

Assessing Patient Experience Across the Rehabilitative Care Continuum

**A Report Prepared for the
Waterloo-Wellington Local Health Integration Network
Rehabilitative Care Council**

by

**The Geriatric Health Systems Research Group,
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Assessing Patient Experience Across the Rehabilitative Care Continuum

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Executive Summary

A 2012 review of rehabilitative care services in the Waterloo-Wellington Local Health Integration Network identified three gaps preventing the delivery of optimal care. The impact of subsequent transformation measures to improve the quality of care, will be measured using an evaluation framework modelled after the Institute for Health Improvement “Triple Aim” using the dimensions of “better care”, “better health” and “better value”. This report informs the development of patient experience measures to support the “better care” aims of the new Rehabilitative Care System.

A systematic analysis of peer-reviewed literature identified 25 valid and reliable survey tools and accompanying patient experience measures and uncovered a number of constructs that are particularly salient to rehabilitative care clients. These constructs were thematically consistent with the insights provided by rehabilitative care clients participating in a large ethnographic study in the Waterloo Wellington region, and were member-checked by patients and their caregivers who had experienced care across the system.

Selection of patient experience indicators should be guided by the following recommendations:

1. In the short term, patient experience indicators must address the performance gaps identified by the 2012 review.
2. Patient experience questions should be based on psychometrically tested instruments, where possible, and new questionnaires rigorously tested for reliability and validity.
3. Themes identified in the literature review and secondary analysis of ethnographic data are resilient, and consistent with previous literature. At least one question, that is representative of each thematic construct should be selected and included in any survey tool for a comprehensive view of the patient experience.
4. The choice of questions, and resource concerns, will influence the data collection methodology chosen.
5. A mix of leading and lagging indicators will ensure that governors are able to assess current operations, but also anticipate future performance allowing for mid-course correction where appropriate.
6. In the interests of data quality, patient experience data collection from across the rehabilitative care system should be managed centrally by a coordinating organization such as the WWLHIN. A mechanism for longitudinal tracking of results and accountability will ensure that feedback provided by patients is considered for incorporation into clinical practice
7. The WWLHIN explore data collection techniques and tools that specifically address patients with cognitive and communication impairment.
8. That data collection tools and questions be developed and administered with the input and guidance of patients and their caregivers, as well as healthcare providers and survey experts.

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Background

In 2011, the Rehabilitation Review Committee (RRC), commissioned by the Waterloo-Wellington Local Health Integration Network (WWLHIN), completed a comprehensive review of rehabilitative care services in Waterloo Wellington. The ensuing report (Sharma & Dean, 2012) identified three key issues that were to be addressed by a redesigned regional system of care(Sharma & Dean, 2012):

1. Best practices and standards had not been fully implemented
2. A lack of trust pervaded the system and was an obstacle to the achievement of optimal patient outcomes. Both patients and providers lacked confidence in the ability of rehabilitative care services' ability to meet their needs.
3. Services were not integrated across the care continuum nor was patient data flowing seamlessly between providers.

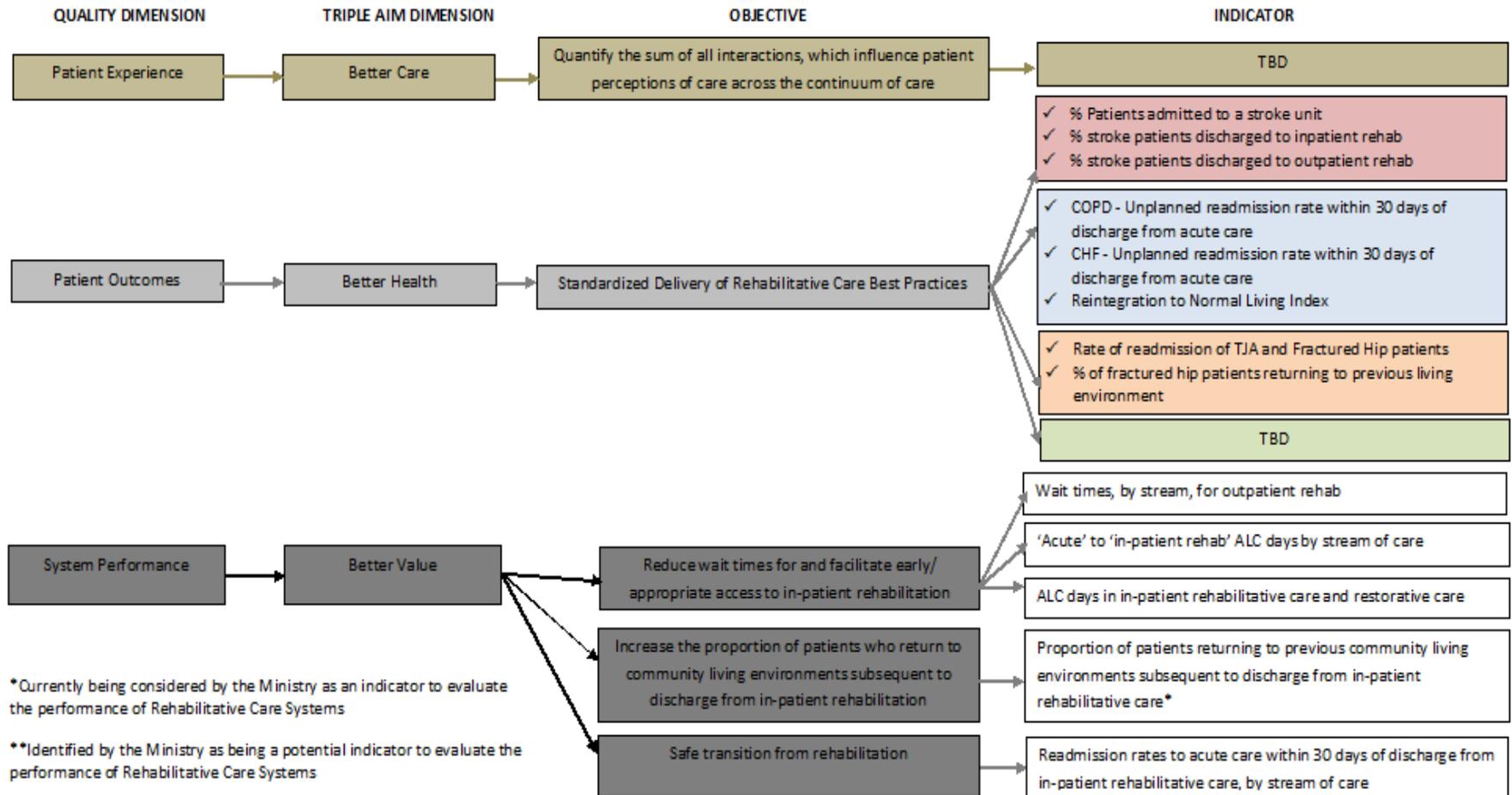
The report proposed a transformed system based on a best practices model for regional Rehabilitative Care. This system of rehabilitative care would integrate services across the continuum of care to “collaboratively maintain or restore patients’ function”. “Rehabilitative care” was described as a “set of standardized, evidence-based interventions that adapt in order to provide functional activation up to a patient’s current tolerance level and that concurrently address a patient’s medical, therapeutic and psycho-social needs”(Rehabilitation and Complex Continuing Care Expert Panel, 2011). Four “streams” were configured to streamline care: Musculoskeletal (MSK), Frail Elderly/Medically Complex (FEMC), Stroke/Neurology (Neuro), and Cardiopulmonary (CP), in order of the volume of admissions to in-patient rehabilitation units in 2010, as reported by the Health Analytics Branch of the Ontario Ministry of Health and Long Term Care (Sharma & Dean, 2012).

To support evaluation and ongoing monitoring of the impact of this new model, an evaluation framework was proposed, and included a set of key system performance indicators (Figure 1). The measurement framework is guided by the “Triple Aim” dimensions of “better care”, “better health” and “better value” (Berwick, Nolan, & Whittington, 2008). Adequate measures of patient experience to address the “better care” dimension were not identified or developed. The authors were asked by the WWLHIN Rehabilitative Care Council to propose a set of coordinated activities to identify distinctive patient experience measures to support the “better care” aims of the new Rehabilitative Care System. Both quantitative and qualitative components were to be considered, with a focus on measures that would be appropriate across the continuum of care (i.e., in multiple care settings).

This report, prepared for the RCC, will:

1. summarize methods and findings from the systematic review, secondary data analyses, consumer consultations and key informant interviews;
2. provide recommendations for quantitative and qualitative assessment of patient experience that are feasible for implementation within current practice constraints, and that can be used across multiple care settings; and
3. where possible, suggest data collection tools/methodology for assessing patient experience in rehabilitative care.

Figure 1. WWLHIN Rehabilitative Care System - Evaluation Framework and Key Performance Indicators (Draft)



Confounding the development of reliable and valid patient experience measures in rehabilitative care, is the definitional ambiguity between “patient experience” and “patient satisfaction”. Jenkinson and colleagues (2002) describe experience as a report of what occurred in a patient’s health encounter and satisfaction as their evaluation of that encounter. Thus, patient satisfaction is less objective in its representation of “reality” (Sitzia & Wood, 1997), and patient experience may be more helpful in pinpointing areas for improvement (Jenkinson et al., 2002).

Our premise is that a “patient experience” measure reports an individual’s perspective of the presence or absence of elements encountered while receiving care. This might include specific areas of experience such as “my therapist treats me respectfully”, or “the waiting area is comfortable” , or a universal measure such as “overall impression of rehabilitation institution” (Beattie, Dowda, Turner, Michener, & Nelson, 2005; Beattie, Pinto, Nelson, & Nelson, 2002; P. Beattie, Turner, Dowda, Michener, & Nelson, 2005; Grotle et al., 2009). Satisfaction, on the other hand, alludes to an individual’s “pleasure or disappointment” that comes from comparatively assessing a service against their personal values and expectations of it (Delanian Halsdorfer et al., 2011; Kotler & Keller, 2009, p789). If a patient expresses satisfaction with a service, one assumes therefore that they are happy after its consumption, and that their expectations have been met. Some have referred to this as a “zone of tolerance”, where adequacy is measured by achieving the minimal threshold of service that will be adequate to satisfy an individual’s service expectations (Johnston, 1995). Below this service level patients will express frustration at perceived inadequacy of the service, and at the upper level of the zone, will be delighted with the service. These measures more often than not refer to satisfaction in either the question, for example, “I am satisfied with the services I received”, or the response options “Not at all satisfied” or “Extremely satisfied”. The contrast between experience and satisfaction therefore, is the difference between living a care event, and feeling contentment about the way it fulfilled your service expectations.

Methods

The following methods, 1) a literature review, 2) key informant interviews, 3) secondary analysis of regional ethnographic study data gathered from MSK/EFMC patients, and 4) patient focus group interviews, were used to ensure that all contemporary peer-reviewed instruments and measures were considered, that the voices of the patient and their informal caregivers were heard, and that the opinions of experts in the field informed our study. The voice of the patient from within the rehabilitative care system was acknowledged by the inclusion of the qualitative methods, that Cohen (1996) suggests are better able to explore and improve the care environment that the patient experiences. Data from all sources were aggregated and analyzed for common themes and best practices that might inform the WWLHIN’s development of a rehabilitative care system patient experience indicator.

Literature Review

A search was conducted of peer-reviewed literature for measures of patient experience, particularly those developed for systems of rehabilitative care. Our search used a systematic search and review method that requires decisions to be made before the search regarding inclusion and exclusion criteria, and documentation of procedural decisions (Armstrong, Hall, Doyle, & Waters, 2011; Kastner et al., 2012; Levac, Colquhoun, & O'Brien, 2010). The search methodology to identify articles describing empirically tested rehabilitative care patient experience measurement instruments, was developed in collaboration with a health sciences librarian subject matter expert, as were details of the search strategy, including search terms (see Appendix A) and databases. Figure 2. Flow chart for article selection details the paper selection process.

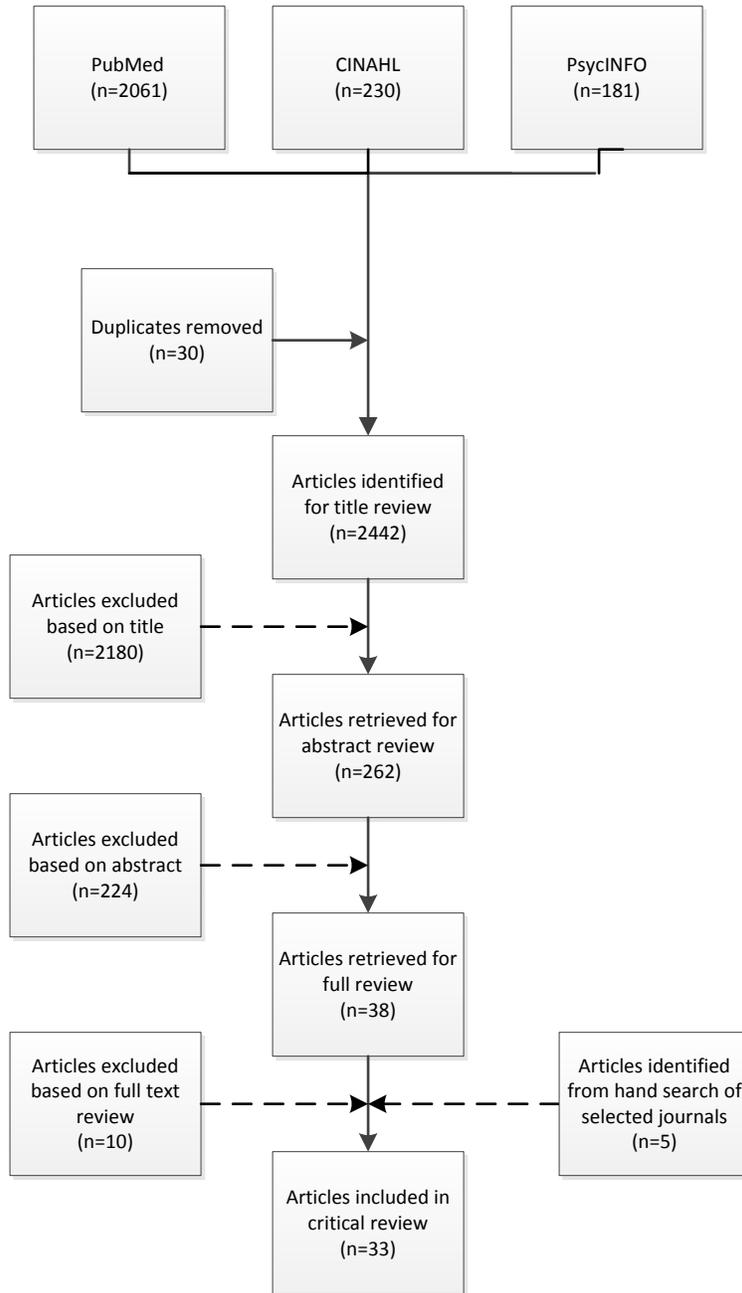
Data Sources and Searches

A comprehensive search was conducted of the MEDLINE (Pubmed), CINAHL (Ebsco), and PsycINFO (APA PsychNET) databases. The final search strategy is outlined in Appendix A. The bibliographies of articles selected for complete review were hand searched for relevant citations not captured by the original search strategy. Further searches were conducted in relevant databases including Healthcare Policy, WHO Bulletin, Health Affairs, and the International Journal for Quality in Health Care. The reference lists of the final accepted articles were hand-searched to ensure that pertinent and eligible articles were not missed.

Eligibility Criteria and Study Selection

For inclusion in this review, articles must have been published in a peer-reviewed journal in the English language since 2004. This frame was selected based on an observed shift in interest from patient "satisfaction" to patient "experience". To confirm this observation, the term "patient experience" was entered into Google Trends, an online log of internet search volumes; results indicated that prior to 2005 there was little interest in this term (though the literature clearly indicates that research was ongoing), with much of the recent activity originating from the United Kingdom, and to a lesser extent the United States, and Canada. Additional inclusion and exclusion criteria were assigned to ensure that the articles retrieved were focussed on our domain of interest. Articles addressing mental health, palliative care, pediatrics, dental, or veterinary rehabilitation were excluded as the contributing factors were deemed materially different in nature from our area of interest and thus the scope of this review. Inclusion criteria comprised articles that had a direct and obvious relevance to rehabilitative care, were patient experience focused, and discussed a specific measurement tool that was or had been empirically tested. Qualitative study designs were excluded from the review but were retained to inform the discussion section of this paper.

Figure 2. Flow chart for article selection



Data Abstraction

A title screening of the articles was first conducted to rule out and delete any obviously irrelevant articles the search retrieved. Following this, the abstracts of the remaining articles were screened; those meeting inclusion criteria were then scanned in full-text. The search team discussed themes and challenges, mainly surrounding the lack of conceptual clarity of “patient satisfaction” vs. “patient experience” but came to a clear consensus on terms for the full text review.

