9. Did this provider's office give you information about what to do if you needed care during evenings, weekends, or holidays?

[1] ☐ Yes
[2] ☐ No

10. In the last 6 months, did you contact this provider's office with a medical question during regular office hours?

[1] ☐ Yes
[2] ☐ No → **If No, go to #12**

11. In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

12. In the last 6 months, how often did this provider explain things in a way that was easy to understand?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

13. In the last 6 months, how often did this provider listen carefully to you?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

14. In the last 6 months, how often did this provider seem to know the important information about your medical history?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

15. In the last 6 months, how often did this provider show respect for what you had to say?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

16. In the last 6 months, how often did this provider spend enough time with you?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

17. In the last 6 months, did this provider order a blood test, x-ray, or other test for you?

[1] ☐ Yes
[2] ☐ No → **If No, go to #19**

18. In the last 6 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

19. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

☐ 0 Worst provider possible
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 Best provider possible

20. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you see a specialist for a particular health problem?

[1] ☐ Yes
[2] ☐ No → **If No, go to #22**

21. In the last 6 months, how often did the provider named in Question 1 seem informed and up-to-date about the care you got from specialists?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Please answer these questions about the provider named in Question 1 of this survey.

22. In the last 6 months, did someone from this providers' office talk with you about specific goals for your health?

[1] ☐ Yes
[2] ☐ No

23. In the last 6 months, did someone from this providers' office as you if there are things that make it hard for you to take care of your health?

[1] ☐ Yes
[2] ☐ No

24. In the last 6 months, did you and someone from this provider's office talk about things in your life that worry you or cause you stress?

[1] ☐ Yes
[2] ☐ No

25. In the last 6 months, did you take any prescription medicine?

[1] ☐ Yes
[2] ☐ No → **If No, go to #27 on page 4**

26. In the last 6 months, how often did you and someone from this provider's office talk about all the prescription medicines you were taking?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

Clerks and Receptionists at This Provider's Office

27. In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

28. In the last 6 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

About You

29. In general, how would you rate your overall health?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

30. In general, how would you rate your overall **mental or emotional** health?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

31. What is your age?

1 ☐ 18 to 24
2 ☐ 25 to 34
3 ☐ 35 to 44
4 ☐ 45 to 54
5 ☐ 55 to 64
6 ☐ 65 to 74
7 ☐ 75 or older

32. Are you male or female?

1 ☐ Male
2 ☐ Female

Appendix C

Focus Group Discussion Guide / Script

Focus Group Template

Study title: Pilot Adaptation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient-Centred Medical Home Survey for Use in Patient Medical Homes in Prince Edward Island, Canada

Principal Investigator: Guillermo Villegas Molero, MD

1. Welcome and Introductions (5 minutes)

Hello and thank you for joining us today. My name is Guillermo Villegas, and I'm part of a research project with Dalhousie Family Medicine here in PEI.
Today's session is part of a study to adapt a patient experience survey—called the Consumer Assessment of Healthcare Providers and Systems Patient-Centred Medical Home item set or CAHPS PCMH survey—so it works better for Patient Medical Homes here in PEI.

We want to understand what you think about the language, format, and topics in this survey. Your feedback will help us make sure it reflects your experience at Sherwood Medical Home, whether you're a patient, a provider, or part of the clinic team.

Your participation is voluntary. The session will be recorded for transcription purposes only, and your comments will not be linked to your name. Everything you say will be anonymized.

Do you have any questions before we start?

2. Consent Confirmation and Survey Review (15–20 minutes)

Before we start the discussion, please take a few minutes to read through the informed consent form, which outlines what the session involves. Once you're comfortable with the information, I'll ask you to confirm your agreement to participate.

Now I'll give you time to review the CAHPS PCMH survey. Feel free to make notes or underline anything that stands out—something confusing, important, missing, or unclear. I'll give you about 10-15 minutes to go through it.

3. Discussion Questions (40–50 minutes)

Let's start the discussion. I'll ask a few questions to guide us, but please feel free to share any thoughts. There are no right or wrong answers—we're here to learn from you.

