

Original Article

Validation of the “Mind the Gap” Scale to Assess Satisfaction with Health Care among Adolescents

Kızıler et al. Validation of “Mind the Gap” Scale in Turkish Adolescents

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This study was presented as an oral presentation at the 5th National and 2nd International Mediterranean Pediatric Nursing Congress on 15–18 November 2015, in Ankara, Turkey

Background: At present, more than 90% of adolescents with chronic conditions survive into adulthood as health care users and move pediatric to adult care with their chronic illness. Therefore, the need satisfaction scale focuses specifically on transitional care and reflect the increasing expectations among youth and their parents.

Aims: This study aimed to examine the validity and reliability of the Turkish version of Mind the Gap Scale (MGS).

Study Design: Methodological study.

Methods: The Turkish versions of MGS and Patient Assessment of Chronic Illness Care scale were applied to the participants in two tertiary hospitals in Ankara. The validity was evaluated with factor analyses and content-scope validity; the reliability was evaluated with item-total score correlation, internal consistency, and continuity methods.

Results: A total of 109 adolescents and 157 parents completed the questionnaire. The content validity was confirmed. Exploratory factor analysis was used to determine the factor structure of the scale. Both adolescent and parent scales formed three sub-dimensions and explained 71% and 73% of the variation, respectively. The Cronbach's alpha reliability coefficient of MGS1 and MGS2 were .89 and .87, respectively, with internal consistencies of the parent's scales reaching .92 and .90. The test-retest reliability coefficients totalled .88 and .85 for the adolescents and parents, respectively. The suitability of the model was examined with confirmatory factor analysis. A good fit was observed with the chi square degrees of freedom statistics and the other conformity indices of the model.

Conclusion: The Turkish version of the MGS was decided to be a valid and reliable scale for evaluating the needs, expectations, and satisfaction of adolescents and their parents in terms of health care.

Keywords: Transitional care, patient satisfaction, diabetes, parent of an adolescent with diabetes

The life expectancy of children with chronic conditions has risen over the past few years. Today, most adolescents with chronic diseases transition to adulthood (1). The successful transition interventions for chronically ill youth from pediatric to adult care also gained importance. The American Academy of Pediatrics emphasizes the importance of high-quality, age-appropriate, and uninterrupted health care services as a person transitions from adolescence to adulthood and providing self-management and independent living activities to adolescents (2-6). This purposeful and high-quality health care transition process, which starts in the early adolescence, aims to maximize the lifelong functioning and well-being of youth with special healthcare needs (2,7).

The quality of health care is assessed by the care satisfaction of the patients. Studies evaluating care satisfaction are commonly performed in the adult population (8). These studies show that the care satisfaction in adults

affects the adjustment to care procedure, symptom management, continuity of care, trusting the healthcare providers, and decrease in hospital admissions (9-13). However, children and adolescents have been provided with limited opportunities to assess patient care, and most studies focus on assessing their expectations, needs, and insufficient care satisfaction (7,8,14,15). The existing patient satisfaction surveys evaluate the services from the care provider's point of view, neglect the user's expectations, and not specific to the disease. In our country, no satisfaction scale focuses specifically on transitional care nor reflect the youth and their parents's expectations and needs. However, the care quality and patient satisfaction must be evaluated from the patient's perspective to provide effective communication with individuals with chronic conditions and include them in the treatment process (8,16).

This study aimed to evaluate (i) the validity and reliability of the Turkish "Mind the Gap Scale" (MGS) to evaluate the transition health services satisfaction in adolescents with diabetes and their parents. The scale, which is focused on the transition care, is expected to contribute to the assessment of the needs and satisfaction of adolescents and their parents.

MATERIALS AND METHOD

Design and Participants

This methodological study was conducted with volunteers and randomly selected adolescents (n=109) and accompanying parents (n=157) who were recruited from two pediatric endocrinology clinics of two tertiary hospitals in Ankara. The inclusion criteria for adolescents were as follows: (i) followed-up diagnosis of diabetes at least one year where the study was conducted; (ii) age between 14–21 years old; (iii) ability to read and understand Turkish. The adolescents were excluded from the study if they presented diabetes-related complications and diabetes-related or unrelated neurological problems as they might alter the perspective of diabetes and diabetes care. A total of 5–10 subjects were recommended for each item to achieve the validity and reliability studies (17).