The accepted articles were summarised into two pre-made data abstraction templates, created by the authors in order to assist with interpretation of the results. Where questions from the survey instruments were not available in the article, the actual instrument was independently sourced. While this objective analysis systematically selected available literature, NVivo version 10 (QSR International Pty Ltd., 2014), a qualitative data analysis software application, mediated a naturalistic analysis of the selected papers. This process allowed for multiple, and occasionally divergent, data points to be considered in the context of studies they described, and to identify themes in the constructs being measured (Guba & Lincoln, 1982) particularly in relation to their distinctiveness from sectors outside of the rehabilitative care system. These themes were discussed amongst the authors and conflicts resolved via consensus. Despite the abundance of literature on both patient experience and patient satisfaction, the scarcity of literature in the rehabilitative care domain suggested a grounded theory approach to our analysis would be appropriate. Sensitizing concepts related to patient-centred care, the patient experience, and patient satisfaction were developed to lay a foundation for the analysis, and to assist the authors interpret collected data in the research context.

Key informant Interviews

Key informant interviews were conducted with experts engaged in health system performance measurement. Interviews were conducted with two representatives from the Canadian Institute for Health Information (CIHI). One identified Alberta and British Columbia as the two provinces that have focussed on developing programs to measure patient experience. An independent consultant from Alberta who has done work in similar domains, and a representative of the B.C. Ministry of Health who manages their patient-centred performance measurement project, were subsequently interviewed.

One of the authors also attended a Patient Experience Conference organized by the Ontario Hospital Association in order to familiarize the group with current research on system-level patient experience measurement. Attempts were made to contact key personnel who were identified as being involved in advanced research, empirical testing or implementation in the field at the Ontario Ministry of Health and Long-Term Care, Health Quality Ontario and the National Health Service. No responses were received at the time of writing.

Ethnographic Abstraction of Secondary Data

Insight into the aspects of a positive care experience for rehabilitation clients making transitions across the health care system was gained from analysis of data collected as part of the InfoRehab project (Toscan, Mairs, Hinton, & Stolee, 2012). The larger study, titled *InfoRehab: Better Information for Better MSK Health and Quality of Life for Older Persons*, was a CIHR-funded research initiative that examined the information needs and care transition experiences of hip fracture patients. The InfoRehab project used ethnographic methods to follow complex musculoskeletal patients from acute care (post-surgery) discharge to all subsequent care settings (e.g., home care, rehabilitation hospital) until their final destination (e.g., home, long-term care). Ethics clearance was obtained from the University of Waterloo Office of Research Ethics, The Tri-Hospital Research Board and the Grand River Hospital Research Committee, and the Waterloo Wellington Continuing Care Access Centre.

Data were collected from January 2010 to November 2010 from patients who had been admitted to acute care post-hip fracture surgery, along with their informal and formal care providers. A series of tetrads each consisting of a patient, a caregiver and two health practitioners was selected from each of the settings across the trajectory to represent differences in transitional care experiences. Participants were recruited during their acute care hospital stay by an attending nurse until the sample size was large enough to reach saturation (Clemmer, Ward-Griffin, & Forbes, 2008; Yin, 2003).

A semi-structured interview guide was used to elicit responses focusing on **transitional care experiences across the continuum**. Interview guides were tailored to each participant group at each setting to reflect their unique perspectives. The interview guide focused on asking the participants about communication with each other, attitudes about care, gaps in information, and involvement in the transition. The interviews were recorded and transcribed verbatim.

At each care transition, interviews were conducted with the patient, a family caregiver, and health care providers. The InfoRehab study team used a focused ethnographic approach (Hammersly & Atkinson, 2007) where observations were conducted at the care settings, interviews with patients, families, and health care providers were completed, and relevant patient documents were gathered from three sites [Waterloo, Strathroy (London), and Vancouver]. Overall the study generated 171 interviews with 134 patients, caregivers, and health care providers. For the purposes of this study, only the data from Waterloo site, namely 6 patients (3 female, 3 male) and their informal caregivers, were included, consisting of 16 interviews.

Two researchers were responsible for coding the data as part of an internal validity check (Denzin & Lincoln, 1994). With the topic of “patient experience” in-mind, each researcher engaged in a process of emergent coding. Although the researchers allowed the data to speak for itself, much of the coding focused on the experiences of the patients and their caregivers as they travelled through their rehabilitation journey. Codes were then compared and organized into categories, clarifying

and identifying variations between them (Charmaz, 2006). Once the coding and theming was complete, the two independent researchers came together to discuss the differences in coding.

The codes were grouped together as sub-themes and a title was applied to the group as the theme name. Excerpts from the data were gathered to help explain each theme/sub-theme. For many of the themes there were examples of both positive experiences and negative experiences. Table 1 describes the care transitions for each of the interviewed patients analysed for this review.

Table 1. Waterloo Site Transitions

Patient	Gender	Residence Prior to Hip Fracture	Transitions
1	F	Home →	Acute Care → Inpatient Rehab → Retirement Home → Home Care
2	M	Home →	Acute Care → Inpatient Rehab → Home Care
3	M	Home →	Acute Care → Home Care
4	M	Home →	Acute Care → Home Care
5	F	Home →	Acute Care → Inpatient Rehab
6	F	Long Term Care →	Acute Care → Long Term Care

Focussed Patient Interviews

In order to validate the thematic categories constructed from the literature review, secondary data analysis and key informant interviews, focussed patient interviews were conducted with a convenience sample of rehabilitative care users. The participants were members of the SHARP (Seniors Helping as Research Partners) network of older persons who have agreed to collaborate with the GHSRG on research projects.

Individual interviews were conducted with three persons with rehabilitative care experiences. Two females and one male participated in the discussions; their ages ranged from 66 to 91. The interviewees had either personal or family experience with each of the four streams of care within the WWHLIN including cardiopulmonary, frail elderly, stroke and MSK (hip replacement, knee replacement and back problems). Participants received rehabilitative care through community and in-home services. Two participants had experiences caring for family members during rehabilitation as well as personal rehabilitative experiences. Two interviews were conducted in person at a retirement home and one was conducted over the phone. Consent to participate in this research project and to audiotaping was obtained; ethics clearance was received by the University of Waterloo Office of Research Ethics.

Interviews lasted between 20-40 minutes. Participants were first asked to give a general account of their rehabilitative experiences. Following general questions, a list of the themes uncovered in the literature review and secondary patient data analysis were presented to the participants (see Figure 4) and they were asked to provide feedback (i.e. agreement, disagreement, missing information). The interview guide questions and prompts included:

- 1) What did you receive rehabilitation for? (Stroke, Musculoskeletal, Frailty, Cardiopulmonary)
- 2) Where did you receive your care? (For example, at home? At the hospital? Long term care?)
- 3) Having had experience with rehabilitative care, is there anything that stood out as being important to your rehabilitation experiences?
 - a. Prompts: For example, what made your experience good or bad?
- 4) We have printed out a list of the themes that have emerged from our previous and ongoing research as being important aspects of rehabilitative care experiences.
 - a. We would like to go through these themes with you to discuss what you agree with and whether there is anything that you disagree with.
- 5) Is there anything that we should have talked about, but have not included on this list?

Findings

Literature Review

Search Yield

The aforementioned search strategy yielded a total of 2472 articles between the three databases. Once duplicates were removed, 2442 articles underwent a title review using the specified inclusion and exclusion criteria, yielding a total of 262 articles; this was followed by an abstract review that left 38 articles for full text review, after which ten were removed as not meeting inclusion criteria. Hand-searching the reference lists of the remaining articles resulted in the inclusion of five additional articles, creating a final sample of 33 articles. The studies were conducted in a total of 15 countries, with the largest number occurring in the United States (Table 2). Appendix B. Systematic Literature Review Selected Articles provides an abstraction of the articles selected for analysis.

Country	No. of Studies Using Data from this Location
Australia	3
Australia & Korea	1
Canada	1
England	2
France	2
Germany	2
Ireland	1
Italy	2
Netherlands	3
Norway	2
Scotland	2
Spain	3
Sweden	2
Switzerland	1
United States	6
	33

All papers satisfied the pre-established criteria for selection, including the expectation that they measure some component of our conceptualization of the patient experience. A total of 25 discrete measurement instruments were documented in the selected literature (see Appendix

B. Systematic Literature Review Selected Articles). The ambiguity between patient experience and patient satisfaction was evident, even in the selected papers. While some papers explicitly focussed on patient experience rather than satisfaction (for example, Medina-Mirapeix et al., 2012), others appeared to be focussed on patient satisfaction (for example Quaschnig, Körner, & Wirtz, 2013; Roush, Jones, & Nassaney, 2007), while others examined both (Medina-Mirapeix, Jimeno-Serrano, Escolar-Reina, & Del Baño-Aledo, 2013a). The only literature review of empirically tested instruments did not differentiate between satisfaction and experience and examined both (Slade & Keating, 2010). Cognizant of the patient experience/patient satisfaction ambiguity, we carefully examined all articles and instruments for respondent questions that satisfied our conceptualization of patient experience measurement; these were harvested to create an inventory of questions that were indicators of patients' experience of rehabilitative care (see Appendix C. Validated Patient Rehabilitative Care Experience Questions by Instrument). Consistent with our focus on experience over satisfaction, questions that asked the respondent to make an evaluation based on their happiness with a service, rather than on whether a process or event did or did not occur, were excluded from the analysis. Despite excluding all search terms related to patient satisfaction, there were a large number of papers whose focus was patient satisfaction, that were captured by in our search, and that survived the rigorous selection process. Patient satisfaction and patient experience are tightly woven constructs.

Some instruments (the ZUF-8, WCCS, P.A.I.NT, PPE-15 and DPEQ) were either not available for public examination or in the case of the P.A.I.NT, not available in English and thus were not included in Appendix C. Others, such as the SAT-16 and Satisfaction with Musculoskeletal Care Questionnaire were excluded when a full examination of the instrument's questions revealed all were focussed exclusively on satisfaction rather than experience. Where an instrument included questions related to the patient experience, the study was retained.

Types of Study Settings, Rehabilitative Care, and Populations

Approximately half of the papers were published since 2010; unsurprising given the growing interest in measuring patient experience as a reflection of care quality and safety (Doyle, Lennox, & Bell, 2013). Twenty (61%) of the studies were conducted in an outpatient rehabilitative care setting (differences between national funding models for rehabilitative care means that outpatient settings were deemed to be those that did not involve an overnight hospital stay) (Baumann, Rat, Mainard, Cuny, & Guillemin, 2011; Beattie, Dowda, et al., 2005; Beattie et al., 2002; P. Beattie, Turner, et al., 2005; Dibbelt, Schaidhammer, Fleischer, & Greitemann, 2009; Duijin, Coe, Bevins, & Jack, 2008; Fernandez, Salamonson, Juergens, Griffiths, & Davidson, 2007; French, Keogan, Gilsenan, Waldron, & O'Connell, 2010; Grotle et al., 2009; Hills & Kitchen, 2007; Hush et al., 2013; Kneebone, Hull, McGurk, & Cropley, 2012; Knight, Cheng, & Lee, 2010; F. Medina-Mirapeix et al., 2012; Francesc Medina-Mirapeix,

Jimeno-Serrano, et al., 2013a; Normann, Moe, Salvesen, & Sørsgaard, 2012; Roush et al., 2007; Van der Linde, Hofstad, Geertzen, Postema, & Van Limbeek, 2007; Vanti et al., 2013). Of the remaining studies, eight recruited patients in an inpatient rehabilitative care hospital setting (Cott, Teare, McGilton, & Lineker, 2006; Delanian Halsdorfer et al., 2011; Elwood et al., 2010; Grosset & Grosset, 2005; Monnin & Perneger, 2002; Ottonello, Franchignoni, Giordano, & Benevolo, 2012; Quaschnig et al., 2013; Slade & Keating, 2010), four were conducted in an acute care hospital that cared for patients at the start of their rehabilitative care journey i.e. post-stroke, post-arthroplasty (Almborg, Ulander, Thulin, & Berg, 2009; Cramm, Strating, & Nieboer, 2012; Soderback, 2008; Stubbe, Gelsema, & Delnoij, 2007) and one involved a cross continuum study from the hospital to the community (Curry & Sinclair, 2002).

Of the 33 studies, 18 (54.4%) measured physical rehabilitative therapy, three measured occupational therapy, two measured speech therapy, one measured all of the previous therapies in addition to respiratory and psychological therapy as well as social work interventions. One focussed on orthotics and prosthetic interventions. The study populations were described as those characterized by issues with musculoskeletal (9), stroke/neuro (5), frail/elderly and medical complexity (2), multiple sclerosis (1), occupation related musculoskeletal (1), cardiopulmonary (1), rheumatological disorders (1), or were discharged patients (2), in-patients (2), stroke patients and their caregivers (1), patients and their physicians (1), patients (1), receiving unspecified rehabilitative care (5), or amputees (1).

Measurement Instruments

Of the 25 discrete tools described in the selected papers, only seven were not specifically developed to measure experience in a rehabilitative care setting. The Medical Interview Satisfaction Scale (MISS-21) with its focus on the physician-patient relationship, communication and compliance intent, is particularly suited to the rehabilitative care delivery model, despite its not having been designed for the purpose. The OPEQ (Normann et al., 2012), PEQ (Slade & Keating, 2010), PPE-15 (Slade & Keating, 2010), QCS (Baumann et al., 2011), QUOTE (Slade & Keating, 2010; Van der Linde et al., 2007), and SERVQUAL (Curry & Sinclair, 2002) were all developed for populations other than patients experiencing rehabilitative care.

Soderback's (2008) pilot study of frail elderly/medically complex clients was the smallest of the studies with a sample size of 9 but is also the most diverse in that it drew respondents from geriatric rehabilitation, orthopaedic and internal medicine wards with patients whose diagnoses included stroke, heart disease, musculoskeletal pain and an accidental fall. This study examined the use of the DPEQ discharge survey to evaluate occupational therapy services provided in the community. Apart from the small sample size, there were methodological limitations related to the internal consistency and validity of the DPEQ that suggest the results should be viewed with caution. With a sample size of 7274, Ottonello et al.'s (2012) methodologically rigorous study, was the largest in our analysis, and provided a wealth of reliable insights. Patient satisfaction with in

patient rehabilitative care quality was analysed using the SAT-16, and validity-tested using factor analysis. Satisfaction subscales of clinical care and hospital organization/facilities underwent Rasch analysis to further test validity associated with the rating scale. Findings suggest that patient's satisfaction with the care ecosystem of the organization and surrounding facility features, or what the author called "hotel" aspects of care, and satisfaction with clinical care differed conceptually and in reality. Furthermore, the results of the Rasch Analysis suggest that collapsing five level scales, to three ("dissatisfied", "satisfied", "very satisfied") improved the performance of the scale by removing irrelevant variance, and prevented the well-known ceiling effect, where patients who are asked about their level of satisfaction with a health service will respond very positively.

Only one instrument was used to measure patients' service experience, across the continuum in a rehabilitative care system. The SERVQUAL instrument has been widely adopted in other industries and shown to perform consistently in those sectors (Carrillat, Jaramillo, & Mulki, 2007). Early research by Parasuraman, Berry, & Aeithaml (1991) identified the five dimensions under which questions are grouped in the SERVQUAL instrument. Respondent rankings of those five dimensions scored reliability as the most important attribute, followed by responsiveness, assurance and empathy, and tangibles as the least important of the service experience. The instrument requires respondents to scale their expectations of a service, then their perceptions of the service; gaps between these scales represent opportunities for improvement. The Curry & Sinclair (2002) study used a modified SERVQUAL questionnaire to remove irrelevant questions for each setting i.e. patients receiving care in the community would not be asked about physical facilities. The ability of this questionnaire to retain its validity across settings suggests that the constructs associated with a service experience may be the same whatever the environment in which it is delivered. It has been used in a variety of different settings in healthcare (Bakar, Akgün, & Assaf, 2008; Dagger, Sweeney, & Johnson, 2007). This supports the notion that a common underlying framework of service quality allows the use of general service quality questions to gather feedback; but in order to gain deeper insight into the responses, more qualitative methods such as open-ended questions, interviews or focus groups are required.

Patient experience instruments that attempt to gather a granular level of data, exchange that level of detail for increased time to complete the questionnaire, lower response rates (VanGeest, Johnson, & Welch, 2007) and in the case of the Curry study (2002) included in our review, creates problems for elderly patients who found the (SERVQUAL) instrument long and it to be difficult to rank some of the service dimensions. This is particularly troublesome for a sector such as rehabilitative care where the elderly and those with cognitive deficits are more likely to be receiving services. Where a patient population was included but known to experience difficulties such as those with neurological deficits (Kneebone et al., 2012), instruments were occasionally amended to accommodate those deficits, such as using positive rather than negative questions or discrete response choices rather than evaluation scales. Others have noted the variability in length of patient experience survey instruments. Castle, Brown, Hepner, & Hays' (2005) literature review

reported on 54 instruments used in hospitals where the number of questions ranged from eight to 121, with an average of 45 questions for mail surveys.

Four papers describe the process of development then subsequent psychometric evaluation of the Measuring Patient Satisfaction with Physical Therapy (MRPS) tool using pilot test data, (Beattie, Dowda, et al., 2005; Beattie et al., 2002; Beattie, Turner, et al., 2005; Hush et al., 2013). The only other instrument to be used by more than one study was the PTOPS which was compared to the PSQ survey on measures of missing data, the ceiling effect, reliability, and validity (Roush et al., 2007), and the PTOPS-I that described the development and testing of an Italian version of the PTOPS instrument for use with patients who receive physical therapy.

