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Running head: INTEGRATED PRIMARY CARE PATIENT SATISFACTION

Integrated Primary Care: Development of a Patient Satisfaction Measure

by

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B.A., Stonehill College, 2014
M.S., Antioch University New England, 2017

DISSERTATION

Submitted in partial fulfillment for the degree of
Doctor of Psychology in the Department of Clinical Psychology
at Antioch University New England, 2019

Keene, New Hampshire



Department of Clinical Psychology

DISSERTATION COMMITTEE PAGE

The undersigned have examined the dissertation entitled:

**INTEGRATED PRIMARY CARE: DEVELOPMENT OF
A PATIENT SATISFACTION MEASURE**

presented on March 14, 2019

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Abstract

Primary care is often the first stop for individuals seeking services for a variety of behavioral health concerns including mental health and substance use disorders. However, many such patients are inadequately treated in these settings. Integrated primary care addresses this issue by adding a behavioral health provider to the primary care team to improve care and patient outcomes. A growing body of evidence suggests that increased integration of behavioral health and primary care yields a variety of significant outcomes including improved patient care, increased access to mental health treatment, and increased patient and provider satisfaction. When thinking about healthcare improvement and increasing patient outcomes, the patient perspective is an incredibly valuable factor to consider and utilize in assessment of healthcare delivery. As such, patient experience and satisfaction are important concepts to consider in the evaluation of integration implementation and success. No measure has been created to specifically assess patient satisfaction with integrated primary care. The current study aimed to develop such a measure through a qualitative approach with the use of semi-structured individual interviews with patients from two integrated primary care practices. Thematic analysis was used to identify themes across the data. The results yielded positive patient impressions of integrated primary care and suggested that the questionnaire could be a successful way to gather more information about patient satisfaction with the unique elements of integrated care. Implications, limitations, and future research suggestions are also explored.

Keywords: integrated primary care, behavioral health, patient experience and satisfaction

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Integrated Primary Care: Development of a Patient Satisfaction Measure

Establishing the Need for Behavioral Health Services in Primary Care

Behavioral health problems are ubiquitous in primary care settings. Behavioral health care includes the treatment of mental illness and substance use as well as health behavior change and other related needs (Peek & The National Integration Academy Council, 2013). The majority of medical needs that patients seek assistance for in primary care are not purely physical (Kroenke & Mangelsdorff, 1989). Approximately 75% of physical symptom complaints from patients in primary care facilities cannot be connected to a biological etiology or the result of a physical illness or disease (Blount, 2003; Hine, Howell, & Yonkers, 2008). Life stressors and behavioral health disorders can worsen the course of a patient's medical condition, and vice versa (Bluestein & Cubic, 2009). Behaviors that patients engage in (i.e., exercise routine, diet, medication compliance, social engagement or isolation, etc.) can have a profound impact on their health generally and their behavioral health.

The 2015 Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health indicated that a substantial number of individuals with mental health and/or substance use concerns do not receive treatment (Park-Lee, Lipari, Hedden, Copello, & Kroutil, 2016). Out of adults aged 18 or older who received treatment for substance use, an estimated 15.4% received specialty treatment while 26.6% received treatment in non-specialty settings and 49.6% received treatment in both specialty and non-specialty facilities. Only about 43.1% of adults with mental illness-related needs received treatment in the year prior and of those with co-occurring mental illness and substance use disorders, around half of them did not receive treatment for either mental health or substance use (Park-Lee et al., 2016).

Individuals who are suffering from mental health concerns and substance abuse problems are much more likely to end up seeking services in general medical practices than specialty mental health treatment centers, and many patients will not follow through on referral to an outside provider (Regier et al., 1993). Many individuals suffering from such issues who seek out services in primary care are not receiving the diagnosis or treatment they need. Despite an increase in treatment of mental health problems in primary care, many of these issues continue to go undetected and/or untreated in most general medical environments (Kessler et al., 2005; Wang, Berglund, & Kessler, 2000). Young, Klap, Sherbourne, and Wells (2001) examined the quality of care in primary care for depressive and anxiety disorders, and found that upwards to 80% of patients received either inappropriate care or no care at all. Mechanic (2014) discussed the fact that many individuals suffering from a range of mental health disorders are initially identified and treated in non-specialty mental health arenas, most predominantly primary care, but that despite this, treatment is still lacking. Much of the treatment for mental health occurring in primary care is characterized by prescription of psychiatric medication without appropriate or effective follow-up or co-occurring psychotherapeutic options (Mechanic, 2014). Patients also rarely engage in behavior change based solely on their medical provider's suggestion, making efficacious behavioral intervention necessary to treat those for whom behavioral change would be appropriate (Blount, 2003).