Procedure

The data were obtained by using the individual questionnaire based on self-evaluation, Turkish MGS, and Turkish Patient Assessment of Chronic Illness Care (PACIC). Written informed consent was obtained from all participants. The project was approved by the local ethics committee (*Ethics Committee No: 50687469-1491-164-15/1648-4-289*). The data collection period was approximately 30 min per participants. As a re-test, after 3 weeks, the scale was filled by 54 adolescent with diabetes to assess the reliability.

Measures and data

Demographic data form: The demographic data included questions about the age, sex, date of diagnosis, and being informed about diabetes.

MGS: The "Mind the Gap" scale, which was developed by Shaw et al. (2006), is a seven-point Likert scale which allows the assessment of the health care satisfaction of adolescents with chronic conditions and their parents. The construction of the scale was based on multiple inconsistency theories relating to the gap between individual expectations and perceptions (18). The scale comprises four forms, two forms for adolescents and two forms for parents; one for the "best care (MGS₁)" and one for the "current care (MGS₂)." A total of 22 items were selected for adolescents and 27 items for parents to assess the interpersonal relationships, health care process, and care environment (Table 1). The difference between the participant's rating of the "best" and "current" care in the study shows the quality of the transition care.

PACIC: The scale, which was developed by Glasgow et al., was validated by Incirkuş (2010). PACIC is a simple tool, which consists of 20 items and 5 subscales, to assess the health care among patients with chronic conditions (19). The respondents were asked to rate the items using a five-point Likert scale anchored by "strongly disagree" at 1 and "strongly agree" at 5. The increase in score from the scale indicates the increasing satisfaction of the patient (20).

Equivalence of language and content validity

After obtaining the permission to adapt the MGS into Turkish, the scale was independently translated by three language experts and two Turkish researchers. Then, the Turkish version was retranslated into English by two other experts in the English language. The final form of the scale was obtained after the expert opinions of two nursing academicians, a biostatistician, and pediatric endocrinologist experienced in transitional care and research methods.

After the language equivalence was established, the scale was tested on 10 participants who were then excluded from the remainder of the study. After the expert opinions, we determined to use the MGS without making any changes on the scale items.

Analyses

All analyses were performed using the IBM SPSS Statistics for Windows, Version 21.0. Armonk, NY: IBM Corp. The reliability was tested using Cronbach's alpha coefficients, item-total subscale correlations, and

repeatability of the scale for the complete scale and for each subscale. The self-care scale was used to determine the criterion validity of the scale. Validity was evaluated using the exploratory factor analysis (EFA) and confirmatory factor analysis (CFA). Principal component analysis and varimax rotation were used for exploring the dimensionality. The items with loadings >0.4 were selected as a factor. The Kaiser–Meyer–Olkin (KMO) measure and Bartlett’s test of sphericity were used to evaluate the sample’s adequacy. The relational assumptions between subscales were compared with oblimin rotation.

Ethic

The ethical approval for the study was obtained from Gulhane Military Medical Academy (E.C.Nu: 50687469-1491-164-15/1648-4-289) and Ankara Childen and Oncology Hematology Training and Research Hospital (E.C. Nu: 13.05.2015/18) local ethic committees.

RESULTS

The present study was conducted with 266 volunteer participants (109 adolescents with diabetes and 157 accompanying parents), who met the inclusion criteria, to evaluate the validity and the reliability of “Mind the Gap Scale (MGS).”

Participants’ characteristics

The mean age of the adolescents was 15.28 ± 1.44 years; 53.2% were boys ($n = 58$). The average age at diagnosis was 10.47 (2.0–16.0) years, and the average duration of disease was 4.8 (1.0–15.0) years. The average age of the parents was 41.9 ± 2.17 years; 66.9% were mothers, and 76.5% reached high school or higher education.

Validity of MGS

EFA

First, the sampling adequacy was confirmed with the KMO measurement (adolescent: .729, parent: .787) and Bartlett’s test of sphericity ($p < 0.01$). The test results confirmed the appropriateness of the sample and the sufficient association between variables to perform factor analysis (21). The factor loads were analyzed with the principal component and orthogonal varimax rotation technique and found to be higher than .4 (22–24). All items in the adolescent and parental forms presented an Eigenvalue higher than 1 and were considered as factors (23,24). According to the EFA results, the adolescent and parents scales consisted of a three-factor structure which explained 71% and 73% of the variation in adolescent and parental scores, respectively (Table 1).