All of the instruments focus on the self-reporting of perceptions about rehabilitative care services. As with many self-report surveys there is an expectation that respondents will be provided with anonymity to avoid the risk of retaliation; many of the surveys referenced anonymity provisions (such as Kneebone et al., 2012; Normann et al., 2012; Roush et al., 2007), whereas others collected data through face to face interviews (Almborg et al., 2009), sometimes combining the interview with a chart review (Soderback, 2008), or as with Cott (2006), and others documented no concerns nor process to conceal respondent identities. None of the studies reported the use of online or web-based technology for distribution or data collection of instruments; the majority of studies reported the use of paper-based surveys.

Some studies focussed on the development of a new measurement instrument. Kneebone et al. (2012) for example, conducted psychometric analysis, such as test-retest reliability, internal reliability testing and concurrent validity, and statistical testing of the instruments. The study explored effect size and moderating variables to establish the impact of variables such as gender, previous experience with rehabilitation, and whether or not respondents had someone to assist them with completing the survey, on survey responses. Vanti et al.'s (2013) development of an Italian version of the PTOPS survey provides insight into the processes required to validate modifications to previously tested instruments. These papers demonstrate approaches to the development and psychometric testing of instruments to measure the quality of rehabilitative care that have been previously lacking.

Twenty of the studies involved rehabilitation clients in the development of the survey tools. This is a particularly important methodological approach when developing patient experience questionnaires in rehabilitative care. Slade & Keating (2010) suggest that patient satisfaction questionnaires address questions that are relevant to care providers and researchers, while experience questionnaires are relevant to patients and recognize their expertise as assessors of their healthcare encounter.

A number of themes related to the dimensions of care, instruments and questions (where available) emerged during an iterative analysis of the selected papers, namely: Group Identities, Patient and Healthcare Provider Relationship, Client and Informal Caregiver Relationship, Rehabilitative Care

Ecosystem, Body Function, and Qualitative. The number of patient experience questions by Instrument and Category is listed in Table 3.

Table 3. Number of Questions by Theme in Each Questionnaire/Instrument

Questionnaire/Instrument	C	E	F	I	Q	R	Total
CCRQ	11	5	4	2	0	2	24
CQI	3	7	2	0	0	9	21
CRPF-R	6	6	3	1	0	1	17
MISS 21	5	0	0	0	0	16	21
MRPS	3	3	0	0	0	3	9
NREQ	6	6	0	0	0	3	15
OAKHQOL	3	3	38	0	0	1	45
OPEQ	9	11	0	0	0	4	24
PEQ	4	1	0	0	0	9	14
POPS	2	10	10	1	0	11	34
PPE-15	9	13	0	0	0	14	36
PPTO	1	0	5	0	0	0	6
P-QPD	14	0	0	0	0	0	14
PSQ or PTPSQ	0	9	0	5	0	3	17
PTOPS	3	24	0	0	0	7	34
QCS	13	5	5	0	0	3	26
QUOTE	3	6	0	0	0	2	11
Re-PEQ	10	14	0	0	1	2	27
SAPHORA	4	8	5	2	1	1	21
SASC or C-SASC	5	5	0	0	0	0	10
SERVQUAL	0	8	0	3	0	6	17
Unnamed (Knight)	1	7	0	0	0	4	12
Unnamed (Medina-Mirapeix, 2012)	7	9	2	0	0	4	22
Unnamed (Medina-Mirapeix, 2013)	1	8	2	1	0	2	14
Unnamed (Monnin)	2	6	1	0	0	2	11
TOTAL	125	174	77	15	2	109	502

§

- C** Client and informal caregiver engagement i.e. shared decision making,
- E** Rehabilitative care ecosystem i.e. wait times, clinic culture
- F** Body function i.e. pain control
- I** Identification as individual or with a group i.e. gender, ethnicity
- Q** Qualitative (open ended question)
- R** Patient and healthcare provider relationship i.e. trust in therapist

Key informant Interviews

CIHI is currently working with various provincial Ministries of Health to implement their recently developed acute care patient experience tool. This Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) based instrument is being presented to acute care hospitals in Canada as an alternative to the National Research Corporation Canada (NRCC) Patient and Family Experience survey. The focus of this survey is the acute care sector, and at this time CIHI has not explored a cross-sectoral instrument citing the difficulty of finding a generic pathway across providers, concerns about taking questions from an acute care survey and applying them to other sectors, and difficulty finding questions that every patient across the continuum will be able to answer.

None of the key informants were aware of any tools being used to specifically measure rehabilitative care patients' experience. B.C. is currently developing a tool that will be used in the acute care sector. It has specific questions about rehabilitative care services and will be focussed on transitions of care between in-hospital services, and then between the hospital and the next attending care provider.

A common theme in our discussion with the key informants was the redundancy built into many patient experience survey instruments. Questionnaires are often designed to gather data using over 50 data points in their quest for comprehensiveness and specificity. The downside risk of these instruments is their cost, and the impact they have on return rates. It was suggested it would be a wise investment of time for surveyors to identify key elements that are important to everyone in the system. One caveat is that the information gathered may have less specificity. However, if you view patient experience feedback as information on WHERE to look for a problem rather than WHAT the problem is, the onus is on the provider to determine what needs to be "fixed" in the context of their service environment.

Perhaps the most advanced exploration of patient experience in Ontario is occurring in the Northumberland Community PATH Partnership funded by The Change Foundation. This system-wide project is being co-designed by patients, caregivers and providers and is focussed on engaging seniors and caregivers in their care, providing navigators to improve transitions, and altered funding models. Technology is being used to gather patients' clinical and experience data across the care continuum, however detailed information about these applications, and their potential for wider applicability, is scant. Little is known about the empirical testing of the experience measures, nor is it known whether there is any specific focus on rehabilitative care services.

Ethnographic Secondary Data Analysis

Two researchers (JG, JE) separately coded the InfoRehab transcripts using NVivo 10. First, the two researchers began the process with a small segment of data, and then discussed their results to consider inter-rater reliability. After determining that they had similar codes, the researchers coded the other 14 interviews. After coding was complete, the researchers met to discuss the codes. The coding files were merged together and in total 40 codes were generated from the emergent coding process (see Figure 3). The researchers worked through each code, and grouped codes together to create themes by clustering codes whose meanings are linked. The output from this process is a document describing the themes that characterize the case, including a theme name, description, illustrative quotations from the data, and a list of codes that support the theme.

In total, the researchers identified 9 themes from the secondary analysis of InfoRehab data: *Inclusion of family in the circle of care, Need for communication with patients and families, Patient-centered care, Environment, Pain Management, Safety, Social Issues, Planning Ahead, and Role Clarity.*

The research team came together (JM, HM, SB, JE, JG, CL) to compare the themes that emerged from the secondary data analysis with those that emerged from the literature review. The themes fit nicely together, and through discussion, the team was able to combine the themes into 5 strong themes (see picture below). The themes from the data analysis gave depth and supported the themes from the literature, and vice versa.

The 5 themes are: **Group and Individual Identity (I), Patient and Healthcare Provider Relationship (R), Client and Informal Caregiver Engagement (C), Rehabilitative Care Ecosystem (E), and Body Function (F)**. A methodological theme was also noted; the inclusion of open ended questions ensured that constructs of importance to the respondents but not included in the survey questions, prepared by the researchers, were acknowledged. This theme is identified as **Qualitative (Q)**.

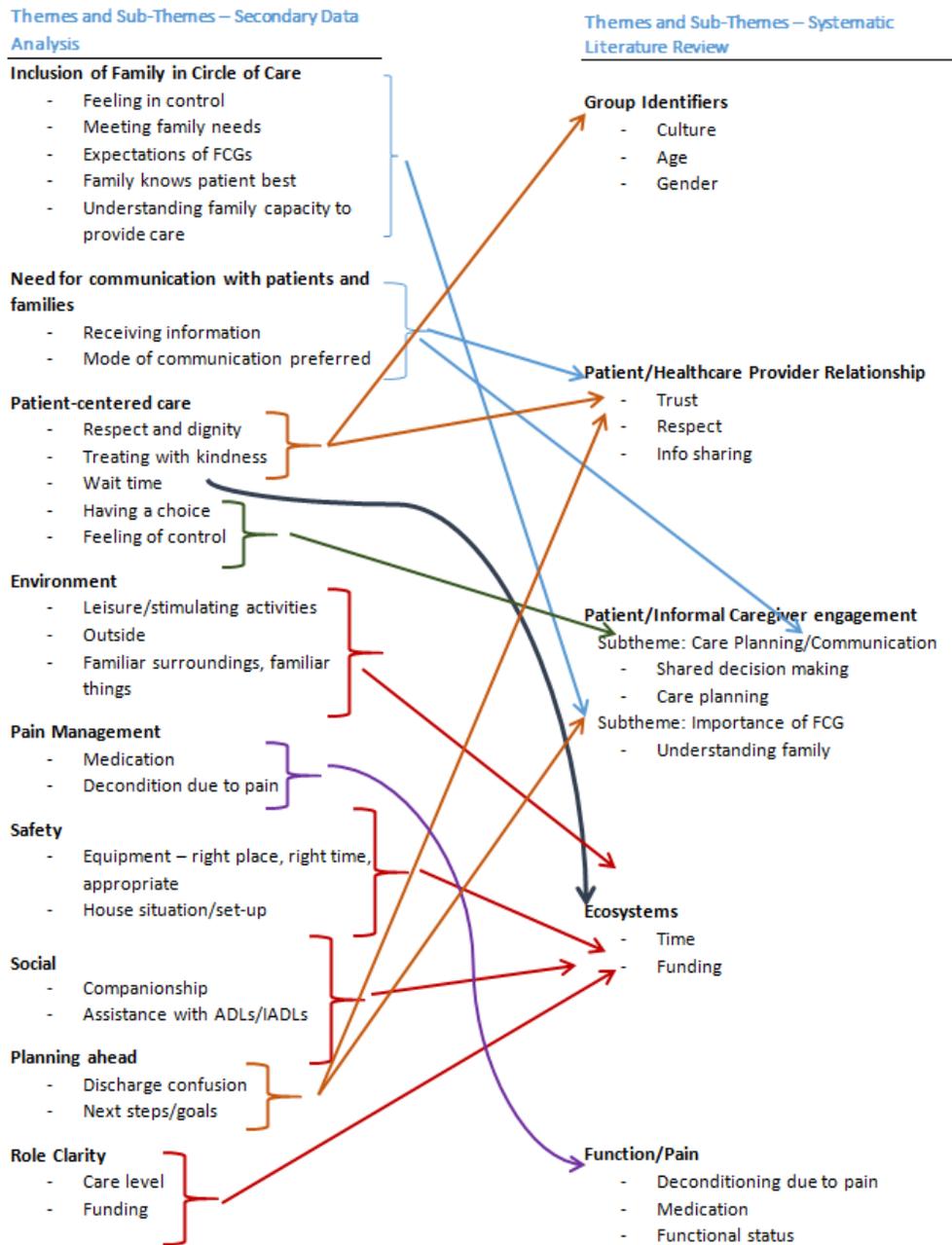
Figure 3. Initial Coding List from Secondary Analysis

Code Name
Appreciate any help that is given
Being able to go outside is important to me
Being in the familiar surroundings of my home is important to me
Family dynamics influence how care is shared
fear of backlash if I complain
Funding for equipment and services is confusing
I did not know who was who
I felt alone
I had to take the initiative to get information I need and communicate with health care providers
I knew about home care only because of my previous experience
I need verbal and written information
I was frustrated so I didn't care anymore
I was given choice
it is important for me and my family to set goals
It is important to consider emotions
It is important to plan ahead for discharge
Kindness goes a long way
Leisure is important to me
Losing faith in the health care system
Maintaining my independence is important
Need for clarity about home care and ongoing roles of providers
Need for more information on prognosis, rehabilitation, next steps and the future
not being mobilized soon enough
Not feeling in control of care situation
Not feeling informed
Not really. I never felt well informed since the whole thing happened.
Pain management is important to me
Providers need to talk to family members about patient needs, preferences, etc.
Safety is a priority
Social support and caregiving and companionship around me is important
Support needed to assist with Activities of Daily Living and Independent Activities of Daily Living
The atmosphere and environment were depressing
The food wasn't very good
The importance of a smooth admission
The nurses were great over there and I have real rapport with 2 or 3 of them and you know.
There is too much waiting
They didnt treat my family well
Treating me as a human being
Understanding the schedule at different facilities

Aggregate Emergent Themes from the Literature Review & Secondary Data Analysis

At a meeting of all researchers, codes from the secondary data analysis, and literature review were discussed and aggregated (see Figure 4); a list of five general themes were agreed upon through consensus. Common findings are reported here – insights from the literature review are supported by quotes from the patients and caregivers from the InfoRehab study.

Figure 4. Validation and Mapping of Themes and Sub-Themes from the Secondary Data Analysis and Systematic Literature Review



Group and Individual Identity (I)

“Ring the bell and you don’t know – it might be – well in the middle night a couple of times it was a big [man]...that came. And I know it’s just one...to help you but more...to physical health. There’s more to health than just physical health. There’s that feeling of support, of not being a – well just another fish in the pond. I guess that’s the way I’m feeling here. You’re just another fish in the pond. And when they come along with the hook they’ll pull you up and if you’re trout they’ll put you one place, and if you’re...they’ll put you another place, and if you’re pike, they’ll put you another place.”- Patient

“Well I think that one of the things that worked really well was that they gave you, they made you feel terribly much at home and first thing you know they’re calling you by your first name and I thought how in the world they can remember my first name.” - Patient

Focus group findings have established that patients with chronic conditions, particularly those who are treated in the community, view themselves as “people first and patients second” (W. Kolodziejczak, personal communication, July 21, 2014). Thus, patients’ identity as an individual, but also as a member of larger groupings, will impact their experience of care. This is borne out in a number of studies where, for example, tools designed for specific national health systems required adjustment to accommodate such things as rehabilitative care that is publicly funded versus privately funded (Fernandez et al., 2007; French et al., 2010). Hush and colleagues (2013) determined that there are real differences in perceptions of care between nations such as Australia and the United States, suggesting the latter is more concerned about convenience of clinic hours, parking, physical comfort and facility cleanliness, but also similarities such as “person-focussed” care. In either case, therapists may be able to improve an individual’s experience by sensitizing their approach to suit a patient’s cultural dimensions (Deschepper et al., 2008).

One’s membership in a group that influences ethnicity or gender identity may have a bearing on patient experience. For example, Welch (2010) identified the under-treatment of pain in women and ethnic minorities in the ED department - this has the potential to significantly alter their experience of the service encounter. Similar influences were identified in this review; Almborg et al. (2009) noted that not only gender, but age, education and functional status determined patients’ experience of involvement in care and decision making post-stroke. In Fernandez et al.’s (2007) study of cardiac rehabilitation, the women participants were more likely to value the program’s convenience factors – perhaps correlated with the group’s high likelihood of being widowed.

Clearly, individual and group circumstances change the context of care, and thus the circumstances that are likely to positively or negatively impact a patient’s care experience. Normann et al. (2012) speculates that a lack of variance between groups’ experience of rehabilitative care may be related to a therapist’s ability to customize their approach to changing body functionality, gender and age.

Delivering rehabilitative care that is client or patient-centred suggests that a health care provider understands the “people first, patients second” paradigm, and is willing to adjust their therapy to the autonomous context in which their client lives. These therapeutic customization strategies are likely to improve a patient’s experience of care. Survey questions in the instruments reviewed for this study might include “The treatment was tailored to my needs” (POPS) or, in the negative “Employees in these firms cannot be expected to give customers personal attention” (SERVQUAL).

Patient and healthcare provider relationship (R)

“Well one of the positives is the hospital porter, the guy who comes with the wheel chair to take you downstairs, they know their way around, they know what they’re doing, they get there right away you know that was a speedy process.” - Patient

*“The nurses were great over there and I have real rapport with 2 or 3 of them-
Patient*

Slade & Keating's (2010) systematic review of experience and satisfaction with exercise programs for lower back pain painted a picture of a quintessential care provider:

*“Listens, explains, educates, demonstrates clinical skills, thorough, competent, friendly, spends appropriate amount of time, respectful, shows empathy, understanding, respectful of patient preferences, recognizes impact of the problem, establishes rapport, provides effective treatment, ethical practice, enables emotional comfort, enables connectedness, punctual, reliable, transparent, open to second opinion, fully informing, and welcomes questions.”
(p1493)*

The relationship between rehabilitative care clients and their providers is a key enabler of both a positive experience, and improved outcomes. Dibbelt et al.'s (2009) study of inpatient rehabilitation found a clear relationship between the quality of interaction between patients and physicians, and treatment effects. Other studies highlighted the importance of caring and empathy that puts patients at ease (Curry & Sinclair, 2002; French et al., 2010; Knight et al., 2010; Slade & Keating, 2010), respect (Beattie et al., 2002; Beattie, Turner, et al., 2005; C. a Cott et al., 2006; Cramm et al., 2012; Hush et al., 2013; Kneebone et al., 2012; Normann et al., 2012; Slade & Keating, 2010), reliability that staff were engaged and interested in helping to solve clients’ problems in a timely fashion (Curry & Sinclair, 2002), responsiveness through timely care (Curry & Sinclair, 2002), the ability to manage expectations (Curry & Sinclair, 2002; Elwood et al., 2010; Hills & Kitchen, 2007), understanding patient’s needs (Medina-Mirapeix et al., 2012), and informing and educating clients (Grosset & Grosset, 2005; Hush et al., 2013; Kneebone et al., 2012; Medina-Mirapeix, Jimeno-Serrano, et al., 2013a), as important to their having a positive care experience. The perceived expertise of the care provider appears to impact satisfaction but also figures prominently in the quality of the patient experience (Knight et al., 2010). Patient experience questions in the survey instruments reviewed for this study that touch on these concepts include “Nurses listened

carefully” (CQI), “The doctor seemed interested in me as a person” (MISS-21), “My therapist treats me respectfully” (MRSP), “My therapist gave me encouragement and praise” (POPS), and “Didn’t always have confidence and trust in doctors” (POPS).