A. General Impressions

- What were your first impressions of the survey?
- Was the purpose of the survey clear to you?
- Did the survey feel relevant to your experience in this clinic? Why or why not?

B. Clarity and Language

- Were there any questions that were hard to understand? Which ones?
- Was the wording appropriate for someone in your role (as a patient, provider, or staff)?
- Were there any terms or phrases that felt out of place or unfamiliar in a PEI context?

C. Content and Topics

- Do the survey questions cover the most important parts of your experience with this clinic?
- Are there any important topics you think should be added?
- Were any sections too long, too short, or repetitive?

D. Format and Structure

- What did you think of the layout and flow of the questions?
- Was the survey too long, too short, or just right?
- Would you feel comfortable completing this survey after a clinic visit? Why or why not?

E. Local Adaptation

- What changes would make this survey feel more connected to the care delivered here in PEI?
- Is there anything about the Patient Medical Home model that you feel is missing from this survey?

F. Final Thoughts

- If you were asked to complete this survey in the future, what would encourage or discourage you from doing it?
- Is there anything else you'd like to share that we haven’t asked about today?

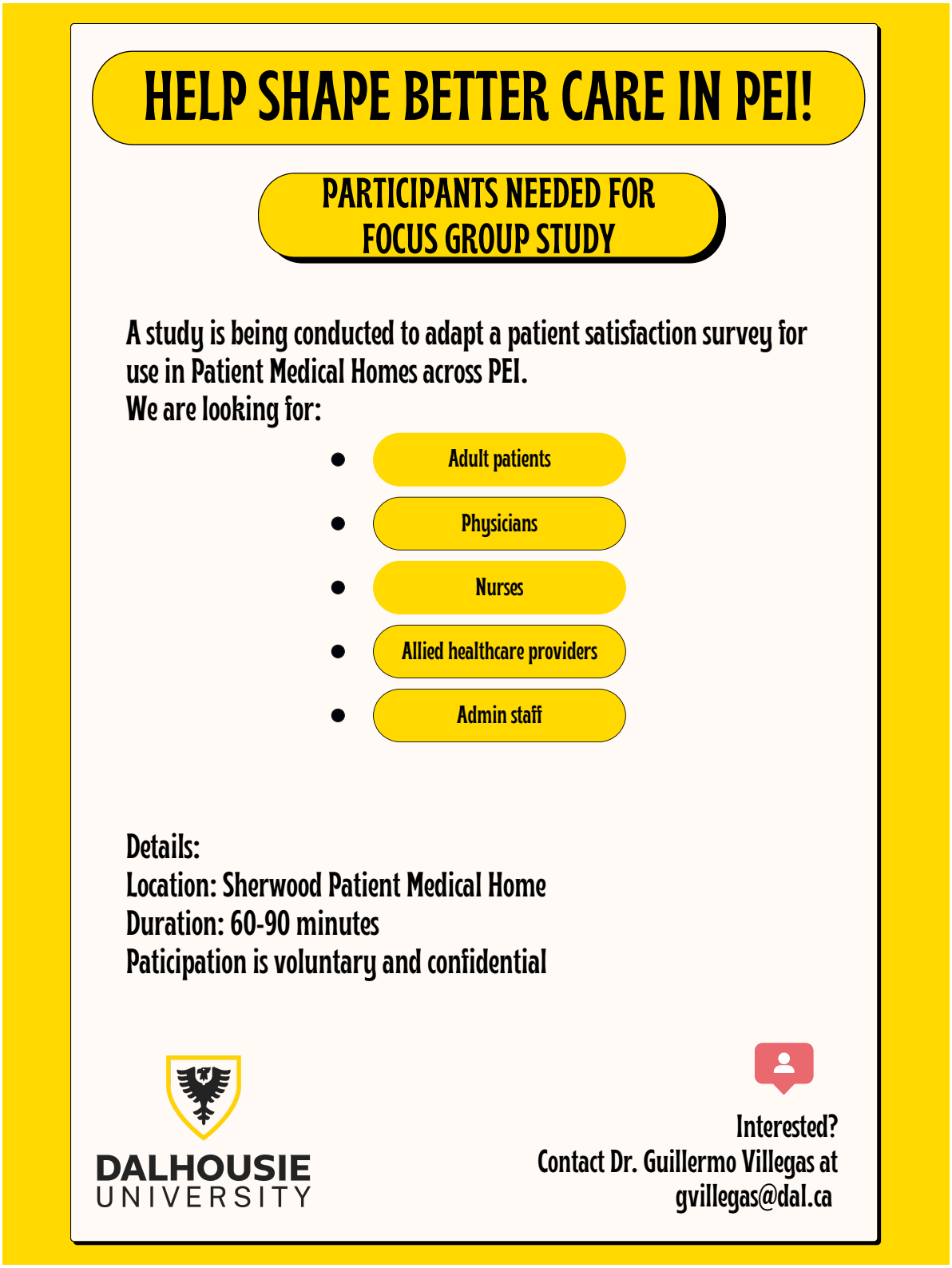
4. Closing (5 minutes)