CFA

The suitability of the model structure obtained with EFA was tested with CFA. The first criterion assessed for model suitability; chi square degrees of freedom statistics (χ^2/df) yielded values of 3.46 ($\chi^2 = 377.807$; $df = 109$; $p = 0.000$) and 3.157 ($\chi^2 = 252.534$; $df = 80$; $p = 0.000$) for MGS₁ and MGS₂, respectively. According to the CFA of the MGS₁ and MGS₂ for parents, χ^2/df values reached 3.07 ($\chi^2 = 199.55$; $df = 65$; $p = 0.000$) and 3.40 ($\chi^2 = 309.401$; $df = 91$; $p = 0.000$), respectively. Table 2 shows the goodness-of-fit index (GFI) values of the scale model obtained in the study. Our study showed that the χ^2/df values showing an overall model fit were in a desirable range, whereas the GFI and adjusted GFI index (AGFI) values showed a good fit.

Although most of the GFIs were in acceptable limits, the values of other indices— comparative fit index CFI, incremental fit index (IFI), Tucker–Lewis index (TLI), root mean square residual (RMR), and root mean square error of approximation (RMSEA)—were out of acceptable limits (Table 2). Therefore, the model of the scale was analyzed in terms of modification indices and residuals, and causal relationships between the data and model fit indices were evaluated (25). Modification indices and residuals can invalidate the whole model by affecting the coherence between the data and the model or the causal relationships among data (25). None of the variables were excluded from the model given the high values of modification indices that indicate the relationship between the variables and regression coefficients with the factors; additionally, none of the variables were higher than 2.8 according to the standardized residuals (24,25). Several covariances have been observed between the variables as most of the GFIs were also within the acceptance limits. The CFA was reapplied to the model of the scale, and results showed that the measurement model better matched the data after covariances (Table 3). In this context, the three-factor model of MGS is in accordance with the sample group and will be used without any change in the model of the scale as the item loads were not under .4, and the variables were subdivided into factors similar to those of the original scale model according to the EFA.

Criterion-related Validity

For the criterion-related validity, the Turkish PACIC was applied to the research group, and the correlation between the two scales was examined. According to the correlation coefficient (Pearson correlation) value, statistically significant positive correlations existed between the Turkish PACIC and MGS₂ of both adolescents ($r = 0.60$, $p < 0.01$) and parents ($r = 0.51$, $p < 0.01$).

Reliability of MGS

Internal consistency

For the Cronbach’s alpha internal consistency reliability coefficient, the values for MGS₁ and MGS₂ were .89 and .87 (adolescent) and .92 and .90 (parent), respectively. Table 4 lists the item-total score correlations and

Cronbach's alpha internal consistency coefficient values of the adolescent and parent scales and their sub-dimensions (management of the environment, provider characteristics, and process issues). The Cronbach's alpha coefficient of the sub-dimensions of adolescent and parental forms ranged between 0.70–0.89 and 0.80–0.92 respectively.

Reliability of the scale

The adolescent and parent MGS forms were reapplied to 44 adolescents and 56 parents, respectively, three weeks after the first implementation. The correlation coefficients (Pearson Correlation) between the scale scores obtained in the two implementations were calculated. The test–retest correlation coefficients for adolescent and parent scales were .88 and .85, respectively ($p < .05$). For the test–retest correlation coefficients, the values ranged between .45–.89 for adolescent MGS₁ and .51–.84 for MGS₂ ($p < .01$); for the parents, the values were between .36–.90 for MGS₁ and .56–.90 for MGS₂.

DISCUSSION

The MGS is a simple self-assessment scale designed to assess the health care satisfaction of adolescents with chronic conditions and their parents (8). In this study, the psychometric properties of the MGS in the Turkish sample were evaluated.

First, the scale was translated and back-translated from the original language into the target language to evaluate the language equivalence of the scale (26,27). Then, the scale items were examined by experts in terms of clarity and intelligibility for content validity. The scale assesses the individual care satisfaction in the transition period and was used in the adolescent and parent sample groups. The scale was considered as understandable and easy to apply.

The EFA was performed to examine the scarcely definable significant factors, which can be defined collectively by a large number of variables (26,27). The EFA of the adolescent scale resulted in a 22-item scale with 3 identified subscales that clarified 71% of the total variance, whereas that of the parent scale resulted in a 27-item scale with 3 identified subscales that clarified 73% of total variance (Table 1). The EFA results of Turkish MGS were similar to those of the original scale and proved the high structural validity of the Turkish MGS features. The variables were subdivided into factors similar to those of the original scale model according to the EFA (8). When we evaluated the factor loads of the items by principal components analysis and varimax orthogonal rotation technique, as expected, the item loads were higher than 0.30 (28).