Two constructs that were less frequently identified in survey items, but seem intuitively relevant for patients experiencing long term, multi-provider rehabilitative care were hope, and care continuity. Hope has been reported as a necessary component of a patient or family centred approach to care delivery (Lewis, 2009), and is a particularly important component of effective emotional oversight for patients who are coming to terms experiencing altered functionality or progressive recuperation (Cott et al., 2001). Yet the Hills & Kitchen study (2007) in this review was the only one to use an unnamed survey tool that clearly investigated this component of a patient’s rehabilitative care experience, using items such as “My therapist gave me confidence I was going to get better”, and “I expected the treatment would get me better”. Continuity of care describes care that is provided to a patient that they experience as unified, coherent and connected over time across the healthcare system (Haggerty et al., 2003). Patients’ experience is clearly affected by the level of care continuity, yet this level is demonstrative of operational decisions or care provider preferences that may not be obvious to a patient. For instance, a lack of investment in electronic medical records may result in necessary background information not being available prior to an appointment. In this review, Beattie et al.’s (2005) study of 1,502 outpatients receiving physical therapy found that the operational practice of scheduling patients with whichever therapist is available, rather than with a single therapist of their choice, were three times less likely to say that their experience was optimal. While some patient experience questions might allude to rehabilitative care continuity outcomes, there were none found in the survey instruments identified in this study.

Client and informal caregiver engagement (C)

“Yeah and I guess, the way I’m looking at it if I hadn’t asked the right questions at the right time I may have had difficulties and because I’m able to communicate and get the answers, demand them I was ok. I can see people without the language or not knowing the system can having, can have a lot of problems. I understand how to negotiate” – Family Caregiver

Different interpretation of “patient centredness” will impact the type of engagement activities that are used, and consequently their outcomes. Engaging rehabilitative patients in their own care encourages independence in a situation where they often perceive they have none. Not only is this involvement important to the patient (Mothabeng, Malinga, Van der Merwe, Qhomane, & Motjotji, 2007), therapists who involve patients believe that it positively impacts outcomes (Baker, Marshak, Rice, & Zimmerman, 2001).

Actively engaging patients in their care is correlated with better outcomes, and involves such things as allowing more patient control, more reciprocal sharing of emotional responses, more information exchanged particularly by patients, a mutual understanding of the issues (Kaplan &

Greenfield, 1989; Potter, Gordon, & Hamer, 2003). Many of the studies correlated engagement activities, such as shared decision making or better communication, with an improved patient experience (Delanian Halsdorfer et al., 2011; Grosset & Grosset, 2005; Hills & Kitchen, 2007; Hush et al., 2013). However, there is a continuum of engagement from low level consultation such as uni-directional information flow from the provider, to higher level partnership where there is sharing of power and responsibility (Carman et al., 2013). This may be defined by provider organizations but also by the patient, whose desire for involvement may vary during the course of a rehabilitative care episode depending upon such things as pain and an individual's desire for information (Carman et al., 2013; Quaschnig et al., 2013). Instruments that ask questions such as "I received the information that I needed when I wanted it" (Cott et al., 2006) account for the variance of information need by patient and over time. In spite of the reluctance of some patients to engage in a discussion about their condition and treatment, rehabilitation specialists are encouraged to engage all patients to the level they will tolerate, and as providers should be measured on their ability to do so (Almborg et al., 2009). Survey questions such as "I felt as though the staff and I were partners in the whole process of care" (Kneebone et al., 2012) try to address this construct.

As healthcare systems struggle with rising costs and aging populations, the business case for modelling rehabilitative care systems that include informal caregivers such as friends and family, becomes compelling (Abelson, Forest, Casebeer, & Mackean, 2004). In parallel, we increasingly understand the role of families and other informal caregivers on both patient experience and its outcomes (Jackson, Oelke, Leffelaar, Besner, & Harrison, 2009). A number of the survey instruments in this study acknowledged the importance of this relationship by including measures of informal caregiver involvement, for example Cramm et al. (2012), who recognized the interdependency of patients and caregivers in stroke recovery. Cott et al. (2006) ask whether family and friends received enough information to provide care, and whether the information was timely; Kneebone et al. (2012) whether they were involved in treatment discussions.

Communication is at the core of engagement in the rehabilitation sector (Hush et al., 2013). Those who experience better care suggest that developing strong listening and communication skills, increasing patients' access to information, and explaining treatments, support improvements to a patient's experience (Curry & Sinclair, 2002). Furthermore, Grosset & Grosset (2005) suggest that this improved communication is correlated with intent to comply with treatment, and thus could be a potential mediator of improved outcomes. Many of the questions included in patient experience measurement tools in this sector refer to constructs that are dependent on communication skills, such as trust, respect, being listened to, and having things explained clearly (Cott et al., 2006; Stubbe et al., 2007). The corollary includes the ability of care providers to identify and respond quickly to such things as reports of pain, need for support, and being truly understood. Communication also appeared to drive the rationale for measuring the impact of self-help strategies on the patient experience, for instance, "I learned what I needed to know in order to manage my condition at home" (C. a Cott et al., 2006). Surprisingly this was not a universally important construct and was evident in only two survey instruments (CCRQ and OPEQ).

Discharge planning with patients to identify goals and individual needs is optimal yet even when it does occur the information to inform these processes is not always adequate, nor is the information tailored to patient age, education and functional status (Almborg et al., 2009). Patients don't always have an opportunity to participate in decision-making about rehabilitative therapy (Quaschnig et al., 2013). Therefore if therapists are merely guessing at a patient's goals rather than engaging them in the goal-setting process, it is unlikely that services will support the achievement of what is important for the patient (Almborg et al., 2009). Goal setting has been identified as an important component of an optimal rehabilitation experience, yet it is often overlooked (Almborg et al., 2009). In our review, just four of the studies specifically addressed the issue of goal-setting in rehabilitative care (Almborg et al., 2009; C. a Cott et al., 2006; Slade & Keating, 2010; Soderback, 2008). Instruments included questions such as "Did you have the opportunity to discuss the goals of your rehabilitation after discharge?" (P-QPD).

Rehabilitative care ecosystem (E)

"I would suggest that they check the walkers. Even not that they check them daily but check them at least weekly. Check them to make sure they don't jiggle at all because when you're compromised with a bad hip, if anything jiggles you've had it. There's not a damn thing you can do about it. And I think make sure their equipment is really – it's the equipment that's the most important because if the equipment does not work properly, then the patient isn't really able to work properly either. " – Patient (suffered a second hip fracture from a fall in-hospital)

"Because he wanted to come home and I mean he's home but he's home still to be safe, he's safe at home. He got to stay a few extra days until we made it safe..." – Informal Caregiver

This category merges themes that are primarily operational, and focusses on how patients experience the environment created by organizations and policy-makers, in which they receive rehabilitative care. That includes issues that directly affect care delivery such as staffing, location and physical facilities, but also those that are indirect factors such as training, scheduling, bureaucracy, hiring practices, culture, and wait times, that have an impact on the patient experience. All 25 instruments identified for this study included ecosystem and body function patient experience questions. Ecosystem exemplar questions included "Acceptable cost", "The waiting area is comfortable", "Convenient parking", "I had to wait a long time to get my first appointment for treatment", "Calm and relaxing atmosphere in physical therapy rooms", and "The office staff is attentive to my needs".

Slade & Keating's (2010) literature review identified a number of experience factors related to the rehabilitative care ecosystem that included support staff (such as qualifications, knowledge, professionalism, friendliness and education), access (such as hours of operation, wait times, affordability and ease of making an appointment), facilities (such as location, ambience, parking,

physical comfort, and access to public transportation), and governance (such as paperwork, organizational structure, cost, and accurate billing). The authors noted the lack of experience measures for therapeutic exercise sessions. One might conclude that such sessions introduce a level of risk to patients who are functionally compromised, and that the physical and therapeutic environment might induce concerns around their personal safety. However, just three of the studies addressed the issue of patient safety from the patient's perspective. Two concluded that safety was not a significant performance indicator, and speculated that rehabilitation professionals' expert understanding of the falls risk is protective (Medina-Mirapeix et al., 2012; Medina-Mirapeix, Jimeno-Serrano, et al., 2013a). Curry & Sinclair (2002) found that the highest expectation scores related to physiotherapy services and patients' need to feel safe. Perceptions of safety are not confined to conditions in the physical environment, but also to the skill and knowledge of therapists who can instil trust and confidence in vulnerable clients that they know what they're doing.

There is a connection between service governance and operational effectiveness. The volume, workflow and staffing, contribute to the culture of service and individual interactions with clients are influenced by provider behaviour patterns, time to treatment, and treatment time (Medina-Mirapeix et al., 2012). So, for instance, what might be viewed as a lack of sensitivity and customization of programs to individuals' needs or overly long wait times, might quite simply be the outcome of a high volume clinic whose operational efficiency relies upon minimizing therapist-patient interaction time.

The importance of staff training is clear in healthcare; ratings of service quality are often dominated by patient's desire for improvements in courtesy, friendliness, and respect (Blank et al., 2013; Watson, Peterson, & Black, 2009). Yet, just one of the studies in this review included a patient experience measure asking about the friendliness of the therapist (Unnamed 2010), three asked about courtesy (PPE-15, Unnamed 2002, Unnamed 2010), and nine about respect (CCRQ, CQI, MRSP, PPE-15, QUOTE, Re-PEQ, SASC, PSQ, SAPHORA). Unlike patient experience surveys in other settings, questions regarding wait times featured in just two of the 25 instruments, "Had to wait during treatment because tables/equipment were occupied" (Unnamed, 2012), and "How did you perceive the waiting times between the day's different appointments?" (SAPHORA). A foundational understanding of patient-centred care, and techniques that support its delivery by patient-facing staff who are committed to creating a supportive ecosystem, may improve patients' experience in the rehabilitative care sector, yet there are few measures available to assess longitudinal progress.

Body function (F)

"Yeah, I didn't want to go, like she wanted me to go to her place. Now going to her place got 27 steps, ok and I would have been there alone all day....Now what if I fell at 9:00 in the morning, split my head open, nobody around..." – Patient

"But I was, they had me on morphine, hey, so I don't remember too much but other than the hospital stay was great after you know I started coming around hey. I

couldn't ask for anything better. The treatment that they gave ya, medication, you know." - Patient

This category includes themes that closely align with the World Health Organization's International Classification of Functioning, Disability and Health (ICF) (World Health Organization, 2001). The ICF is designed to evaluate an individual or population's body functions, body structures, activities and participation, and environmental factors; in clinical settings it is used to assess and monitor functional status and plan treatments. The two themes identified under the Body Function category are pain and functional status; activities are discussed as a subset of both due to the limitation they both impose.

Pain and functional status were mentioned, though not always measured, in all but one of the studies – not surprising as the large majority addressed patient experience of physical rehabilitation. As a service evaluation tool emanating from the management literature SERVQUAL measures provider empathy and responsiveness; it would require further modification to specifically assess how patients experience pain and the impact of functional status on that experience (Curry & Sinclair, 2002). Controlling rather than eliminating pain was the focus of most survey instrument questions, thus pain was often discussed in parallel with medication, and effective communication between providers and with patients when new medications were prescribed (Stubbe et al., 2007).

Pain control is particularly important in the rehabilitation environment as therapists require a patient's active involvement and where pain is present or where a therapy induces pain, the likelihood of active engagement and even compliance with a course of treatment may be threatened (Monnin & Perneger, 2002). Awareness of pain, and its functional sequelae, is the responsibility of the healthcare providers and contributes to the patient's perception that they were customizing the program to their needs (Medina-Mirapeix, Jimeno-Serrano, et al., 2013a). Strong communication between prescribing physicians was found to improve patients' experience of pain intensity and frequency (Dibbelt et al., 2009).

The subjectivity of pain related to individual traits, introduces variance that is not always controllable by care providers or medication (Stubbe et al., 2007). Furthermore, patients' experience of pain has a longitudinal and anticipatory component so that patients' experience in care was impacted when pain control was uncertain during a change in setting, for instance post-discharge (Elwood et al., 2010; Vanti et al., 2013).

Changed functionality, whether in the short or long term, is a reality for many rehabilitative care patients. How rehabilitative care providers identify those functional changes will often provide insight into the quality of communication, technical skill of the provider, and level of engagement of the patient. It is clear that improving patient functionality positively influences the patient's experience of rehabilitative care (French et al., 2010). Almborg et al (2009) notes that participation in discharge planning requires the ability to ask and respond to questions, receive information, and

make decisions. A large number of rehabilitative care clients may be unable to experience a high level of engagement due to cognitive deficits. The OAKHQOL instrument measures not only physical activities but also social activity dimensions experienced during care as a predictor of longer term quality of life (Baumann et al., 2011).

Questions in the survey instruments in our review related to the body function category included “My physical pain was controlled as well as possible”, (CCRQ), “I achieved the treatment goal set by my therapist” (PPTO), and “I received enough help in my daily routine” (QCS).

Qualitative (Q)

A final theme was generated from the literature review analysis only. It is purely methodological and addresses the need for open-ended and general questions to identify patients’ experiences that are not addressed by the prescriptive questions outside the focus of any one survey instrument.

The final theme generated just two questions in the inventory of survey tools identified in the selected papers. The SAPHORA questionnaire (Delanian Halsdorfer et al., 2011) asked the open-ended question “Do you have any additional comments you would like to share?” and the Re-PEQ (Grotle et al., 2009) asks “Overall impression of rehabilitation institution?” While under-sized in comparison to the other themes, this category of questions is crucial if patients are to be provided with an opportunity to provide feedback on issues outside those investigated in the other survey questions. Furthermore, general and open-ended questions such as these acknowledge that the patient is expert at discerning what factors influence their experience while receiving care. Where human and financial resources demand judicious selection of a small set of key performance indicators, analysis of the responses to these more descriptive questions may reveal early signs of unanticipated trends that require closer scrutiny.

Key Questions by Theme

Given the resilience of the emergent themes across each stage of this review, identifying a parsimonious set of questions from each theme, may help to measure constructs that are important to improving the experience of patients in the rehabilitative care sector, and differentiating that experience from care in other sectors. Questions from Appendix C were re-categorized by theme and instrument, and by consensus, a small subset of questions were identified as exemplars of the key issues in that theme (see

Table 4). It should be noted that this list is not exhaustive and is meant for illustration only; as previously mentioned, selected questions will vary depending upon the goals and resources of each rehabilitative care system. As long as the questions retain the context and meaning of the instrument from which they are drawn they are editable. For instance, a positive rather than negative perspective can be derived by changing “the therapist does not spend enough time with me”, to “the therapist spends enough time with me”.

The “Client and Informal Caregiver Engagement” (C) category questions focussed primarily on education and information sharing to both engage the patient in their care in real time, but to also involve them in decision making regarding future care possibilities i.e. post discharge. Furthermore, the engagement included the notion that an informed patient and their caregivers, will cope better when educated about their choices and given an opportunity to influence the course of rehabilitative treatment. In the “Rehabilitative Care Ecosystem” (E) category, questions focussed on wait times, length, timing and scheduling of appointments, privacy, physical comfort, access/wayfinding to appointments, accessibility of service locations related to driving and parking. It also included constructs such as organizational processes related to oversight and training of the professionals, or ensuring respectful interchanges between patients and non-clinical staff, adequate staffing, and patient-friendly scheduling to allow clinical personnel sufficient time with each patient.

Questions from the “Body Function” (F) category relate particularly to the interplay between activity and the limitations and impairments for which the patient is receiving rehabilitative care. It also includes experiences related to the management of pain, receiving support for daily routines, and feelings of safety. Questions in “Identification as Individual or With a Group” (I), addresses factors which have been identified as mediating the patient experience or its measurement such as age, gender and culture (Hush et al., 2013). It also accommodates questions that speak to the care that has been individualized based on an understanding of the patient’s personal, functional and disease/disability profile. Normann et al., (2012) suggest that this individualisation may account for similar levels of satisfaction amongst disparate groups of patients receiving rehabilitative care from the same provider.

The “Qualitative” (Q) category identifies a question that allows an opportunity for more granular feedback and feedback on events that have shaped the patient’s experience but were not adequately covered in other closed ended questions. The “Patient and Healthcare Provider Relationship” (R) category includes questions that speak to the interaction between patient and healthcare providers, perhaps the most influential experience measure in rehabilitative care. Experience of such events as treatment specific communication, courtesy, empathy, trust, respect, listening skills, reliability in the patient/clinician relationship, and reflecting an understanding of the patient’s problems and needs, are measured in this category of questions.