Thank you so much for your time and input today. Your feedback will help us adjust the survey so it better fits the needs of people and providers here in PEI.

We’ll be reviewing comments from all focus groups and preparing a draft version of the adapted survey. If you’d like to be updated on the results, you’re welcome to leave your contact information—but that is completely optional.

Appendix D

Recruitment Materials



Appendix E

Participant Consent Form

CONSENT FORM

Pilot Adaptation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient-Centred Medical Home Survey for Use in Patient Medical Homes in Prince Edward Island, Canada

Principal Investigator:	Dr. Guillermo Villegas Molero Dalhousie Family Medicine Program - QEH 60 Riverside Drive, PO Box 6600 Charlottetown, PE C1A 8T5 Tel: 1-902-894-2536	**Supervisor:**	Dr. Shannon Curtis Sherwood Patient Medical Home 15 Brackley Point Rd, Charlottetown, PE C1A 6Y1 Tel: 1-902-367-3747

INTRODUCTION

You are invited to take part in a research study. The study will take place at the Sherwood Patient Medical Home in Charlottetown, PEI. The goal is to adapt an existing survey that measures how satisfied people are with their care in Patient Medical Homes in PEI. This document will help you decide if you want to be part.

WHY IS THIS STUDY BEING DONE?

Patient satisfaction is an important part of healthcare quality. When patients are satisfied, they are more likely to follow their treatment plans and have better outcomes. This study will help us adjust an existing survey so that it fits the PEI healthcare system. We will use it to better understand how patients feel about the care they receive. This can help improve services in the future.

WHY AM I BEING ASKED TO JOIN THIS STUDY?

You were invited because you are a patient, healthcare worker, or staff member at Sherwood Patient Medical Home. You also showed interest when we talked to you about this study. Taking part is your choice. If you say yes, you can still change your mind at any time.

WHO CAN TAKE PART IN THIS STUDY?

You may join this study if:

- You are 18 years or older
- You are a patient, healthcare provider or admin staff at Sherwood Patient Medical Home
- You can give informed consent
- You speak English
- You are willing to take part

You should not take part if:

- You are under 18
- You are not linked to Sherwood Patient Medical Home
- You cannot give informed consent
- You do not speak English
- You do not want to participate

We will go over these points with you in detail.

WHAT HAPPENS IN THIS STUDY?

You will be asked to look at a survey and tell us what you think about it. You will take part in a small group discussion (focus group). In the focus group, you can share your opinions on the survey—like how long it is, what kind of questions it asks, and how clear or useful it is.

Your comments will be written down in a way that no one can identify you. This will help us improve the survey.

The whole process, including reviewing the consent form and the discussion, will take up to two hours. You only need to come once. We will schedule this visit at a time that works for you, ideally while you are already at the Sherwood clinic.

If you choose to stop being in the study, just let the researcher know in writing. There will be no penalty or problem if you decide to leave.

ARE THERE RISKS TO THE STUDY?

This study has a very low risk. Some possible issues are:

- Feeling uncomfortable: You might feel uneasy talking about your opinions. You can skip any question you don't want to answer.
- Privacy: Your name and identity will not be shared. What you say will be kept anonymous.
- Time: The sessions take up to 2 hours. We will work with your schedule to make it as convenient as possible.