The fitness of the model obtained by EFA was examined with GFI, and the results are shown in Table 2. The most commonly adopted ones are the resemblance rate (χ^2/df), RMSEA, GFI, and AGFI (29). Published reports indicated that values of χ^2/df ratio lower than 3.0 are considered as indicator of good fit, and those between 0 and 1 for RMR and below 0.05 for RMSEA are desirable (23,24,26,29). Our study showed the good fit indicated by the χ^2/df ratio (2.49) and GFI and AGFI. Although the GFIs were within acceptable fit limits, the other indices (CFI, IFI, TLI, RMR, and RMSEA) were beyond the acceptable ranges. Therefore, the model of the scale was analyzed in terms of modification indices and residuals, and causal relationships between the data and model fit indices were evaluated (25). None of the variables were excluded from the model given the high modification indices and regression coefficients of the factors; similarly, none of the variables were higher than 2.8 according to the standardized residuals (23–25). According to the results of the EFA, The item loads were not under .4, and the variables were subdivided into factors similar to the original scale model. Certain covariances have been observed between the variables as most of the GFIs were also within the acceptance limits. The CFA was reapplied to the model of the scale, and the results revealed that the measurement model better matched the data after determining the covariances (Table 3). The fit indices obtained in our study support the acceptability of the structural model of Turkish MGS.

The Turkish PACIC, which was developed with the same population and tested for validity and reliability, was performed to test the criterion validity. The correlation between the results of both scales was analyzed, showing a statistically positive significant relation at a level of 0.01 between the total scores of Turkish PACIC and MGS₂ scores of both adolescent and parents (Adolescents: $r = 0.60$, $p < 0.01$; Parents: $r = 0.51$, $p < 0.01$). Both scales showed satisfaction with the current care. In our study, the results showed that MGS₂ accurately assesses the current care satisfaction of the adolescents with diabetes and their parents in the period of transition.

The reliability of the scale was assessed by internal consistency using Cronbach's alpha and item-total correlations. The item-total score correlation coefficient should be higher than or equal to 0.30, and the items with a value lower than 0.30 should be excluded (24,27). High correlation coefficient values indicate the strong association of the scale items with the scale construct. The item-total score correlations of MGS₁, MGS₂, and their subscales were similar to those of the original scale and ranged between 0.36 and 0.83 (Table 4). In this context, a strong correlation exists between the items and the whole scale. Table 4 shows the Cronbach's alpha internal consistency reliability coefficient values of the whole scale and sub-dimensions (management of environment, provider characteristics, and process issues). The Cronbach's alpha values for the MGS₁ and MGS₂ totaled .89 and .87 (adolescents) and .92 and .90 (parents), respectively. The internal consistency of each sub-dimension was indicated by the Cronbach's alpha values ranging between 0.71 and 0.92. High Cronbach's alpha

coefficients indicate that the scale comprises consistent and balanced substances (17,22,24,26). The Cronbach's alpha of the original entire scale for adolescents and parents were 0.91 and 0.94, respectively. Based on these results, our study obtained alpha coefficient values similar to the findings of Shaw et al (8).

In conclusion, the "Mind the Gap Scale (MGS)" adapted to Turkish is a valid and reliable tool to assess the satisfaction and determine the health care expectations and needs of Turkish adolescents with diabetes and their parents.

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Table 1. EFA Results of Adolescent and Parent MGS₁ and MGS₂												
Dimensions and items	ADOLESCENT SCALE						PARENT SCALE					
	MGS ₁ (Best Care)			MGS ₂ (Current Care)			MGS ₁ (Best Care)			MGS ₂ (Current Care)		
	F1	F2	F3	F1	F2	F3	F1	F2	F3	F1	F2	F3
Management of Environment												
Has a physical environment that caters for my age group	.809			.894			.860			.885		
Provides opportunities for me to meet other young people with diabetes	.778			.865			.808			.831		
Displays relevant health-related information in waiting areas for me to read.	.746			.831			.738			.779		
Does not waste my time at clinic	.719			.816			.717			.730		
Provides appointments that are convenient for me (and my son/daughter)	.625			.701			.686			.671		
Provides opportunities for to meet other parents of young people with diabetes	NA			NA			.520			.504		
Provider Characteristics												
Allows me (my son/daughter) to decide who should be in the consultation/examination room		.868			.845			.764			.907	
Gives me (my son/daughter) opportunities to be seen in clinic alone (if I/they want to)		.894			.830			.755			.905	
Has staff who are very knowledgeable about arthritis and the latest treatments		.848			.810			.740			.872	
Has staff who know me (and my son/daughter) well		.843			.794			.739			.828	
Has staff who understand the realities of being a teenager		.708			.717			.698			.738	
Has staff who know who to talk and listen to teenagers		.696			.683			.690			.716	
Has staff who I can talk to about sensitive or difficult issues		.608			.680			.644			.702	
Treats me (and my son/daughter) as individuals and understand our specific		.605			.646			.624			.699	