Table 4. Exemplar Patient Experience Questions by Category and Tool

Theme § & Survey Tool	Questions
C	
CCRQ	My family/friends were given the information that they wanted when they needed it I learned what I needed to know in order to manage my condition at home
OAKHQL	My family or carer was involved in discussions about my treatment if I wanted them to be
P-QPD	Have you had the opportunity to participate in discussions concerning your examinations/treatments? Have you had the opportunity to discuss the goals of your treatment with the physician?
QCS	I was involved in discharge management
SASC or C-CASC	I was able to talk to the staff about any problems I might have had
E	
CCRQ	I knew who to contact if I had problems or questions during my rehabilitation program
CGI	Help as soon as wanted Doctors spent enough time Doctors kept their appointments
CRPF-R	Convenience of parking. Available transportation
MRPS	The office receptionist is courteous The waiting area is comfortable. My therapist does not spend enough time with me
POPS	I was not always seen promptly for my treatment sessions I had to wait a long time to get my first appointment for treatment. The treatment sessions were too short. Treatment sessions were too infrequent to get any benefit.
PSQ or PTPSQ	My privacy was respected during my physical therapy care
PTOPS	The office staff is attentive to my needs. The facility is in a desirable location. I have to wait too long between appointments
Unnamed (2002)	Calm and relaxing atmosphere in physical therapy rooms
F	
CCRQ	My physical pain was controlled as well as possible
PPTO	I achieved the treatment goal set by my therapist
QCS	I received enough help in my daily routine
I	
PSQ or PTPSQ	Age (years) Sex (M/F)
CRPF-R	Receive individualized attention

Themes & Survey Tools

Q

Servqual	Do you have any additional comments you would like to share?
REPEQ	Overall impression of the rehabilitation institution

R

CQI	[Care providers] take me seriously [Care providers] listened carefully [Care providers] explained things clearly
PPE-15	Didn't always have confidence and trust in [care provider]

§

- C** Client and informal caregiver engagement i.e. shared decision making,
- E** Rehabilitative care ecosystem i.e. wait times, clinic culture
- F** Body function i.e. pain control
- I** Identification as individual or with a group i.e. gender, ethnicity
- Q** Qualitative
- R** Patient and healthcare provider relationship i.e. trust in therapist

Focussed Patient Interviews

Participants generally agreed with the themes presented. Agreement with each major theme was established with each participant. Some themes stood out as being particularly important. Specifically, all participants stressed the importance of family engagement and group identifiers. In cases where participants did not discuss the importance of subthemes, the reason for this lack of elaboration was that the construct was not one they personally experienced rather than disagreement with its inclusion. For example, one participant noted that funding for expenses not covered by Medicare was not an issue due to full funding from Veterans Affairs.

Suggestions for improvement

The subtheme of “treating with kindness” was problematic for two of the three participants. One participant did not believe that kindness was an important aspect of care and one participant believed that the wording implied negativity. Specifically, the participant noted that “treating with kindness” might be interpreted as “feeling sorry” for the patient. It was suggested that a focus on empathy would be more appropriate.

One participant noted that “understanding the capacity to provide care” implied that families know their own capacity to provide care. Having had experience as a family caregiver, the participant stated that families often do not know their own capacity to provide care until they reach a breaking point or limit to capacity.

Another participant suggested that “discharge confusion” could be worded more clearly, however an alternate wording was not provided. Similarly, a participant took issue with the statement “family knows patient best” and suggested that it might be worded differently. Were family not able to understand or accept the circumstances of the patient’s new health status, they might not necessarily know what was best for the patient.

Missing information

One participant suggested that a focus on preparation and education for rehabilitation (of both the patient and the family) was extremely important and should be emphasized. Furthermore, it was suggested that “cooperation of family members” must be taken into account during rehabilitation because without family cooperation, family engagement is impossible. Finally, a participant advised that “transportation” should be included within the “ecosystems” theme. The frequency and number of appointments can place considerable strain on the resources of the patient and their informal caregivers, particularly when the appointments are with specialists in distant locations. “Honesty” was a theme that was discussed by participants but not explicitly included on the theme list. However, themes such as “trust” and “information

sharing” might encompass the idea of honesty as the person was particularly referring to physicians providing realistic ranges for wait times for appointments for diagnosis or therapy.

While this member-checking process was an important one to review our findings, it was determined that no substantial changes to the themes or focus of our recommendations was necessary.

Interpretive Cautions

The primary limitations of the literature review are the rigorous inclusion and exclusion criteria. This is a domain where definitions are equivocal. Restricting the search strategy to peer reviewed journals and psychometrically tested instruments may have resulted in relevant material being excluded from consideration. The second limitation of the literature review is that many of the selected studies were conducted in private hospitals or clinics (Medina-Mirapeix et al., 2012) and others in publicly funded systems with universal access to care (for example Cott et al., 2006), thus the generalizability of our themes is predicated on the notion that funding models do not violate the thematic category descriptions. Methodologically, extrapolation of the findings to other rehabilitative care populations may be limited by the small sample size of some of the studies, and in many cases (for example Almborg et al., 2009; Delanian Halsdorfer et al., 2011; Fernandez et al., 2007; Kneebone et al., 2012) participants were ineligible to participate if they experienced cognitive or communication problems. Given that this characterizes many patients in the rehabilitative care sector who are the most vulnerable i.e. the frail elderly, and neurorehabilitative patients post-stroke or traumatic brain injury, the development of instruments that ensure their voices are heard should be a priority for the research community.

Finally, the wide variety of surveys, populations, and study quality, makes it difficult to draw meaningful comparisons. A number of the studies allude to high dropout rates; Dibbelt, Schaidhammer, Fleischer, & Greitemann (2009) reported 40%, or lower relative response rates (Duijin et al., 2008) which may include patients who don't participate due to inaccessible, irrelevant or less than satisfactory care, or who are unable to participate due to the stage of their illness or state of health. This may have selectively and positively biased the reported results. Because this review was more interested in the instruments and less interested in the outcomes, however, this is not expected to have a material impact on the analysis.

Recommendations

The WWLHIN Rehabilitation Services Review of 2012 identified three key issues that were to be addressed by a redesigned regional system of care(Sharma & Dean, 2012):

1. Best practices and standards had not been fully implemented
2. A lack of trust pervaded the system and was an obstacle to the achievement of optimal patient outcomes. Both patients and providers lacked confidence in the ability of rehabilitative services' ability to meet their needs.
3. Services were not integrated across the care continuum nor was patient data flowing seamlessly between providers.

Furthermore, the WWLHIN has endorsed the guiding principles of the Rehabilitation and Complex Continuing Care Expert Panel (Sharma & Dean, 2012):

1. Equitable access for all patients as close to home as practical regardless of where their surgery or acute care may have taken place.
2. Equitable access to appropriately resources care regardless of ability to pay
3. Rehabilitation services will be provided within a regional context, with linkages between hospitals and community services supported by system-wide navigation
4. Rehabilitation services must be supported by recognized IT tools and databases
5. Clinical best practices, metrics and standards will be based on the best available scientific evidence and updated as necessary by content Expert Panels

These issues and principles were integrated with the findings of this report to produce the following recommendations:

Recommendation 1. In the short term, patient experience indicators must address the performance gaps identified by the 2012 review.

A systematic analysis of peer-reviewed literature identified 25 valid and reliable survey tools and accompanying patient experience measures and uncovered a number of constructs that are particularly salient to rehabilitative care clients. These constructs were thematically consistent with the insights provided by rehabilitative care clients participating in a large ethnographic study in the Waterloo Wellington region, and were member-checked by patients and their caregivers who had experienced care across the system. A number of questions from the survey tools could be used to measure performance in the transformed rehabilitative care system, however indicators capable of measuring progress on remediation of the gaps identified in the 2012 review should be a priority.

Recommendation 2. Patient experience questions should be based on psychometrically tested instruments where possible, and new questionnaires rigorously tested for reliability and validity.

The 2010 Excellent Care for All Act (ECFAA) requires that all hospitals conduct an annual survey of patients to measure their satisfaction with the services they experienced while receiving care¹. This legislation does not currently extend to other health care providers in the system. Thus, data collection and public reporting on patient experience is largely confined to the hospital sector. To ensure the quality of the data collected many Ontario hospitals subscribe to the National Research Council Patient Experience Survey, which is continuously administered to discharged patients, is customized for various areas of the hospital such as Emergency and Obstetrics, and has been extensively psychometrically tested for validity and reliability (Jenkinson, Coulter, Bruster, Richards, & Chandola, 2002). Outsourcing comes at a price; the survey is costly (an average community hospital spends approximately \$33,000 per year on the one patient satisfaction survey alone), return rates are modest, and there is a considerable lag between when the data is collected and the hospitals receive actionable results.

An alternative is for the WWLHIN to develop its own rehabilitative care patient experience questionnaire. If an existing psychometrically tested data collection tool (See) does not provide all the information required to assess the experience of WWLHIN rehabilitative care clients, we recommend the use of a rigorous methodology to design and test a new instrument. A measurement tool which is to be used for effective decision-making must ensure collected data is of good quality, and accurately represents activities occurring across the sector. Tests for missing data, ceiling effects, reliability and validity should be applied to data collected using questionnaires that are administered to appropriate populations and samples, use constructs that are valid, and offer response options that are relevant and controlled for bias.

Recommendation 3. Themes identified in the literature review and secondary analysis of ethnographic data are resilient, and consistent with previous literature. At least one question that is representative of each thematic construct should be selected and included in any survey tool for a comprehensive view of the patient experience.

The questions associated with each theme are remarkable only in their similarity. The coding and identification of themes was relatively uncomplicated, and consensus was achieved on those themes. While consensus was achieved, it was noted that none of the themes stands alone. Overlap between those themes suggests that their relationships are fluid, for instance,

¹ Source: <http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/patientsurvey/update.aspx> Accessed on June 25, 2014

the quality of the patient healthcare provider relationship influences patient engagement and the patient's ability to have their individual needs identified and their care adjusted accordingly, and so on.

Recommendation 4. The choice of questions, and resource concerns, will influence the data collection methodology chosen.

Whatever method is chosen, it will represent a trade-off between the need for more granular data, and a larger sample size, and the additional costs of the latter.

Hampson, Hart, & Kimber's (2002) systematic review of patient satisfaction measurement in healthcare provided some direction on data collection methodology in the rehabilitative care sector, that remains relevant 12 years later; for instance, that low response rates introduce bias (non-response is more likely with visible minorities and those who are less educated). Quantitative data collection is efficient but reductive, and so provision should be made for some qualitative or open-ended questions. Finally the timing of survey questions is equivocal and inconsistent, and should be decided based upon the context of the measurement instrument, and healthcare setting.

Our study identified many different methods for collecting self-reported experience data, from face to face interviews to phone and mail surveys (no web-based or online surveys were identified). Clearly, the availability of data from instruments currently in use and resources to support the development and use of new tools, will drive the selection of measures and methods by which the data are collected. This may prove particularly challenging, and require innovative new methods, in a system where outpatient and community care represents the majority of delivered service. These groups are unused to the strong culture of public accountability that is the new norm for in-patient rehabilitative care in the hospital sector; there is currently neither the infrastructure, nor the capacity for the systematic collection of patient experience data outside of hospitals, the CCAC, and some long term care facilities. Other issues related to the consistent and timely collection of data across the rehabilitative care system will also have to be addressed in order to avoid the introduction of negative biases due to survey timing (Bjertnaes, Sjetne, & Iversen, 2012)

Recommendation 5. A mix of leading and lagging indicators will ensure that governors are able to assess current operations, but also anticipate future performance allowing for mid-course correction where appropriate.

A number of patient experience metrics are known to be correlated with processes/outputs with known sequelae. For instance, a positive alliance with the primary therapist is positively correlated with adherence and therapeutic success (Hall, Ferreira, Maher, Latimer, & Ferreira, 2010). Including one or more questions that assess the working relationship between therapist and client may be correlated with therapy outcomes, for instance, “My therapist and I have built a mutual trust”. These correlations should continue to be rigorously investigated in the context of patient experience measurement. In the meantime, careful selection of metrics may optimize the value of collected data and provide the opportunity for mid-course correction based on formative performance evaluation.

Recommendation 6. In the interests of data quality, patient experience data collection from across the rehabilitative care system should be managed centrally by a coordinating organization such as the WWLHIN. A mechanism for longitudinal tracking of results and accountability will ensure that feedback provided by patients is considered for incorporation into clinical practice

While recommendations on methodology were within the scope of the project if there were sufficient time and resources, the size of the investigation to identify and locate survey instruments did not allow the time to conduct a comparative or evaluative study of the methodological options. However, it is clear that at least in the interim, any new instruments should be developed, coordinated and administered by a central, oversight body such as the LHIN. The LHIN would psychometrically test survey instruments before use, create processes for regular collection and submission of experience data, create data quality standards and common vocabularies for interpreting and reporting the data, and share this specialised knowledge with all the organizations participating in the regional rehabilitative care sector.

Recommendation 7. The WWLHIN explore data collection techniques and tools that specifically address patients with cognitive and communication impairment.

We identified a gap in the literature that suggests a significant portion of the population may be under-represented in these findings. Most studies specifically exclude those with cognitive impairment, are unable to communicate, or are unable to speak English. The rehabilitative care population has a disproportionate number of these patients, suggesting that any data collection protocol, or instrument, should be selected and tested for its ability to accommodate this special population. This might take the form of allowing proxies to respond, or the use of data collection technologies that support impaired patients. One stakeholder has suggested that the

tools and techniques used in the performance measurement of paediatric rehabilitative medicine may provide solutions that can be adapted for an older population.

Recommendation 8. That data collection tools and questions be developed and administered with the input and guidance of patients and their caregivers, as well as healthcare providers and survey experts.

Most of the survey instruments identified in this study involved patients in their development. Given the spirit of the Ontario Provincial government's ECFAA legislation, and consumers' desire for more involvement, and oversight of tax-payer funded patient-facing services, the service users should be consulted and where possible, directly involved with the development of patient experience survey instruments and data collection methodologies.

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Appendix A. Search Terms

health care surveys[mesh] OR health surveys[mesh] OR interviews as topic[mesh] OR questionnaires[mesh] OR "outcome and process assessment (health care)"[mesh:noexp] OR "outcome assessment (health care)"[mesh:noexp] OR "process assessment (health care)"[mesh] OR patient outcome assessment[mesh] OR survey*[tiab] OR questionnaire*[tiab] OR interview*[tiab] OR focus group*[tiab] NOT (dent* OR oral OR reconstruct* OR paediatric* OR pediatric* OR vet*)

AND

measure*[tiab] OR assessment[tiab] OR scale*[tiab] OR tool*[tiab] OR metric*[tiab] OR indicator*[tiab] OR "quality indicators, health care"[mesh]

AND

patient experience*[tiab] OR person centered care[tiab] OR person centred care[tiab] OR patient satisfaction[mesh] OR patient participation[mesh] OR patient centered care[mesh] OR patient engagement[tiab] OR (trust in physician[tiab] AND patient[tiab]) OR (compassion[tiab] AND patient[tiab]) OR shared decision-making[tiab] OR (therapeutic alliance[tiab] AND patient[tiab]) OR (decision-making[tiab] AND patient[tiab]) OR (autonomy[tiab] AND patient[tiab]) OR (caring[tiab] AND patient[tiab]) OR (honesty[tiab] AND patient[tiab]) OR (participation[tiab] AND patient[tiab]) OR (physical comfort[tiab] AND patient[tiab]) OR (continuity of care[tiab] AND patient[tiab])

AND

rehabilitation[mesh] OR rehabilitation[subheading] OR physical therapy modalities[mesh] OR occupational therapy[mesh] OR physical therapy specialty[mesh] OR physiotherapy[tiab] OR rehabilitation[tiab] OR physical therapy[tiab] OR occupational therapy[tiab] OR rehabilitation centers[mesh:noexp]

PsycINFO was searched on the PsycNET platform

Because of lack of articles in database a decision was made to expand the search and screen more articles manually to ensure we weren't missing any important articles, in both PsychInfo and CINAHL.