WILL IT COST ME ANYTHING?

No. There is no cost to take part in this study. You will not be paid for participating.

WHAT ABOUT MY RIGHT TO PRIVACY?

We will protect your personal information. Your name will be used only on the consent form. After that, you will be given a number. No one outside the study team will know who you are.
The data will be kept in a safe, password-protected folder. After the study, the records will be stored securely for five years.

The following people may look at the study records to make sure everything was done correctly:

- The researcher and research supervisor
- The PEI Research Ethics Board (REB)

The REB may also contact you for feedback about how the study was done. They are responsible for making sure research is done safely and fairly.

WHAT IF I WANT TO QUIT THE STUDY?

You can leave the study at any time. Just tell the principal investigator in writing. If you leave, there will be no negative consequences. Any information collected before you leave will still be used in the study.

WHO DO I CONTACT IF I HAVE QUESTIONS OR PROBLEMS?

For further information about the study call Dr. Guillermo Villegas Molero at 1-902-894-2536. Dr. Guillermo Villegas Molero is in charge of his study at Sherwood Patient Medical Home, PEI (he is the "Principal Investigator").

The Principal Investigator is Dr. Guillermo Villegas Molero.
Telephone: (902) 894-2536

His Research Supervisor is Dr, Shannon Curtis.
Telephone: (902) 367-6747

If you have any questions about your rights as a research participant, contact the PEI Research Ethics Board Office at 902-569-0576.

CONSENT FORM SIGNATURE PAGE

After you have signed this consent form, you will be given a signed copy.

I have reviewed all of the information in this consent form related to the study called: Pilot Proposal for a Tool to Evaluate Patient Satisfaction Within Patient Medical Homes in Prince Edward Island, Canada

I have been given the opportunity to discuss this study. All of my questions have been answered to my satisfaction.

My signature on this consent form means that I agree to take part in this study.

I understand that I am free to withdraw at any time.

_____	_____	____ /_____/ _____
Signature of Participant	**Name (Printed)**	**Year Month Day***
_____	_____	____ /_____/ _____
Signature of Investigator	**Name (Printed)**	**Year Month Day***

I Will Be Given a Signed Copy of This Consent Form

Thank you for your time and patience

Appendix F

Thematic Coding Framework and Summary Table of Themes

Focus Group Question	Physicians (MD)	Nursing Professionals (LPN/RN)	Allied Health Professionals	Administrative / MOA Staff	Patients
GENERAL IMPRESSIONS					
1. What were your first impressions of the survey?	Clear, simple, comprehensible; focused heavily on individual provider. Not focused on the medical home or all health services/providers	Easy to answer but confusing whether "provider" refers to doctor vs team; some uncertainty; very long	Overall strong questions; generally positive first impression; suggestion to specify "Sherwood Medical Home provider" to contextualize	Detailed; asks right questions; purpose partially clear but some hesitation due to level of detail	Not easy to understand who the "provider" is Focusing on one individual rather than an overall look to the services provided
2. Was the purpose of the survey clear to you?	Purpose understood as personal experience evaluation; seems like KPI evaluation of providers	Clear intention: measure experience, satisfaction and access; confusion over whether intended to assess individual or team	Purpose interpreted as general experience and with medical care; broad but understandable	Yes and no. Clear that it measures experience, but unclear whether evaluating system or individual	Yes, to evaluate patient experience and satisfaction with a provider
3. Did the survey feel relevant to your experience in this clinic? Why or why not?	Narrow relevance—individual provider model does not reflect interdisciplinary PMH model	Survey does not reflect patient's full journey across different providers; continuity issues	system constraints in PEI limit applicability Allied health roles not represented; "MD-heavy" instrument; does not reflect AH contribution or value	Some relevance, but system of care in PEI differs from US model; specialties and test access differ	It is relevant but does not consider the patient medical home as a whole
CLARITY AND LANGUAGE					
4. Were there any questions that were hard to understand? Which ones?	No, except typo in question 23	No conceptual difficulty; demographic phrasing problematic	Question on "needing care right away" viewed as subjective and poorly defined	None—clear wording	No – easy to understand
5. Was the wording appropriate for someone in your role (as a patient, provider, or staff)?	Yes, below physicians' level	Gender phrasing outdated; literacy implications important	Provider terminology unclear; ambiguity when patients have multiple appointments/providers	Yes, very comprehensible	Yes, it is everyday language
6. Were there any terms or phrases that felt out of place or unfamiliar in a PEI context?	"Physician assistant" not commonly understood; provider term ambiguous	"Are you Hispanic/Latino" irrelevant in PEI; male/female binary inappropriate	"Checkup" and "routine care" poorly defined; dental care irrelevant; Hispanic/Latino isolated and not	Reflects US-based system where patients "pay for services;" specialists questions misaligned	Payment, specialist and demographic questions are not