A solution to the need for more adequate management of behavioral health issues in primary care is integrating behavioral health services into existing primary care practice. The goal of integration is not to replace specialty mental health practice but to improve the functioning of behavioral healthcare delivery in primary care, leading to an overall improvement in the ability to meet the needs of the larger population (Robinson & Reiter, 2016). The

development of the biopsychosocial model and the ever-growing realization of behavioral and emotional issues and their role in health provide a basis for integrating behavioral health treatment into primary care (Engel, 1997). The unique collaboration among team members in integrated practice allows for a comprehensive, biopsychosocial conceptualization of each patient (Blount & Bayona, 1994). As Blount and Bayona stated, “The biopsychosocial model with its emphasis on understanding a patient in his or her context provides a conceptual basis for integrating the biomedical and psychosocial primary care of patients into one service” (p. 171).

Integrated Care

The Agency for Healthcare Research and Quality (AHRQ) defines integrated care as:

The care that results from a practice team of primary care and behavioral health provider, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization. (Peek & The National Integration Academy Council, 2013, p. 2)

Two common models of integration exist. The Collaborative Care Model is an evidence-based model for integrating services which includes a primary care provider, care management staff, and a psychiatric consultant—all of whom make up the care team (Unützer, Harbin, Schoenbaum, & Druss, 2013). The team works together to monitor and track each patient’s progress for various diagnostic presentations, and then collaboratively intervene to systematically adjust to patient specific needs when their health is not evidencing expected improvements. Brief, evidenced-based behavioral interventions are often enough to address the

challenges encountered, but the team in this model is also prepared to refer patients in need of more specialty mental health treatment to appropriate community resources when needed (Unützer et al., 2013).

Primary care behavioral health (PCBH) is another common model of integrated care (Robinson & Reiter, 2016). PCBH integrates primary care medical and mental health services by adding a behavioral health provider, often a psychologist or other mental health professional, to the primary care team (Robinson & Reiter, 2016; Strosahl, 1998). The behavioral health provider serves as a consultant to the primary care provider about psychosocial concerns regarding their patients in addition to providing direct patient intervention (Robinson & Reiter, 2016).

Behavioral health sessions in primary care are typically shorter than those of specialty mental health care (15–30 minutes long as opposed to 45–50 minutes long; Robinson & Reiter, 2016; Strosahl, 1998). While specialty mental health treatment goals are focused more on specific diagnosis and long-term therapeutic intervention for symptom reduction, PCBH mental health interventions emphasize increasing a patient's functioning with brief intervention strategies (Robinson & Reiter, 2016). Unique goals of PCBH include (a) managing at-risk patients and delivering interventions, (b) educating primary care providers about mental health issues and appropriate treatments, and (c) identifying patients in need of specialty care (Strosahl, 1998).

While the evidence for the PCBH model is a challenge to collect because the model is focused on improving the behavioral health services in the practice as a whole rather than on a specific diagnosis, most efforts support the experiences of health team members and that patients' lives are improved substantially (Hunter et al., 2018). Hunter et al. reviewed the available literature focused on PCBH implementation which focused on clinical outcomes, ethical considerations, cost, and workforce development. They argued for continued focus in this

area to improve understanding and use of the PCBH model.