Rehabilitation[ti] OR "physical therapy"[ti] OR "occupational therapy"[ti] OR "cognitive rehabilitation"[index term] OR "neuropsychological rehabilitation"[index term] OR

“neurorehabilitation”[index term] OR “occupational therapy”[index term] OR “physical therapy”[index term]OR Rehabilitation[index term] OR “rehabilitation centers”[index term] OR “rehabilitation counseling”[index term] OR Rehabilitation[ab] OR “physical therapy”[ab] OR “occupational therapy”[ab]

AND

“Patient experience”[ti] OR “person centred care”[ti] OR “person centered care”[ti] OR “patient centered care”[ti] OR “patient centred care”[ti] OR “patient satisfaction”[ti] OR “patient expectation”[ti] OR “patient experience”[ab] OR “person centred care”[ab] OR “patient satisfaction”[ab] “person centered care”[ab] OR “patient centered care”[ab] OR “patient centred care”[ab] OR “patient expectation”[ab]

= 181

CINAHL was searched on the EBSCOHOST platform

Title: Rehabilitation OR "physical therapy" OR "occupational therapy" OR Abstract: Rehabilitation OR "physical therapy" OR "occupational therapy" OR MM Exact Major Subject Heading: "cognitive rehabilitation" OR "neuropsychological rehabilitation" OR "neurorehabilitation" OR "occupational therapy" OR "physical therapy" OR Rehabilitation OR "rehabilitation centers" OR "rehabilitation counselling"

AND

Title: "Patient experience" OR "person centered care" OR “person centred care” OR "patient satisfaction" OR “patient expectation” OR Abstract: "Patient experience" OR "person centered care" OR “person centred care” OR "patient satisfaction" OR “patient centered care” OR “patient centred care” OR “patient expectation” MM Exact Major Subject Heading: “patient satisfaction” OR “patient centered care”

Appendix B. Systematic Literature Review Selected Articles

Author & Year & Place of Publication	Study Location	Setting	Focus	Type of Rehabilitative Care	Study Population	Sample Size	Study Design	Tool(s)	
								Name	Concepts Tested
(Almborg et al., 2009) (United Kingdom)	Sweden	Acute care hospital – Stroke unit	Patient participation in discharge planning	Not specified	Stroke/neuro	188	Survey	Patients' Questionnaire on Participation in Discharge Planning (P-QPD) based on Pyramid Questionnaire that measures perceptions of quality of care	Three subscales: - P-Information - P-Medical Treatment - P-Goals and Needs
(Baumann et al., 2011) (Netherlands)	France	Outpatient surgery clinic & community care	Patient satisfaction with case post hip or knee replacement as a predictor of self-perceived health status on year post surgery	Not specified	Musculo-skeletal	189	Quantitative survey	Quality of Care Scale (QCS) and OsteoArthritis Knee and Hip Quality Of Life (OAKHQOL) instrument	QCS: <ul style="list-style-type: none"> • Medical Information <ul style="list-style-type: none"> ○ health status ○ relations with doctor ○ instructions at discharge ○ info to family/friends • Relationships with staff and daily routine <ul style="list-style-type: none"> ○ relations with nursing staff and departmental functioning ○ attitudes of medical and nursing staff ○ well-being OAKHQOL: <ul style="list-style-type: none"> • Physical activities • Mental health • Pain • Social support • Social activities
(Beattie, Turner, et al., 2005) (United States)	United States	Outpatient – community clinic	Differences in satisfaction with	Physical therapy	Unspecified physical therapy	1502	Quantitative survey	MedRisk Instrument for Measuring Patient Satisfaction with Physical Therapy Care	Relationship with therapist

Author & Year & Place of Publication	Study Location	Setting	Focus	Type of Rehabilitative Care	Study Population	Sample Size	Study Design	Tool(s)	
								Name	Concepts Tested
			physical therapy and longitudinal continuity					(MRPS)	
(Beattie et al., 2002) (United States)	United States	Outpatient – community clinic	Predictor variables of patient receiving outpatient physical therapy and satisfaction	Physical therapy	Occupation-related musculoskeletal impairment	2059	Quantitative	Unnamed but MedRisk Instrument for Measuring Patient Satisfaction with Physical Therapy Care (MRPS)	Two broad variables: <ul style="list-style-type: none"> • Personal aspects of therapist • System/external level items
(Beattie, Dowda, et al., 2005) (United States)	United States	Outpatient – community clinic	Psychometric testing of the measurement instrument	Physical therapy	Musculoskeletal	1449	Quantitative survey	MedRisk Instrument for Measuring Patient Satisfaction with Physical Therapy Care (MRPS)	Relationship with therapist
(C. a Cott et al., 2006) (England)	Canada	Hospital – rehabilitation / chronic care	Client-centred rehabilitation from the client’s perspective	Musculoskeletal, stroke, acquired brain injury, geriatric rehabilitation, spinal cord injury, complex, neurology, amputee, trauma and cardiovascular	Clients discharged from two rehabilitation hospitals	1002	Cross-sectional survey	Client-Centred Rehabilitation Questionnaire	<ul style="list-style-type: none"> • Participation in decision making and goal setting • Client-centred education • Evaluation of outcomes from the client perspective • Family involvement • Emotional support • Coordination and continuity • Physical comfort
(Cramm et al., 2012) (Netherlands)	Netherlands	Hospital inpatient stroke service facility	Actor-partner interdependence and satisfaction with care		Stroke patients and their caregivers	251	Mixed Methods (literature review, qualitative interviews)	Satisfaction with Stroke Care (SASC) and Caregivers Satisfaction with Stroke Care (C-SASC)	Not Specified
(Curry & Sinclair, 2002) (United Kingdom)	Scotland	Hospital, practice-based, and community rehab	The difference between perceptions and expectation	Physical therapy	Frail elderly/medically complex, and stroke/ neuro	134	Cross-sectional survey	Servqual adapted to a 22 item instrument (7 point Likert scale).	Five criteria for evaluation: <ul style="list-style-type: none"> • Reliability • Responsiveness • Assurance (competence, courtesy, credibility)

Author & Year & Place of Publication	Study Location	Setting	Focus	Type of Rehabilitative Care	Study Population	Sample Size	Study Design	Tool(s)	
								Name	Concepts Tested
			of care						<ul style="list-style-type: none"> Empathy (communication, access, and understanding) Tangibles
(Delanian Halsdorfer et al., 2011) (Netherlands)	France	Physical and rehabilitation day hospital	Assessing patient satisfaction	Physical therapy, occupational therapy, speech, respiratory, social work, and psychological therapy	Nervous system diseases, loco-motor diseases, motor and invisible handicaps	100	Quantitative survey	Unnamed self- reported survey developed from the SAPHORA survey. 30 questions in six domains	<ul style="list-style-type: none"> Reception Accessibility Meals, cleanliness & noise Care quality Delays Organization
(Dibbelt et al., 2009) (Ireland)	Germany	Rehabilitation community clinics (three orthopaedic & four internist)	Assessment of physician- patient interaction on treatment	None noted	Patients and their physicians	470	Mixed methods (interviews, surveys)	P.A.INT (Patient-Arzt- Interaktion) *German tool	<ul style="list-style-type: none"> Affective Behaviour Instrumental Behaviour Participation Involvement of Patients
(Duijin et al., 2008) (United States)	United States	Outpatient, physical therapy clinics	Relationship between patient satisfaction and treatment outcomes	Physical therapy	Patients discharged from outpatient physical therapy	47	Paired survey	1) PTPSQ (satisfaction with the delivery of care) 2) Created PPTO (satisfaction with the effectiveness of care)	<p>PTPSQ</p> <ul style="list-style-type: none"> Overall impression of therapy experience <p>PPTO</p> <ul style="list-style-type: none"> Based on domains of outcomes identified in the Guide to PT practice
(Elwood et al., 2010) (United States)	United States	Hospital – physical medicine and rehabilitation inpatient		Not specified	Inpatients	158	Quantitative survey – cross- sectional	Unnamed tool – 20 elements in 2 sections: retrospectively before hospitalization and during current admission	<ul style="list-style-type: none"> Plans after discharge Duration of hospitalization Pain management Follow-up of medical issues Cost Insurance Familiarity with diagnosis, physician, and medications Patient input Global satisfaction rating
(Fernandez et	Australia	Outpatient	Examine the	Not specified	Cardio-	140	Quantitative	Revised Cardiac	<ul style="list-style-type: none"> Program features

Author & Year & Place of Publication	Study Location	Setting	Focus	Type of Rehabilitative Care	Study Population	Sample Size	Study Design	Tool(s)	
								Name	Concepts Tested
al., 2007) (United States)			psychometric properties and quality a new cardiac rehabilitative care patient preference tool		pulmonary – patients following percutaneous angiographic intervention			Rehabilitation Preference Form measuring 17 items	<ul style="list-style-type: none"> • Convenience features
(French et al., 2010) (Ireland)	Ireland	Outpatient	Patient satisfaction with exercise for knee osteoarthritis (OA)	Physical therapy	Musculo-skeletal	27	Comparative psychometric testing	Physiotherapy Outpatient Survey (POPS)	<ul style="list-style-type: none"> • Expectations • Communication • Therapist’s manner • Organization • Outcome
(Grosset & Grosset, 2005) (United States)	Scotland	Hospital – rehabilitation /chronic care (inpatient)	Patient-perceived involvement in therapy decisions and satisfaction with consultation	Not specified	Stroke/ neuro	107	Randomized control trial	Assessment adapted by Medicines Partnership (Makoul and colleagues): 4 – question Likert scale converted to a numerical score and MISS-21 (Medical Interview Satisfaction Scale)	MISS-21: <ul style="list-style-type: none"> • Distress relief (six items) • Communication comfort (four items) • Rapport (eight items) • Compliance intent (three items)
(Grotle et al., 2009) (Sweden)	Norway	Outpatient	Development of the Rehabilitation Patient Experiences Questionnaire for rehab patients with rheumatological disorders.	Physical therapy, and occupational therapy	Rheumatological	412	Cross-sectional survey	Rehabilitation Patient Experiences Questionnaire (Re-PEQ)	<ul style="list-style-type: none"> • Rehabilitation care and organization • Information and Communication • Availability of Staff. • Social environment
(Hills & Kitchen,	England	Outpatient	Patients	Physical	Musculo-	279	Quantitative	Unnamed survey (5-	<ul style="list-style-type: none"> • Expectation

Author & Year & Place of Publication	Study Location	Setting	Focus	Type of Rehabilitative Care	Study Population	Sample Size	Study Design	Tool(s)	
								Name	Concepts Tested
2007) (England)			with acute and chronic musculo-skeletal conditions and satisfaction with physiotherapy outpatient treatment.	therapy	skeletal		survey	point Likert Scale)	<ul style="list-style-type: none"> • Communication • Therapist • Organisation • Outcome • Satisfaction
(Hush et al., 2013) (unknown)	Australia & Korea	Outpatient	Cross-cultural influences on patient satisfaction with musculo-skeletal physiotherapy care.	Physical therapy	Musculo-skeletal	1666	Quantitative survey	MedRisk Instrument for Measuring Patient Satisfaction with Physical Therapy Care (MRPS)	Relationship with therapist
(Kneebone et al., 2012) (United States)	England	Outpatient	Development & validation of Neuro-rehabilitation Experience Questionnaire; important experience service elements	Physical therapy, speech therapy, and other	Stroke/ neuro	Stage 1: 35 Stage 2: 70	Quantitative survey	Neurorehabilitation Experience Questionnaire (NREQ)	<ul style="list-style-type: none"> • Ownership, • Personal value • Holistic approach • Therapeutic atmosphere
(Knight et al., 2010) (England)	Australia	Outpatient	Contributing factors of satisfaction with private outpatient physiotherapy services;	Physical therapy	Other	312	Mixed methods (focus groups and interviews, qualitative survey)	Unnamed Questionnaire	<ul style="list-style-type: none"> • Convenience • Punctuality • Privacy • Staff courtesy • Staff understanding • Empathy • Time

Author & Year & Place of Publication	Study Location	Setting	Focus	Type of Rehabilitative Care	Study Population	Sample Size	Study Design	Tool(s)	
								Name	Concepts Tested
			criteria of quality and applicability of the "consumer model"						<ul style="list-style-type: none"> Physical facilities Therapist understanding Explanation Positive/negative (aspects of treatment explained)
(Medina-Mirapeix et al., 2012) (Italy)	Spain	Outpatient	Variations of musculo-skeletal disorder patients' receiving post-acute care in outpatient rehabilitation settings	Physical therapy	Musculo-skeletal	465	Quantitative survey	Unnamed survey	<ul style="list-style-type: none"> Education Providing information, Emotional support Sensitive manners to patient change Duration of attendance Interruptions during delivery of care Patient safety Waiting times in the sequence of treatment
(Medina-Mirapeix, Jimeno-Serrano, Escolar-Reina, & Del Baño-Aledo, 2013) (England)	Spain	Outpatient	Relationship in outpatient rehabilitation settings between patient experiences and satisfaction and service quality.	Physical therapy, and other	Musculo-skeletal	520	Cross-sectional self-reported survey	Unnamed 23-item instrument	<p>Overall evaluation</p> <ul style="list-style-type: none"> Satisfaction Perceived Service Quality <p>Patient Experiences</p> <ul style="list-style-type: none"> Organizational Environment <ul style="list-style-type: none"> Attendance Duration interruptions during care delivery Wait times in treatment Patient safety Professionals' Attitudes with domains <ul style="list-style-type: none"> Information and education Sensitive manners to patients' changes Emotional support
(Medina-Mirapeix, Oliveira-Sousa, et al., 2013) (United States)	Spain	Outpatient	Elements of continuity that determine satisfaction; and the quality of	Not specified	Musculo-skeletal	218	Cross-sectional self-reported survey	Self-report instrument based on a previous qualitative study (Medina-Mirapeix et al., 2011)	<p>Focused on elements of the 3 types of continuity:</p> <ul style="list-style-type: none"> Informational Management Relational

Author & Year & Place of Publication	Study Location	Setting	Focus	Type of Rehabilitative Care	Study Population	Sample Size	Study Design	Tool(s)	
								Name	Concepts Tested
(Monnin & Perneger, 2002) (Switzerland)	Switzerland	Hospital – rehabilitation /chronic care (inpatient)	continuity experiences in outpatients receiving post-acute rehabilitatio n care. Developme nt of a patient satisfaction questionnai re for physical therapy.	Physical therapy	General physical therapy	528	Cross-sectional self-reported survey	Unnamed 14 item tool describing characteristic of services received using 5 point Likert scale	<ul style="list-style-type: none"> • Treatment • Logistics • Admission • Global assessment
(Normann et al., 2012) (England)	Norway	Outpatient	Multiple sclerosis patients' satisfaction with physiothera py and perception of change after consultation in outpatient services	Physical therapy	Multiple sclerosis	64	Cross-sectional survey	Outpatient Experience Questionnaire (OPEQ)	<ul style="list-style-type: none"> • Pre-visit communication • Access/ standard of clinic • Organization of clinic • Consultation • After Consultation • Background/demographics
(Ottonello et al., 2012) (Italy)	Italy	Hospital – rehabilitation /chronic care	Psychometri cs of the SAT-16 tool for patient satisfaction with the quality of rehabilitativ e care	Not specified	Not specified	7274	Quantitative survey	SAT-16	<ul style="list-style-type: none"> • Humaneness, • Communication skills and • perceived competence of staff • Catering service and meal quality • physical surroundings • Accessory services.
(Quaschnig et al., 2013) (Ireland)	Germany	Hospital – rehabilitation /chronic care	Developme nt and testing of a	Not specified	Not specified	402	Cross-sectional survey	Questionnaire on Patient Satisfaction (ZUF-8)	Not Specified

Author & Year & Place of Publication	Study Location	Setting	Focus	Type of Rehabilitative Care	Study Population	Sample Size	Study Design	Tool(s)	
								Name	Concepts Tested
(Roush et al., 2007) (United States)	United States	Outpatient	theory- based model for empathy, treatment acceptance, team interaction, satisfaction, & shared decision making Comparison of PTOPS and PSQ on missing data, and various psychometri c properties.	Physical therapy	Not specified	156	Cross-sectional survey	Physical therapy Outpatient Satisfaction Survey (PTOPS) and Patient Satisfaction Questionnaire (PSQ)	PTOPS: <ul style="list-style-type: none"> • Enhancers, • Detractors, • Cost, and • Location PSQ is a 20-item Likert scale with no subscales; measures one dimension of satisfaction
(Slade & Keating, 2010) (United States)	Australia	Hospital – rehabilitation /chronic care	Tools that measure or assess satisfaction and experience of exercise programs designed to help people with low back pain	Physical therapy	All rehabilitative populations	N/A	Quantitative comparison of measures	1. Physical Therapy Patient Satisfaction Questionnaire. 2. Patient Satisfaction Questionnaire 3. Quality of Care Through Patients' Eyes 4. Picker Patient Experience Questionnaire 5. Medical Interview Satisfaction Scale 6. Patient Satisfaction with Physical Therapy 7. Satisfaction with Musculo-skeletal Care Questionnaire 8. Patient Experience Questionnaire Discharged Patients'	<ul style="list-style-type: none"> • Care-Provider & Staff • Governance • Access & Facilities
(Soderback, Sweden)	Sweden	Hospital –	Feasibility	Occupational	Frail elderly/	9	Descriptive,		<ul style="list-style-type: none"> • Descriptive stats

Author & Year & Place of Publication	Study Location	Setting	Focus	Type of Rehabilitative Care	Study Population	Sample Size	Study Design	Tool(s)	
								Name	Concepts Tested
2008) (England)		acute care (discharge)	of an occupational therapy clinical tool (DPEQ) that measures quality of care.	therapy	medically complex		structured literature review	Enquiry Questionnaire (DPEQ)	<ul style="list-style-type: none"> ○ Personal conditions ○ Living circumstances ○ Health status ○ Perception of quality of content and services ● Statements on perceived interventions <ul style="list-style-type: none"> ○ Functional capacity evaluation ○ Functional incapacity scores
(Stubbe et al., 2007) (England)	Netherlands	Hospital – acute care	Psychometrics and ability of the CQJ Hip/Knee Questionnaire to measure differences in quality of care between hospitals	Not specified	Musculo- skeletal	1675	Mixed methods (interviews, surveys)	Consumer Quality Hip Knee Questionnaire (CQI Hip Knee)	<ul style="list-style-type: none"> ● General items (aged, education, etc.) ● Global ratings ● Performance items referring to actual experience with quality aspects of care
(Van der Linde et al., 2007) (England)	Netherlands	Outpatient	Wishes and experiences of lower limb amputee patients and information exchange with providers	Prosthetics and orthotics	Amputation	82	Quantitative survey	Questionnaire developed based off of the QUOTE questionnaire	<ul style="list-style-type: none"> ● Service demand ● Prosthetic prescription ● Information ● Insurance aspects
(Vanti et al., 2013) (England)	Italy	Outpatient	The translated, culturally adapted, and validated Italian version of the (PTOPS)	Physical Therapy	Not specified	173	Cross-sectional questionnaire	The Italian Physical Therapy Outpatient Satisfaction Survey (PTOPS - I)	<ul style="list-style-type: none"> ● Enhancers ● Detractors ● Location ● Cost