			reflective of PEI demographics		relevant to the PEI context
CONTENT AND TOPICS					
7. Do the survey questions cover the most important parts of your experience with this clinic?	Covers communication and follow-up but not team-based care	Covers provider role but not nursing or allied health experiences	Allied health care essentially invisible; survey fails to capture AH services, access, and value	Covers provider and reception but missing nursing role and internal workflow	No. It covers one provider mainly.
8. Are there any important topics you think should be added?	Section acknowledging allied health roles; specific items for pharmacist, RN, diabetes educator	Ability to cancel appointments and phone system access; how many services within PMH used	Allied health section: whether AH services accessed; whether AH care would be available outside PMH; medication review, vaccines	Section for nursing team; communication pathways; patient access methods	Different sections for other team members, or just making a general evaluation of the patient medical home
9. Were any sections too long, too short, or repetitive?	Generally good length; caution against expansion	Too long, should be ~20 items; questions about specialists and provider continuity unnecessary	No major redundancy identified; open comment section missing	Just about right	It is a good length
FORMAT AND STRUCTURE					
10. What did you think of the layout and flow of the questions?	Logical flow but front-loaded with provider-specific questions	Acceptable but heavily weighted to one provider	Well-organized with headers; easy to follow	Easy to follow and structured	Easy to follow
11. Was the survey too long, too short, or just right?	Adequate length currently; extension may discourage completion	Too long, risk of survey fatigue	Appropriate length; demographic questions quick to complete	Just about right	About right
12. Would you feel comfortable completing this after a clinic visit? Why/why not?	Only if fully anonymous; not directly handed back to staff	One visit doesn't reflect total care; comfort depends on anonymity	Comfortable if anonymity clear; concern if survey linked to provider or visit	Depends on patient; many correlate experience and satisfaction to last encounter	Yes, however the timing can be a determinant factor after an appointment
LOCAL ADAPTATION					
13. What changes would make this survey feel more connected to the care delivered here in PEI?	Clarify provider vs allied health terminology; Canadianize demographics	Describe PMH services; explain model to patients; ensure multiple provider types represented	Remove dental items; consider My Health Portal context; specialist access limited on island	Remove US-centric context; reflect Canadian realities of access variability	Describe out local setting and services
FINAL THOUGHTS					
14. If asked to complete in the future, what encourages/discourages participation?	Encouraged by improving medical home; discouraged if used for performance ranking	Motivated by opportunity to contribute to improvement; discouraged if linked to identity	Framing around improving patient care and services increases engagement	Motivated by possibility of change; not worried about impacting care	Yes, it can help improve the quality of care and services

15. Anything else to share that wasn't asked?	Format should be paper and digital (QR) for younger adults It should include a section for people to write comments. This could provide specific clarity Demographic questions should reflect Canadian norms	Paper and digital forms are Both required—older population less digitally fluent Patients want to be heard; add a comment section at end Survey should capture whether patients know PMH services exist	Comfortable if anonymity clear; concern if survey linked to provider or visit Before visit may bias encounter and create anxiety about impact on care Depends on demographic; younger prefer digital, older prefer paper; recommend offering both Should be adaptable across PEI PMHs; clarify rostered vs non-rostered patients; define "provider" clearly	Paper and digital forms should be available; many still do not use text/email Comment box can make qualitative input valuable Nursing evaluation absent; access to communication and scheduling important	Are to provide suggestions and comment on what is going well