Integrated care is efficacious. Research has shown that integrated care is efficacious for many common behavioral health difficulties seen in primary care such as depression, anxiety, management of chronic illness, and substance abuse. A randomized trial by Katon et al. (1999) assigned primary care patients with a depression diagnosis to a treatment-as-usual group and an intervention group that included collaborative care from a psychiatrist working with their physician. The results showed that patients in the intervention group engaged in greater adherence to medication, experienced a reduction in their symptoms of depression, and had an increased likelihood of full recovery compared to the control group (Katon et al., 1999). A study of integrated primary care for patients who had both depression and either diabetes and/or cardiovascular disease found that the collaborative care that included brief psychological treatment helped to improve patient self-management of their chronic condition as well as reduce their depressive symptoms (Coventry et al., 2015). Similar results have been found for generalized anxiety, panic disorder, PTSD, social anxiety, sleep disturbance, bereavement, and coping with medical illness (Barber, Frantsve, Capelli, & Sanders, 2011; Roy-Byrne et al., 2010).

Integration of screening, brief intervention, and chronic disease management approaches to the treatment of substance use disorders in medical care settings has proven to be efficacious (Walley, Tetrault, & Friedmann, 2012). Weisner, Mertens, Parthasarathy, Moore, and Lu (2001) conducted a study examining the effects of integrated primary medical care and substance abuse treatment. They found that individuals with substance abuse-related medical conditions exhibited higher rates of abstinence and maintained abstinence for longer periods of time when randomly assigned to the integrated care treatment group as opposed to treatment as usual, where medical

care and substance abuse intervention were provided separately (Weisner et al., 2001).

Measurement of Integrated Care Has Focused on Level of Integration

Given the evidence that behavioral health integration is more effective in caring for mental health, substance abuse, and health behavior change needs than primary care as usual, measuring such integration has been an important area of research and clinical practice. Dane and Schneider (1998) discussed the importance of measuring program fidelity for a variety of reasons. They explained how understanding fidelity is imperative to know whether undesired effects of a given program or intervention are due to the conceptualized elements of the program itself or poor delivery of the program or omission of particular components. Gathering information about fidelity allows more accurate interpretation of efficacy outcomes and related implications for practice. If any adjustments or modifications are to be made to specific elements of the program under consideration, the effects of such changes cannot be adequately assessed without initial data supporting overall program fidelity (Dane & Schneider, 1998). Evaluating level of integration can be an effective way of measuring fidelity, and the existing literature on integrated care is heavily focused on examining practices' level of current integration efforts.

In the efforts of further defining integration-level differentiations for national comparison, the SAMSHA–HRSA Center for Integrated Health Solutions proposed a framework, called *A Standard Framework for Levels of Integrated Healthcare* (Heath, Wise Romero, & Reynolds, 2013). The purpose was to aid in classification of particular sites based on varying levels of integration in order to facilitate both discussion and formal research on the topic (Heath et al., 2013). The framework lists examples of different levels of integration and has six levels that differentiate between coordinated, co-located, and integrated care (Blount, 2003) which practices can use as a guide for their own understanding of their site's degree of

integration (Heath et al., 2013). This research also led to the development of The Integrated Practice Assessment Tool—an instrument to help assess integration at the practice level more specifically based on this framework (Waxmonsky, Auxier, Romero, & Heath, 2014).

The current studies on measurement of integrated care have resulted in a number of other tools that clinics can use to evaluate their implementation of integrated care. In fact, the AHRQ even developed the Atlas of Integrated Behavioral Health Care Quality Measures in order to provide a comprehensive list of the available measures for evaluating integrated care initiatives, the majority of which focus primarily on measuring level of integration (Korsen et al., 2013). For example, the Integration Self-Assessment Checklist is a tool designed to help practices learn about their integration efforts at all stages of implementation and is based on the AHRQ Lexicon for Behavioral Health and Primary Care Integration which consists of definitions and concepts related to integrated care. This checklist is helpful for eliciting discussion among organization team members about the current progress of their integrated practice as well as help to identify areas of care that may need improvement. The Behavioral Health Integration Checklist is another tool allowing practices to highlight which areas of integrated care may need to be improved upon or developed further as well as which they already effectively have in place (Korsen et al., 2013).

Additional research focusing on level of integration includes Fauth and Tremblay's (2011) exploration of the departure from model fidelity that often occurs when integrated care programs are put into actual practice in clinical settings. Their project proposed a practice-based participatory research framework that engages practice stakeholders in quality improvement efforts and highlighted the importance of identifying and assessing the degree of specific integration efforts. This work led to the development of The Level of Integration Measure (LIM), which is completed by providers and/or staff at sites to determine how integrated their practice

is. It consists of 35 items answered on a 4-point Likert type scale which result in scores that suggest varying degrees of integration (Fauth & Tremblay, 2011).