needs												
Is interested in me (and my son/daughter) as a person and not just their diabetes		.605			.607			.584				.683
Provides me (my son/daughter) with honest explanations of my condition and treatment options		.512			.518			.567				.665
Allows my son/daughter) to make their own decisions about health-care options in their own time.		.503			.462			.531				.642
Gives me an opportunity to speak to health professionals alone about my needs as a parent		NA			NA			.511				.637
Provides me with honest explanations of my son/daughter's condition and treatment options including side-effects)		NA			NA			.490				.563
Has staff who understand the realities of being a parent of a teenager with diabetes		NA			NA			.465				.557
Process Issues												
Has a named member of staff who is responsible for co-ordinating my (son/daughter's) care			.694			.774			.830			.885
Provides me (and my son/daughter) with info about other people/organizations who can support me/us			.672			.739			.779			.847
Helps me (and my son/daughter) to plan for my/their future			.652			.702			.770			.748
Helps me (and my son/daughter) to prepare for my move to adult services			.646			.687			.741			.739
Provides information to other professionals involved in my (son/daughters) health care			.596			.635			.683			.647
Lets other people know how diabetes affects me (my son/daughter) (e.g., school teachers)			.588			.619			.518			.576
Helps me to support my son/daughters independence			NA			NA			.502			.478
Cronbach's Alpha Katsayıları	.89	.82	.82	.85	.87	.79	.86	.76	.83	.90	.81	.86
Described Variance	41.9 2	18.6 3	10.4 8	39.1 1	20.4 7	11.7 6	38.1 7	21.6 2	13.6 7	38. 61	19.8 7	14.90
Cumulative Variance	41.9 2	60.5 5	71.0 3	39.1 1	59.5 8	71.3 4	38.1 7	59.7 9	73.4 6	38. 61	58.4 8	73.38
Keiser-Meyer-Olkin (KMO)	.729						.787					

Table 2. Goodness-of-fit indices of the model

Goodness-of-fit Indices	Good Fit Level	Acceptable Fit Level	ADOLESCENT		PARENT	
			MGS ₁	MGS ₂	MGS ₁	MGS ₂
$\chi^2/d.f$	≤3.0	≤4.0–5.0	3.46	3.15	3.07	3.40
GFI (Goodness-of-fit index)	≥ .90	≥ .85	.94	.92	.95	.91
AGFI (Adjusted goodness-of-fit index)	≥ .90	≥ .85	.92	.89	.94	.89
NFI (Normed Fit Index)	≥ .95	≥ .90	.91	.88	.93	.88
RFI (Relative Goodness of Fit Index)	≥ .95	≥ .90	.89	.85	.92	.87
CFI (Comparative fit index)	≥ .97	≥ .95	.88	.89	.87	.85
IFI (Incremental fit index)	≥ .95	≥ .90	.88	.79	.87	.85
TLI (Tucker- Lewis Index)	≥ .95	≥ .90	.82	.72	.82	.81
RMR (Root Mean Square Residual Index)	0–1.0	0–1.0	.08	.37	.03	.34
RMSEA (The root mean squared error approximation)	≤.05	≤.06–.08	.15	.14	.11	.12

Table 3. Goodness-of-fit indices of the model after covariances between the items

Goodness-of-fit Indices	Good Fit Level	Acceptable Fit Level	ADOLESCENT		PARENT	
			MGS ₁	MGS ₂	MGS ₁	MGS ₂
$\chi^2/d.f$	≤3.0	≤4.0–5.0	1.06	2.37	1.27	3.26
GFI	≥ .90	≥ .85	.95	.93	.95	.94
AGFI (Adjusted goodness-of-fit index)	≥ .90	≥ .85	.93	.90	.91	.92
NFI (Normed Fit Index)	≥ .95	≥ .90	.96	.95	.91	.95
RFI (Relative Goodness of Fit Index)	≥ .95	≥ .90	.94	.94	.95	.94
CFI (Comparative fit index)	≥ .97	≥ .95	.91	.94	.93	.95
IFI (Incremental fit index)	≥ .95	≥ .90	.91	.94	.93	.95
TLI (Tucker- Lewis Index)	≥ .95	≥ .90	.92	.91	.90	.90
RMR (Root Mean Square Residual Index)	0–1.0	0–1.0	.08	.03	.04	.03
RMSEA (The root mean squared error approximation)	≤.05	≤.06–.08	.04	.06	.04	.05