Appendix G

COREQ Checklist

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from:

Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care. 2007. Volume 19, Number 6: pp. 349 – 357

Item No	Guide Questions/Description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/ facilitator	Which author/s conducted the interview or focus group? *Principal investigator conducted all focus groups*	Methods: Research Team and Reflexivity
2. Credentials	What were the researcher's credentials? *Postgraduate medical trainee; supervisor academic family physician*	Methods: Research Team
3. Occupation	What was their occupation at the time of the study? *Family Medicine resident*	Methods
4. Gender	Was the researcher male or female? *Not specified; not relevant to study aims*	N/A
5. Experience and training	What experience or training did the researcher have? *Clinical experience in primary care; supervised qualitative research*	Methods
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement? *Professional familiarity acknowledged; no evaluative relationship*	Methods
7. Participant knowledge of the interviewer	What did the participants know about the researcher? *Participants informed of investigator role and academic purpose*	Methods
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? *Reflexivity and mitigation of power imbalance described*	Methods
Domain 2: study design		
Theoretical framework		
9. Methodological orientation	What methodological orientation was stated to underpin the study? *Qualitative descriptive design*	Methods: Study Design
Participant selection		
10. Sampling	How were participants selected? *Purposive quota sampling across stakeholder groups*	Methods
11. Method of approach	How were participants approached? *Posters and in-person invitation via clinic administration*	Methods
12. Sample size	How many participants were in the study? *15 participants, five focus groups*	Methods
13. Non-participation	How many people refused to participate or dropped out? Reasons? *Not formally tracked; voluntary participation stated*	Methods
14. Setting of data collection	Where was the data collected? *Private rooms at Sherwood PMH*	Methods

Item No	Guide Questions/Description	Reported on Page #
15. Presence of nonparticipants	Was anyone else present besides the participants and researchers? *No non-participants present during focus groups*	N/A
16. Description of sample	What are the important characteristics of the sample? *Stakeholder roles described; inclusion criteria outlined*	Methods
Data collection		
17. Interview guide	Were questions, prompts, and guides provided by the authors? Standardized guide aligned with CAHPS domains	Appendix C
18. Repeat interviews	Were repeat interviews carried out? If yes, how many? *No*	N/A
19. Audio/visual recording	Did the research use audio or visual recording to collect the data? *Audio-recorded with consent*	Methods
20. Field notes	Were field notes made during and/or after the interview or focus group? *Field notes taken by facilitator*	Methods
21. Duration	What was the duration of the interviews or focus group? *60 to 90 minutes per focus group*	Methods
22. Data saturation	Was data saturation discussed? *Thematic sufficiency achieved*	Methods
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction? *Not returned to participants; not required for pilot adaptation study*	N/A
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data? *Single coder (PI) with supervisory review*	Methods: Data Analysis
25. Description of the coding tree	Did the authors provide a description of the coding tree? *Codes grouped deductively by domains: audit trail maintained*	Methods
26. Derivation of themes	Were themes identified in advance or derived from the data? *Themes derived deductively with allowance for emergent insight*	Methods
27. Software	What software, if applicable, was used to manage the data? *No qualitative software; manual coding supported by AI transcription tool*	
28. Participant checking	Did participants provide feedback on the findings? *Not conducted; stakeholder validation occurred during group discussion.*	
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? *Themes summarized; exemplar quotes provided*	Appendix F
30. Data and findings consistent	Was there consistency between the data presented and the findings? *Findings aligned with objectives and research question*	Results
31. Clarity of major themes	Were major themes clearly presented in the findings? *Major themes clearly presented in Results section*	Results
32. Clarity of minor themes	Is there a description of diverse cases or a discussion of minor themes? *Subthemes integrated with major domains*	Results

Appendix H

PEI-adapted draft of the CAHPS Patient-Centred Medical Home Survey

Survey Instructions

Answer each question by marking the box to the left of your answer.