Appendix C. Validated Patient Rehabilitative Care Experience Questions by Instrument

Questionnaire/Instrument Name §	Construct Measured	Question/s related to patient experience (excluded patient satisfaction or outcomes questions account for missing numbers)	Thematic Category¶
CCRQ (Cott, Teare, McGilton, & Lineker, 2006)	Client-centred rehabilitation from the client's perspective	1. The program staff and I decided together what would help me.	1. C
		2. I had difficulty getting the health care information I needed.	2. C
		3. I was kept well-informed about my progress in areas that were important to me.	3. C
		4. My family/friends were given the support that they needed by the program staff.	4. C
		5. The program staff treated me as a person instead of just another case.	5. R
		6. The program staff tried to accommodate my needs when scheduling my therapy.	6. I
		7. I had to repeat some information to the different program staff	7. E
		8. My physical pain was controlled as well as possible.	8. F
		9. The program staff took my individual needs into consideration when planning my care.	9. I
		10. I was given adequate information about support services in the community.	10. C
		11. I accomplished what I expected in my rehabilitation program.	11. F
		12. My family/friends were given the information that they wanted when they needed it.	12. C
		13. I was treated with respect and dignity.	13. R
		14. My reports of pain were acknowledged by program staff.	14. F
		15. My treatment needs, priorities and goals were important to the program staff.	15. F
		16. The program staff and I discussed my progress together and made changes as necessary.	16. C
		17. My family/friends received information to assist in providing care for me at home.	17. C
		18. I knew who to contact if I had problems or questions during my rehabilitation program.	18. E
		19. I had adequate time for rest and sleep.	19. E
		20. I was encouraged to participate in setting my goals.	20. E
		21. I received the information that I needed when I wanted it.	21. C
		22. I learned what I needed to know in order to manage my condition at home.	22. C
		23. My family and friends were treated with respect.	23. C
		24. I know who to contact if I have problems following discharge.	24. E

Questionnaire/Instrument Name §	Construct Measured	Question/s related to patient experience (excluded patient satisfaction or outcomes questions account for missing numbers)	Thematic Category¥
CQI (Stubbe et al., 2007)		1. Nurses treat me with respect.	1. R
		2. Nurses take me seriously.	2. R
		3. Nurses listened carefully.	3. R
		4. Nurses explained things clearly.	4. R
		5. Nurses spent enough time.	5. E
		6. Help as soon as wanted.	6. E
		7. Nurses kept their appointments.	7. E
		8. Help with bathing as soon as you wanted.	8. E
		9. Help with going to the toilet as soon as you wanted.	9. E
		10. Doctors treat me with respect.	10. R
		11. Doctors take me seriously.	11. R
		12. Doctors listened carefully.	12. R
		13. Doctors explained things clearly.	13. R
		14. Doctors spent enough time.	14. E
		15. Doctors kept their appointments.	15. E
		16. General practitioner gave good advice.	16. R
		17. General practitioner let me decide about treatment.	17. C
		18. Told me what new medicine was for.	18. C
		19. Told side-effects of new medicine.	19. C
		20. Pain controlled.	20. F
		21. Everything done to help with pain.	21. F
CRPF-R (Fernandez et al., 2007)	Preferences of features of CR program	1. Set own goals.	1. C
		2. Exercise with someone.	2. E
		3. Discuss progress.	3. C
		4. Acceptable drive time to program.	4. E
		5. Convenience of parking.	5. E
		6. Not get overly tired.	6. F
		7. Not have pain while exercising.	7. F
		8. Receive encouragement from professionals.	8. R
		9. Ease of learning exercises.	9. F
		10. Acceptable cost.	10. E
		11. Choose exercises.	11. C
		12. Flexible hours.	12. E
		13. Exercises are not boring.	13. C
		14. See progress.	14. C
		15. Receive individualized attention.	15. I
		16. Does not interfere with other activities.	16. C

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		17. Available transportation. *two items were removed but the study authors did not specify which ones*	17. E
MISS-21 (Grosset & Grosset, 2005; Slade & Keating, 2010)	Consultation satisfaction	<ol style="list-style-type: none"> 1. The doctor told me just what my trouble is. 2. After talking with the doctor, I know just how serious my illness is. 3. The doctor told me all I wanted to know about my illness. 4. I am not really certain about how to follow the doctor's advice. 5. After talking with the doctor, I have a good idea of how long it will be before I am well again. 6. The doctor seemed interested in me as a person. 7. The doctor seemed warm and friendly to me. 8. The doctor seemed to take my problems seriously. 9. I felt embarrassed while talking with the doctor. 10. I felt free to talk to the doctor about private matters. 11. The doctor gave me a chance to say what was really on my mind. 12. I really felt understood by my doctor. 13. The doctor did not allow me to say everything I had wanted about my problems. 14. The doctor did not really understand my main reason for coming. 15. This is a doctor I would trust with my life. 16. The doctor seemed to know what (s)he was doing. 17. The doctor has relieved my worries about my illness. 18. The doctor seemed to know just what to do for my problem. 19. I expect that it will be easy for me to follow the doctor's advice. 20. It may be difficult for me to do exactly what the doctor told me to do. 21. I'm not sure the doctor's treatment will be worth the trouble it will take. 	<ol style="list-style-type: none"> 1. R 2. R 3. C 4. C 5. C 6. R 7. R 8. R 9. R 10. R 11. R 12. R 13. R 14. R 15. R 16. R 17. R 18. R 19. R 20. C 21. C
MRPS (Beattie, Dowda, et al., 2005; Beattie, Turner, et al., 2005; Hush et al., 2013)	Satisfaction with physical therapy care	<ol style="list-style-type: none"> 1. The office receptionist is courteous. 3. The waiting area is comfortable. 4. My therapist does not spend enough time with me. 5. My therapist thoroughly explains the treatment(s) I receive. 6. My therapist treats me respectfully. 7. My therapist does not listen to my concerns. 8. My therapist answers all my questions. 9. My therapist advises me on ways to avoid future problems. 10. My therapist gives me detailed instructions regarding my home program. 	<ol style="list-style-type: none"> 1. E 3. E 4. E 5. C 6. R 7. R 8. R 9. C 10. C
NREQ (Kneebone et al., 2012)	To assess whether neurorehabilitation inpatients	<ol style="list-style-type: none"> 1. When I arrived I was given information about the unit and what would happen during my stay 	<ol style="list-style-type: none"> 1. C

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	experience service elements important to them	2. The facilities on the unit were good (eg, washing facilities, toilets) 3. There was somewhere to secure my belongings 4. I was able to discuss personal matters in private 5. There were enough things to do in my free time (eg, watch television, join in with a group, sit in the garden) 6. There was a friendly atmosphere on the unit 7. I felt the staff really cared about me 8. The staff worked well as a team 9. I felt able to talk to the staff about any problems I had 10. I was asked what I wanted to achieve during my stay 11. I felt as though the staff and I were partners in the whole process of care 12. The staff kept me informed every step of the way 13. My family or carer was involved in discussions about my treatment if I wanted them to be 15. I received enough emotional support (eg, if I was feeling low or finding it hard to cope) 16. I am feeling well supported and prepared for my discharge	2. E 3. E 4. E 5. E 6. E 7. R 8. E 9. R 10. C 11. C 12. C 13. C 15. R 16. C
OAKHQOL (Baumann et al., 2011)	Satisfaction with post-operative care following hip or knee surgery	*Note: these are abbreviated items from OAKHQOL 1.0 1. Walking 2. Bending or straightening 3. Carrying heavy things 4. Going down stairs 5. Climbing stairs 6. Taking a bath 7. Dressing 8. Cutting toe-nails 9. Staying for a long time in the same position 10. Getting moving after staying in the same position 11. Need a stick to walk 12. Able to do things one used to 13. Need help 14. Getting in and out a car 15. Using public transport 16. Had usual physical leisure activities 17. Had usual social and leisure activities 18. Hindered in professional activity 20. Take longer time doing things 21. Intensity of pain	1. F 2. F 3. F 4. F 5. F 6. F 7. F 8. F 9. F 10. F 11. F 12. F 13. F 14. F 15. F 16. F 17. F 18. F 20. F 21. F

Questionnaire/Instrument Name §	Construct Measured	Question/s related to patient experience (excluded patient satisfaction or outcomes questions account for missing numbers)	Thematic Category¥
		22. Frequency of pain	22. F
		23. Having difficulties getting to sleep because of pain	23. F
		24. Wake up at night because of pain	24. F
		25. Feel depressed because of pain	25. F
		26. Feel older than my years	26. F
		27. Been afraid of being dependent on others	27. F
		28. Been afraid of becoming an invalid	28. F
		29. Embarrassed when people see me	29. F
		30. Worry	30. F
		31. Feel depressed	31. F
		32. Able to plan for the future	32. C
		33. Wonder what is going to happen	33. C
		34. Worried about the side-effects of treatment	34. C
		35. Going out whenever would like	35. F
		36. Have friends in whenever would like	36. F
		37. Hindered in family life	37. F
		38. Hindered in life with partner	38. F
		39. Restricted in sexual life	39. F
		40. Feel aggressive and irritable	40. F
		41. Feel being a burden to close relatives	41. F
		42. Talking about arthritis problems	42. F
		43. Feel others understand arthritis problems	43. E
		44. Feel embarrassed to ask for help	44. R
		45. Feel support from people close to me	45. E
		46. Feel support from people around	46. E
OPEQ (Normann, 2012)	Satisfaction	1. Clinic access	1.
		a. Ease of finding clinic/ward	a. E
		b. Ease of finding way within clinic/ward	b. E
		2. Communication	2.
		a. Enough time for dialogue	a. E
		b. Person understandable	b. R
		c. Person competent	c. R
		d. Person caring	d. R
		e. Opportunity to give sufficient information	e. C
		f. Unanswered questions	f. C
		3. Organization	3.
		a. Background information available	a. C
		b. Staff collaboration	b. E

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		c. Organization of work	c. E
		d. Person well prepared	d. R
		4. Hospital standards	4.
		a. Waiting room	a. E
		b. Toilet	b. E
		c. Cleanliness	c. E
		5. Information	5.
		a. Information-self-care	a. C
		b. Information-medication/side effects	b. C
		c. Information-examinations	c. C
		d. Information-examination/test results	d. C
		e. Information-condition/prognosis	e. C
		f. Consulted about examination/treatment	f. C
		6. Pre-visit communication	6.
		a. Acceptability of appointment waiting time	a. E
		b. Information from clinic received in advance	b. E
		c. Ease of accessing clinic staff	c. E
PEQ (Slade & Keating, 2010)		Outcome of this specific visit	
		1. Do you know what to do to reduce your health problem(s)?	1. C
		2. Do you know what to expect from now on?	2. C
		3. Will you be able to handle your health problems differently?	3. C
		Communication Experiences	
		5. We had a good talk	5. R
		6. I felt reassured	6. R
		7. The doctor understood what was on my mind	7. R
		8. I felt I was taken care of	8. R
		Communication Barriers	
		9. It was a bit difficult to connect with the doctor	9. R
		10. Too much time was spent on small talk	10. R
		11. It was a bit difficult to ask questions	11. R
		12. Important decisions were made over my head	12. R
		Experience with the auxiliary staff	
		13. I sensed that other patients could listen in when I was talking to the staff	13. E
		14. I felt like one of the crowd	14. C
		Emotions immediately after the visit	
		15. After this visit, I felt:	15. C
		Relieved <u>7 6 5 4 3 2 1</u> Worried	
		Sad <u>1 2 3 4 5 6 7</u> Cheerful	

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		Strengthened <u>7</u> <u>6</u> <u>5</u> <u>4</u> <u>3</u> <u>2</u> <u>1</u> Worn Out Relaxed <u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u> <u>6</u> <u>7</u> Tense	
POPS (French et al., 2010; Hills & Kitchen, 2007)	Patient satisfaction with physiotherapy outpatient treatment	<ol style="list-style-type: none"> 1. My therapist gave me confidence that I was going to get better. 2. I was not always seen promptly for my treatment sessions. 3. I did not have confidence that the therapist knew what (s)he was doing. 4. I should have got a better result from the treatment I was given in this department. 5. I expected the treatment would help relieve my pain. 6. My therapist did not listen to what I had to say. 7. I have made a full recovery as a result of treatment. 8. I did not have any of my treatment sessions cancelled. 9. I expected the treatment would get me better. 10. The treatment helped me at the time but the effect did not last. 11. My therapist gave me encouragement and praise. 13. I expected the treatment would cure my problem. 14. The treatment was too rushed. 16. The therapist explained my condition to me in great detail. 17. I did not think treatment would be able to help me. 18. I was able to choose the appointment times for treatment. 19. The treatment has helped me in some ways but I am not completely better. 20. My therapist did not seem interested in me. 21. It was important for me to see the same therapist throughout my treatment. 22. The treatment was tailored to my needs. 23. I was able to ask the therapist about anything connected with my treatment. 24. I had to wait a long time to get my first appointment for treatment. 25. The treatment sessions were too short. 26. The treatment has not helped me at all. 27. My therapist put me at ease and was very kind to me. 28. The therapist did not answer all my questions 29. I got on very well with my therapist. 30. Treatment sessions were too infrequent to get any benefit. 31. I am now completely pain free as a result of treatment. 32. I was made aware of my responsibilities in managing my condition as a result of treatment. 33. I did not have the undivided attention of the therapist during my treatment. 35. I have regained full mobility as a result of treatment. 36. I was able to contact the department for help if I had any further problems after discharge. 	<ol style="list-style-type: none"> 1. R 2. E 3. R 4. F 5. F 6. R 7. F 8. E 9. F 10. F 11. R 13. F 14. E 16. R 17. F 18. E 19. F 20. R 21. E 22. I 23. R 24. E 25. E 26. F 27. R 28. R 29. R 30. E 31. F 32. C 33. R 35. F 36. E

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		37. The quality of service I received in this department could have been better.	37. E
		38. The treatment was fully explained to me.	38. C
PPE-15 (Slade & Keating, 2010)		1. Information and Education	1.
		a. Not given enough information in accident and emergency unit	a. R
		b. Delay in admission to ward not explained	b. R
		c. Doctors' answers to questions not clear	c. R
		d. Nurses' answers to questions not clear	d. R
		e. Test results not clearly explained	e. R
		2. Coordination of Care	2.
		a. Emergency care not well organized	a. E
		b. Admission process not well organized	b. E
		c. Long wait to go to ward	c. E
		d. Not told which doctor was in overall charge of care	d. E
		e. Staff gave conflicting information	e. E
		f. Scheduled tests or procedures not performed at appointed time	f. E
		3. Physical Comfort	3.
		a. Didn't get help to go to the bathroom/toilet	a. E
		b. Had to wait too long after pressing call button	b. E
		c. Had to wait too long for pain medicine	c. E
		d. Staff did not do enough to control pain	d. R
		4. Emotional Support	4.
		a. Doctor didn't discuss anxiety or fears	a. R
		b. Didn't always have confidence and trust in doctors	b. R
		c. Didn't always have confidence and trust in nurses	c. R
		d. Not easy to find someone to talk to about concerns	d. C
		5. Respect for Patient Preferences	5.
		a. Doctors sometimes talked as if I wasn't there	a. R
		b. Nurses sometimes talked as if I wasn't there	b. R
		c. Not sufficiently involved in decisions about treatment and care	c. C
		d. Not always treated with respect and dignity	d. R
		6. Involvement of Family and Friends	6.
		a. Family didn't get opportunity to talk to doctor	a. C
		b. Family not given enough information about condition	b. C
		c. Family not given enough information needed to help recovery	c. C
		7. Continuity and Transition	7.
		a. Purpose of medicines not fully explained	a. C
		b. Not told about medication side effects	b. C
		c. Not told about danger signals to watch for at home	c. C

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		d. Not told when to resume normal activities	d. C
		8. Overall Impressions	8.
		a. Courtesy of admissions staff not good	a. E
		b. Courtesy of doctors not good	b. R
		c. Availability of doctors not good	c. E
		d. Courtesy of nurses not good	d. R
		e. Availability of nurses not good	e. E
		f. Doctor/nurse teamwork not good	f. E
PPTO (Duijin et al., 2008)	Patient's perceptions of rehabilitative treatment outcomes	6 items using a 5-point Likert scale:	
		1. The problem that I received physical therapy for improved.	1. F
		2. I have less pain now that I did before I received physical therapy	2. F
		3. I can do more now than I could before going to physical therapy	3. F
		4. I achieved the treatment goals set by my therapist and I	4. F
		5. My physical therapies taught me how to manage my problem/condition and prevent future problems	5. C
		6. Physical therapy improved my overall health and wellness	6. F
P-QPD (Almborg et al., 2009)	Perceived participation in discharge planning	P-Information Have you received sufficient information concerning:	
		1. Your illness/course of illness?	1. R
		2. Tests/examinations/treatments?	2. R
		3. Results of tests/examinations/treatments?	3. R
		4. Medication?	4. R
		5. Rehabilitation?	5. R
		6. Did you have the possibility to ask questions about your illness?	6. C
		7. Did you understand the information you received about your illness?	7. C
		P-Medical Treatment	
		8. Have you had the opportunity to participate in discussions concerning your examinations/treatments?	8. C
		9. Have you had the opportunity to discuss the goals of your treatment with the physician?	9. C
		P-Goals and Needs In connection to discharge:	
		10. Did you have the opportunity to participate in discussions concerning your need for care/services after discharge?	10. C
		11. Did you have the opportunity to participate in discussions concerning your needs for rehabilitation after discharge?	11. C
		12. Did you have the opportunity to discuss the goals of your care/services after	12. C