Table 4. Item-Total Score Correlations and Cronbach's Alpha of MGS

Dimensions and items	Adolescent Item-Total Score Correlations				Parent Item Total Score Correlations			
	MGS	Alpha*	MGS	Alpha*	MGS	Alpha*	MGS	Alpha*
	1		2		1		2	
Management of Environment								
Has a physical environment that caters for my age group	.532	.898	.473	.864	.580	.921	.637	.908
Provides opportunities for me to meet other young people with diabetes	.621	.900	.467	.865	.629	.920	.449	.909
Displays relevant health-related information in waiting areas for me to read.	.644	.887	.540	.862	.690	.919	.400	.911
Does not waste my time at clinic	.447	.893	.638	.868	.517	.924	.474	.914
Provides appointments that are convenient for me (and my son/daughter)	.661	.889	.524	.872	.491	.922	.479	.910
Provides opportunities for to meet other parents of young people with arthritis	NA	NA	NA	NA	.366	.924	.466	.908
Cronbach Alpha	.71	-	.70	-	.80	-	.83	-
Staff Characteristics								
Allows me (my son/daughter) to decide who should be in the consultation/examination room	.465	.899	.460	.876	.523	.922	.455	.909
Gives me (my son/daughter) opportunities to be seen in clinic alone (if I/they want to)	.425	.894	.435	.873	.484	.925	.504	.906
Has staff who are very knowledgeable about arthritis and the latest treatments	.482	.892	.477	.872	.419	.924	.549	.905
Has staff who know me (and my son/daughter) well	.555	.891	.442	.865	.558	.923	.534	.905
Has staff who understand the realities of being a teenager	.510	.892	.534	.862	.503	.922	.674	.903
Has staff who know who to talk and listen to teenagers	.600	.891	.496	.864	.653	.921	.667	.903
Has staff who I can talk to about sensitive or difficult issues	.592	.889	.516	.863	.737	.920	.687	.902
Treats me (and my son/daughter) as individuals and understand our specific needs	.589	.890	.639	.859	.602	.921	.754	.901
Is interested in me (and my son/daughter) as a person and not just their diabetes	.612	.889	.542	.862	.438	.928	.662	.902
Provides me (my son/daughter) with honest explanations of my condition and treatment options	.706	.891	.402	.866	.629	.921	.431	.907
Allows my son/daughter) to make their own decisions about health-care options in their own time	.613	.891	.572	.861	.630	.920	.635	.903
Gives me an opportunity to speak to health professionals alone about my needs as a parent	NA	NA	NA	NA	.556	.922	.631	.903
Provides me with honest explanations of my son/daughter's condition and treatment options including side-effects)	NA	NA	NA	NA	.574	.922	.527	.905
Has staff who understand the realities of being a parent of a teenager with diabetes	NA	NA	NA	NA	.565	.922	.613	.903
Cronbach Alpha	.87	-	.89	-	.91	-	.87	-
Process Issues								
Has a named member of staff who is responsible for co-ordinating my (son/daughter's) care	.838	.882	.672	.857	.778	.919	.546	.905
Provides me (and my son/daughter) with info	.686	.886	.585	.860	.628	.920	.578	.904

about other people/organizations who can support me/us								
Helps me (and my son/daughter) to plan for my/their future	.642	.888	.635	.858	.632	.920	.521	.905
Helps me (and my son/daughter) to prepare for my move to adult services	.640	.884	.657	.851	.629	.917	.563	.902
Provides information to other professionals involved in my (son/daughters) health care	.600	.889	.594	.860	.630	.920	.406	.907
Lets other people know how diabetes affects me (my son/daughter) (e.g. school teachers)	.399	.898	.411	.866	.509	.922	.487	.906
Helps me to support my son/daughters independence	NA	NA	NA	NA	.648	.920	.695	.902
Cronbach Alpha	.89		.86		.90		.92	
Cronbach Alpha of the MGS	.89		.87		.92		.90	
* Cronbach's Alpha's when the item is deleted								

Uncorrected Proof