You are sometimes told to skip over some questions in this survey. When this happens, you will see an arrow with a note that tells you what question to answer next, like this:

☒ Yes → **If Yes, go to #1 on page 1**
☐ No

Your care at this Patient Medical Home in the last 6 months

These questions ask about **your own** health care. Do **not** include care you got when you stayed overnight in a hospital. Do **not** include the times you went for dental care visits.

1. In the last 6 months, how many times were you able to get an appointment at this Patient Medical Home when you needed one?

- ☐ None → **If None, go to #16**
- ☐ 1 time
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 to 9
- ☐ 10 or more times

2. When you contacted the clinic for an illness or concern you felt needed care quickly, how often did you receive timely guidance or care?

- ☐ Never
- ☐ 1 time
- ☐ 2
- ☐ 3
- ☐ 4 or more times

3. How often were you treated with courtesy and respect by members of the care team at this Patient Medical Home?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

4. How often did members of the care team listen carefully to you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

5. How often were explanations about your care easy to understand?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Team-Based Care and Services

6. In the last 6 months, which of the following care team members have you seen at this Patient Medical Home? *Check all that apply*

- ☐ Family Doctor
- ☐ Nurse Practitioner
- ☐ Registered Nurse – COPD, Diabetes, Hypertension programs
- ☐ Family Doctor's nurse
- ☐ Pharmacist
- ☐ Social Worker
- ☐ Dietitian
- ☐ Medical Office Assistant/Receptionist

7. How satisfied were you with the care provided by the overall care team at this Patient Medical Home?

- ☐ Very dissatisfied
- ☐ Dissatisfied
- ☐ Neither dissatisfied or satisfied
- ☐ Satisfied
- ☐ Very satisfied

8. How well did members of the care team work together to coordinate your care?

- ☐ Very poor
- ☐ Poor
- ☐ Acceptable
- ☐ Good
- ☐ Very Good

9. How confident are you that the care team understands your health needs as a whole?

- ☐ Very unconfident
- ☐ Unconfident
- ☐ Neither confident or unconfident
- ☐ Confident
- ☐ Very Confident

Access and Coordination

10. How often did this Patient Medical Home help you coordinate care with services outside the clinic, when needed?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

11. When tests or investigations were ordered, how often did you receive results or guidance in a timely way?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

12. How easy was it to contact the clinic by phone or other means when you had a question or concern?

- ☐ Very difficult
- ☐ Difficult
- ☐ Neither difficult or easy
- ☐ Easy
- ☐ Very Easy

Your experience over time

13. How long have you received care from this Patient Medical Home?

- ☐ Less than 6 months
- ☐ 6 months to 1 year
- ☐ 1-2 years
- ☐ Over 2 years

14. How many visits have you had with this Patient Medical Home in the past 6 months?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4 or more

15. Overall, how would you rate the care you receive from this Patient Medical Home?

- ☐ Very poor
- ☐ Poor
- ☐ Acceptable
- ☐ Good
- ☐ Very Good

About you

16. What is your age?

- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or older

17. How would you describe your gender identity?

- ☐ Male
- ☐ Female
- ☐ Non-binary, gender-fluid, gender-diverse or others
- ☐ Prefer not to answer

18. How would you describe your cultural background?

- ☐ Indigenous: First Nations, Métis, Inuit
- ☐ White
- ☐ South Asian (e.g., Indian, Pakistani, Sri Lankan)
- ☐ Chinese
- ☐ Black (e.g., African, Afro-Caribbean, African-Canadian)
- ☐ Filipino
- ☐ Arab
- ☐ Latin American (e.g., Mexican, Colombian, Salvadoran)
- ☐ Southeast Asian (e.g., Vietnamese, Cambodian, Laotian, Thai)
- ☐ West Asian (e.g., Iranian, Afghan)
- ☐ Korean
- ☐ Japanese
- ☐ Other

19. Do you have private insurance/private coverage for services such as physiotherapy, counselling, dietitian?

- ☐ Unsure
- ☐ Yes
- ☐ No

Additional comments *(optional)*

20. Please use the space below to share any additional comments about your experience at this Patient Medical Home, including what works well and what could be improved

Thank you!