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		discharge?	
		13. Did you have the opportunity to discuss the goals of your rehabilitation after discharge?	13. C
		14. Did you participate in working out your discharge plan?	14. C
PSQ or PTPSQ (Duijin et al., 2008; Roush et al., 2007; Slade & Keating, 2010)		1. Age (in years)	1. I
		2. Sex (M/F)	2. I
		4. Was this your first experience with physical therapy? (yes/no)	4. I
		5. Was this your first experience with this facility? (yes/no)	5. I
		6. Please check the location of the problem for which you received physical therapy (check all that apply)	6. I
		7. My privacy was respected during my physical therapy care.	7. E
		8. My physical therapist was courteous.	8. R
		9. All other staff members were courteous.	9. E
		10. The clinic scheduled appointments at convenient times.	10. E
		12. My first visit for physical therapy was scheduled quickly.	12. E
		13. It was easy to schedule visits after my first appointment.	13. E
		14. I was seen promptly when I arrived for treatment	14. E
		15. The location of the facility was convenient for me.	15. E
		16. My bills were accurate.	16. E
		18. Parking was available for me.	18. E
		19. My physical therapist understood my problem or condition.	19. R
		20. The instructions my physical therapist gave me were helpful.	20. R
PTOPS (Casserley-Feeney et al., 2008; Roush et al., 2007)		1. The cost of treatment is more than I expected.	1. E
		2. I enjoy listening to my therapist.	2. R
		3. I expect the facility to be quieter than it is.	3. E
		4. The facility is flexible about payment options.	4. E
		5. The distance required to get to the facility is acceptable to me.	5. E
		6. I expect my therapist to spend more time with me than he/she does.	6. E
		7. I am given privacy when I need it.	7. E
		8. It is difficult for me to get into the facility from the parking lot.	8. E
		9. I am charged a reasonable amount for my therapy.	9. E
		10. This facility could be more conveniently located for me.	10. E
		11. I feel my therapist overcharges me.	11. E
		12. The office staff is attentive to my needs.	12. E
		13. My therapist acts like he/she is doing me a big favor by treating me.	13. R
		14. The facility is in a desirable location.	14. E
		15. My therapist could communicate with me more.	15. R

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		16. I have to wait too long between appointments.	16. E
		17. The quality of the care I receive is not compatible with the cost.	17. E
		18. This facility is a nice place to get my therapy.	18. E
		19. It is somewhat difficult for me to reach this PT facility.	19. E
		20. The facility is too crowded.	20. E
		21. I have to travel too far to receive my treatment.	21. E
		22. I can get around easily inside of the facility.	22. E
		23. I don't really enjoy talking to my therapist.	23. R
		24. My therapist seems to have a genuine interest in me as a person.	24. C
		25. My therapist does not expect me to pay significantly more than what my insurance covers.	25. E
		26. I anticipate my questions will be answered clearly.	26. C
		27. My therapist doesn't give me a chance to say what is on my mind.	27. C
		28. I should not have to travel this far for therapy.	28. E
		29. This facility appreciates my business.	29. E
		30. It could be easier to make the arrangements to pay for my therapy.	30. E
		31. My physical therapist should be more thorough in my treatment.	31. R
		32. The physical therapy facility is conveniently located for me.	32. E
		33. My therapist should listen more carefully to what I tell him'/her.	33. R
		34. I get along well with everyone in this PT facility.	34. R
QCS (Baumann et al., 2011)	Quality of hospital care	I received clear information about	
		1. Symptoms	1. C
		2. The purpose of the tests	2. C
		3. The results of the tests	3. C
		4. The purpose of the treatment (drugs, operation)	4. C
		5. The possible side-effects of these treatments	5. C
		6. Warning signs to look for	6. C
		7. When to resume activities after discharge	7. C
		8. Medical follow-up	8. C
		9. Physicians answered all of my questions	9. R
		10. I was involved in discharge management	10. C
		11. I could identify in discharge management	11. C
		12. I could identify the physician in charge of me	12. R
		13. My relatives were fully informed	13. C
		14. I was involved in the information session for my relatives	14. C
		15. I received enough help in my daily routine	15. F
		16. I received enough help with meals	16. F
		17. I received enough help with washing	17. F

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		18. I received enough help with going to the toilet	18. F
		19. I received enough help for my psychological problems	19. E
		20. I saw nurses as often as I wished	20. E
		21. Nurses were too overworked to take care of me	21. E
		22. I was upset by physicians bed-side statements	22. R
		23. There was good coordination in the department	23. E
		25. Staff discussed medical issues at my bedside, ignoring me	25. C
		26. There was enough privacy during medical care	26. E
		27. Everything possible was done to relieve my pain	27. F
QUOTE (Slade & Keating, 2010; Van der Linde et al., 2007)	Quality of care from the patient perspective	Process	
		1. Take patients seriously	1. R
		2. Keep appointments punctually	2. E
	From the QUOTE Elderly questionnaire	3. Access to case notes/files	3. E
		4. Information about medicines	4. C
		5. Patient decides about treatment/ help	5. C
		6. Choice of another care provider	6. C
		7. Understanding of patients' problems	7. R
		8. Work efficiently	8. E
		Structure	
		9. Access to hospital specialist	9. E
		10. Home help after hospital discharge	10. E
		11. Good care coordination	11. E
Re-PEQ (Grotle et al., 2009)		1. Rehabilitation care and organization	1.
		a. Staff-caring	a. R
		b. Organization of care	b. E
		c. Staff availability	c. E
		d. Staff collaboration	d. E
		e. Staff gave you the best care	e. E
		f. Physiotherapists had enough time	f. E
		2. Information/communication	2.
		a. Opportunity to express needs	a. C
		b. Staff understandable	b. R
		c. Information – rehabilitation	c. C
		d. Information – tests and examinations	d. C
		e. Information – results of tests and examinations	e. C
		f. Important information about you reached staff	f. C
		g. Information – future problems	g. C

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SAPHORA-based, unnamed 30-item questionnaire (Delanian Halsdorfer et al., 2011)		h. Involvement – medical/rehabilitation decisions	h. C
		3. Availability of Staff	3.
		a. Contact with staff when needed	a. E
		b. Doctors had enough time	b. E
		4. Social Environment	4.
		a. Social environment	a. E
		b. Contact with other patients	b. E
		5. Items not included in the scales	5.
		a. Resources – technical equipment	a. E
		b. Overall impression of rehabilitation institution	b. Q
		c. Staff continuity	c. E
		d. Next of kin – reception	d. C
		e. Next of kin – involvement in rehabilitation process	e. C
		f. Information – relapse	f. C
		g. Quality of leisure activities	g. E
		h. Occupational therapists enough time	h. E
		i. Opportunity for contact with the institution after rehabilitation stay	i. E
1. Sex: (Male/Female)	1. I		
2. Your age: _____	2. I		
4. How did you find the reception you got at the Admissions Office for administrative formalities?	4. E		
5. How did you find the reception you got in the day hospital?	5. E		
6. Were your various displacements difficult?	6.		
a. At the day hospital	a) F		
b. At the offices	b) F		
c. In the WC	c) F		
7. Were you helped by the PRM staff when you needed help?	7. E		
8. How did you perceive the waiting times between the day's different appointments?	8. C		
10. Were you bothered by the lack of privacy during your doctor visit?	10. E		
11. Was the confidentiality related to your case respected?	11. E		
12. Could you ask your doctor the questions that you wanted to ask him/her?	12. R		
13. Did you understand the doctor's responses to your questions?	13. C		
14. Was your pain taken into account?	14. F		
15. Did you feel listened to during the day?	15. C		
16. Did you participate as much as you wanted in the decisions related to you?	16. C		
17. Were you fatigued by the length of the sessions at the day hospital?	17. F		

Questionnaire/Instrument Name §	Construct Measured	Question/s related to patient experience (excluded patient satisfaction or outcomes questions account for missing numbers)	Thematic Category¥	
SASC or C-SASC (Cramm et al., 2012)		22. How did you find the time between the initial consultation and the session at the day hospital?	22. E	
		23. How did you find the time between the session at the day hospital and the second consultation for the session summary?	23. E	
		24. How did you find the time between the spasticity assessment session and the botulinum toxin injection?	24. E	
		25. If you have already come to the day hospital, how did you find the time before the session report was sent to you?	25. E	
		30. Do you have any additional comments you would like to share?	30. Q	
		SASC		
		1. I have been treated with kindness and respect by the staff at the hospital.	1. E	
		2. The staff attended well to my personal needs while I was in the hospital (for example, I was able to get to the toilet whenever I needed).	2. E	
		3. I was able to talk to the staff about any problems I might have had.	3. C	
		4. I have received all the information I want about the causes and nature of my illness.	4. C	
C-SASC				
1. I have been treated with kindness and respect by the staff at the hospital.	1. E			
2. The staff attended to my personal needs while I was in the hospital and tried to support me as much as possible.	2. E			
3. I was able to talk to the staff about any problems I might have had.	3. C			
4. I received all the information I wanted about the causes and nature of the illness of the patient I take care of.	4. C			
10. The hospitalization process went smoothly.	10. E			
11. I received all the information I wanted about recovery and rehabilitation after a stroke.	11. C			
Servqual (Curry & Sinclair, 2002)		Questions reworded and asked a second time to identify difference between what the provider should have (here) and what they do have		
		1. They should have up-to-date equipment	1. E	
		5. When these firms promise to do something by a certain time, they should do so	5. E	
		6. When customers have problems, these firms should be sympathetic and reassuring	6. R	
		7. These firms should be dependable	7. R	
		8. They should provide their services at the time the promise to do so	8. E	
		9. They should keep their records accurately	9. E	
		11. It is not realistic for customers to expect prompt service from employees of	11. R	

Questionnaire/Instrument Name §	Construct Measured	Question/s related to patient experience (excluded patient satisfaction or outcomes questions account for missing numbers)	Thematic Category¥
		these firms	
		12. Their employees don't always have to be willing to help customers	12. R
		13. It is okay if they are too busy to respond to customer requests promptly	13. E
		14. Customers should be able to trust employees of these firms	14. R
		15. Customers should be able to feel safe in their transactions with these firms' employees	15. R
		16. Their employees should be polite	16. E
		17. Their employees should get adequate support from these firms to do their jobs well	17. E
		18. These firms should not be expected to give customers individual attention	18. I
		19. Employees of these firms cannot be expected to give customers personal attention	19. I
		20. It is unrealistic to expect employees to know what the needs of their customers are	20. I
		21. It is unrealistic to expect these firms to have their customers' best interests at heart	21. E
Unnamed (Knight et al., 2010)	Satisfaction and dissatisfaction with private outpatient physiotherapy services	Actual questionnaire unavailable. Only the following 12 dimensions are indicated (NOT questions):	
		1. Convenience of appointment time	1. E
		2. Punctuality of the practice and the waiting times experienced by clients	2. E
		3. Privacy of the treatment area	3. E
		4. Courtesy shown by office staff towards the client	4. E
		5. Understanding shown by the office staff in relation to the presenting problem	5. E
		6. Friendliness and empathy of the therapist	6. R
		7. Amount of time the therapist spent with the client	7. E
		8. Physical facilities	8. E
		9. Therapist's understanding of the presenting problem (including the client's perception of the therapist's ability to accurately diagnose their condition)	9. R
		10. Therapist's explanation of procedures	10. R
		11. Extent to which the therapist explained positive and negative aspects of the treatment	11. R
		12. Education provided by the therapist regarding the presenting condition	12. C
Unnamed (Medina-Mirapeix et al., 2012)		Actual questionnaire unavailable	
		1. Did not get information about their prognostic	1. R
		2. Did not get information about usefulness of their therapies	2. R
		3. Not told how to prevent clinic complications during treatment	3. R

Questionnaire/Instrument Name §	Construct Measured	Question/s related to patient experience (excluded patient satisfaction or outcomes questions account for missing numbers)	Thematic Category¶
		4. Therapist gave poor answers to questions	4. R
		5. Did not get encouragement to address worries	5. R
		6. Therapist seemed not to be enough interested in patient's recovery	6. R
		7. Therapist seemed to be unaware of worries/needs	7. R
		8. Monitoring or exercise practice was less frequent than needed	8. F
		9. Did not have opportunities to talk about worries/doubts	9. C
		10. Treatment not adapted to onset or increase of sudden pain	10. C
		11. Treatment not adapted to changes of patient's mood	11. C
		12. Treatment not adapted to changes in functional status	12. C
		13. Duration of attendance by therapist was shorter than expected	13. E
		14. Therapist seemed to have a time very limited for observing exercise practice	14. E
		15. Not accompanied by therapist to prevent risks during moving or therapies	15. E
		16. Had treatment interruptions because therapist had to help other patients	16. E
		17. Had treatment interruptions because therapist had to attend other professional	17. E
		18. Had treatment interruptions due to therapist's phone calls/administrative demands	18. E
		19. Had to wait during treatment because boxes or devices were occupied	19. E
		20. Had to wait during treatment because tables were occupied	20. E
		21. Had to wait during treatment because other equipment was occupied	21. E
		22. Had to ask help from another patient to prevent risks (e.g. falls)	22. E
		23. Lived dangerous situations (e.g. falls) due to non-help from professionals	23. F
Unnamed (Medina-Mirapeix, Oliveira-Sousa, et al., 2013)	Patients' continuity experiences	1. Therapist seemed not to have enough information on previous physiotherapy treatment.	1. E
		2. Therapist seemed not to have enough information on previous medical treatment.	2. E
		3. Therapist seemed to be unaware of patient needs and preferences related to his/her disability experience.	3. C
		4. Had a delay in starting any session of treatment because of problems of transport service.	4. E
		5. Cancelled some scheduled modality in any regular session of treatment because of delays or other problems.	5. E
		6. Cancelled any regular session of treatment because medical visit was scheduled at the same time.	6. E
		7. Received contradictory information from therapist and physician.	7. E
		8. Received contradictory information from 2 therapists.	8. E
		9. Did not get encouragement to participate in their recovery.	9. C
		10. Treatment not adapted to onset of or increase in pain.	10. F

Questionnaire/Instrument Name §	Construct Measured	Question/s related to patient experience (excluded patient satisfaction or outcomes questions account for missing numbers)	Thematic Category¥
Unnamed (Monnin & Perneger, 2002)		11. Treatment not updated to changes in functional status.	11. F
		12. Therapist gave poor answers to questions.	12. R
		13. Established an excellent or very good relation.	13. R
		14. Had more than 1 therapist along the episode of care.	14. E
		1. Ease of administrative admission procedures	1. E
		2. Courtesy and helpfulness of secretary	2. E
		3. Simplicity of scheduling and time to get first appointment	3. E
		4. Ability of physical therapist to put you at ease and reassure you	4. R
		5. Explanations about what will be done to you during treatment	5. R
		6. Quality of information you received at the end of treatment regarding future	6. C
		7. Feeling of security at all times during the treatment	7. F
		8. Extent to which treatment was adapted to your problem	8. C
	9. Ease of access of physical therapy facilities	9. E	
	11. Comfort of the room where physical therapy was provided	11. E	
	12. Calm and relaxing atmosphere in physical therapy rooms	12. E	

§ Explanation of instrument acronyms in alphabetical order:

CCRQ: Client Centred Rehabilitation Questionnaire

CQI: Consumer Quality Hip Knee Questionnaire

CRPF-R: Revised Cardiac Rehabilitation Preference Form

DPEQ: Discharged Patient Experience Questionnaire

MISS-21: Medical Interview Satisfaction Scale

MRPS: MedRisk Instrument for Measuring Patient Satisfaction With Physical Therapy Care

NREQ: Neurorehabilitation Experience Questionnaire

OAKHQOL: Osteo-Arthritis Knee and Hip Quality of Life

OPEQ: Outpatient Experience Questionnaire

P.A.INT: Patient–Arzt-Interaktion (German)

PEQ: Patient Experience Questionnaire

POPS: Physiotherapy Outpatient Survey

PPE-15: Picker Patient Experience Questionnaire

PPTO: Patients' Perception of Treatment Outcomes

P-QPD: Patients' Questionnaire on Participation in Discharge Planning

PTOPS: Physical Therapy Outpatients Satisfaction Questionnaire

PSQ or PTSPQ: Patient Satisfaction Questionnaire or Physical Therapy Patient Satisfaction Questionnaire

Re-PEQ: Rehabilitation Patient Experiences Questionnaire

QUOTE: Quality of Care Through the Patient's Eyes

QUOTE-HIV: Quality of Care Through the Patient's Eyes- HIV

QCS: Quality of Care Scale

SASC or C-SASC: Satisfaction with Stroke Care or Caregivers Satisfaction with Stroke Care

WCCS: WASCANA Client-Centred Care Survey

ZUF-8: Questionnaire on Patient Satisfaction (German) – based on **CSQ-8:** Client Satisfaction Questionnaire

¥Thematic Categories

- C** Client and informal caregiver engagement i.e. shared decision making,
- E** Rehabilitative care ecosystem i.e. wait times, clinic culture
- F** Body function i.e. pain control
- I** Group or individual identity i.e. as individual or with a group i.e. gender, ethnicity
- Q** Qualitative (open ended question)
- R** Patient and healthcare provider relationship i.e. trust in therapist