The Maine Health Access Foundation's Integration Initiative outlined an evaluation plan that is another great example of the focus on level of integration in the current research (Scheirer, Leonard, Ronan, & Boober, 2010). In the efforts of providing continuous feedback regarding implementation of integration services, the Site Self Assessment Instrument (SSA) was developed. This tool allows for measuring progress of integration efforts as well as eliciting reflection and discussion on the implementation process and necessary future changes to ensure successful integrated care delivery. The measure was created to be completed by staff at sites regarding their current integration practices to show grantees who may be evaluating the practice the extent of the site's implementation progress towards integrated care (Scheirer et al., 2010).

While the existing literature on measuring integrated primary care has centered largely on assessing the degree to which integration is occurring within a given setting, such research has not been consistently guided by specific theory nor psychometrically validated (Macchi et al., 2016). To address this gap, The Practice Integration Profile (PIP) was developed. This is a validated, 30-item measure developed by examining the existing AHRQ Lexicon for integrated care and creating various domains and questions that correspond to the key elements in the Lexicon (Kessler et al., 2016; Macchi et al., 2016). Practices complete the measure and receive an overall score indicating level of integration as well as a score in each of the domains (Macchi et al., 2016). These domains are (a) workflow, (b) clinical services, (c) workspace, (d) shared care and integration, (e) case identification, and (f) patient engagement (Macchi et al., 2016). Prior to the creation of this measure, none of the existing checklists that assessed integration efforts fully captured all of the key aspects of the established Lexicon or offered a final score

corresponding to a level of integration that enables comparisons to be made across practices (Macchi et al., 2016). Previous measurement tools shared little commonality among measured constructs pertinent to integration and there were no established psychometrics for these measures (Macchi et al., 2016). The PIP has been found to be a valid measure to assess the integration level of various practices, specifically to help differentiate between practices that have different levels of integration (Kessler et al., 2016). It is the first supported measure of its kind created to directly assess the level of integration of behavioral health in specific primary care clinics and, as such, has the potential to support specific integration efforts of individual practices as well as larger integration developments (Kessler et al., 2016).

Measurement of Patient Experience Has Been Successful and Useful

Patient satisfaction is an important construct. While it is clear that evaluating integration efforts is important for understanding and improving integrated primary care, information about patient experience of care is also essential for evaluating success of health care initiatives. Developed by the Institute for Healthcare Improvement as a framework for enhancing the performance of health systems, the Triple Aim focuses on improving the patient experience of care in terms of quality of care delivery and satisfaction, improving the health outcomes of populations by focusing on all determinants of health, and reducing costs of quality health care (Institute for Healthcare Improvement [IHI], n.d.). Therefore, focusing on patient satisfaction as its own unique construct is important for understanding ways in which healthcare delivery can be improved upon (IHI, n.d.). There are many different aspects of patient satisfaction with care, and Shikiar and Rentz (2004) suggested a hierarchical model with three levels which are (a) Satisfaction with Health Delivery System (access issues, interactions with physicians, perception of staff, and facility quality); (b) Treatment Satisfaction (specific interventions or services); and

(c) Satisfaction with Medication (related to side effects, efficacy for their symptoms, etc.).

Cleary and McNeil (1988) stated that measuring patient satisfaction is important not only for marketing purposes but also for monitoring quality of care. In a review on the relationship between patient experience and various health care quality measures in both outpatient and inpatient hospital settings, Anhang Price et al. (2014) found that better patient experience was associated with better clinical outcomes, greater adherence, increased safety of patients in hospital settings, and less utilization of health care services. Additional reviews of patient experience, including the construct of patient satisfaction, have demonstrated similar results in primary and secondary care settings (Doyle, Lennox, & Bell, 2013). Other research within various clinical settings has also suggested a relationship among aspects of patient satisfaction and medical adherence (Hirsh, 2004; Sherbourne, Hays, Ordway, DiMatteo, & Kravitz, 1992) and patient satisfaction and clinical outcomes and health status (Alazri & Neal, 2003; Hall, Millburn, Roter, & Daltroy, 1998; Press Ganey, 2011). The evidence clearly supports the utility of the measurement of patient-reported outcomes and, specifically, patient satisfaction. This construct continues to grow as an important focus of healthcare research and evaluation of various medical interventions and services (Speight, 2005).

Patient satisfaction in primary care. Measuring patient satisfaction and experience in primary care, specifically via patient self-report, provides a unique opportunity for learning about what is important to the planning and implementation of future of healthcare delivery in primary care (Sebo, Herrmann, Bovier, & Haller, 2015). The research on assessing patient satisfaction in primary care settings is extensive and varied (Kringos, Boerma, Hutchinson, van der Zee, & Groenewegen, 2010; Pascoe, 1983; Sans-Corrales et al., 2006; van Campen, Sixma, Friele, Kerssens, & Peters, 1995). Press Ganey released a report in 2011 that comprehensively analyzed

and discussed recent trends from patient satisfaction survey findings. The report stated that patient ratings of satisfaction with care in outpatient medical settings, such as family medicine, have been more favorable as time goes on, and patient satisfaction remains a top priority in evaluation, specifically as it relates to provider communication and engaging patients in their care (Press Ganey, 2011). Providers and clinic staff can use what is learned from completed measures of patient satisfaction to better inform and improve specific elements of the primary care endeavor, such as communication to patients about preventative care recommendations and offering instructions for follow-up care (Drain, 2001; Hojat et al., 2011). Research has shown that measurement of patient satisfaction in primary care can also provide valuable information about what is uniquely important to primary care patients themselves, which can help in consideration of areas for more targeted and relevant improvement of care (Day et al., 2013; Glasgow et al., 2005).

Measures of patient satisfaction in primary care fall into two categories: (a) indirect measures which comprise questions that ask about patient satisfaction with healthcare and medical services on a more macro, global level; and (b) direct measures which ask about a patient's experience with actual care they have received (Pascoe, 1983). Pascoe's literature review on measuring patient satisfaction in primary care suggested that direct satisfaction measures are more appropriate for assessing patients' degree of satisfaction with services they actually receive as opposed to assessing their overall satisfaction with the world of healthcare delivery in general. Cleary and McNeil (1988) also specifically recommended that in order to use patient satisfaction as a measure of quality of care, direct, specific measurement should be the favored approach.

Direct micro-measures of patient satisfaction in primary care have focused on a variety of different elements of care, such as (a) satisfaction with one's provider, (b) nonmedical attributes of a practice such as convenience and appearance, additional services provided, continuity of care, and more (Pascoe, 1983). Research on this topic has also examined specific patient characteristics as they relate to overall levels of patient satisfaction in primary care (i.e., age, race, gender, social class, etc.; Cleary & McNeil, 1988; Drain, 2001). There are a number of approaches to measuring patient satisfaction in primary care on the micro level in the existing literature. Many researchers have used Likert scale questionnaires (Fan, Burman, McDonell, & Fihn, 2005; Grogan, Conner, Willits, & Norman, 1995; Sebo et al., 2015) while others have used a variety of formats of patient satisfaction surveys, such as paper forms or responses to survey questions via telephone (Press Ganey, 2011; Roblin, Becker, Adams, Howard, & Roberts, 2004).

The foregoing literature establishes the importance of focusing on patient satisfaction in the overall primary care endeavor. Direct patient input in regard to their level of satisfaction with their care can be a useful avenue for gathering information relevant to improvement of clinical practice in primary care settings in a variety of different domains. The existing research highlights a number of unique characteristics of effective patient satisfaction measures. Focusing on direct, micro-measurement of patients' actual care that they have received leads to rich information that can be applied to specific clinical initiatives at the practice level. Likert scales in particular appear to be a useful approach to assessing patients' varying subjective degrees of satisfaction with different areas of care. Considering the ways that patient satisfaction has been measured in primary care provides an empirical foundation for considering the measurement of patient satisfaction with integrated primary care.

Measures of Patient Experience of Integrated Primary Care Are Lacking

A number of studies have assessed the patient perspective in integrated care or other similar (chronic care) environments (Blount, 2003; Glasgow et al., 2005). Patient perceptions of integrated care have included many favorable opinions and positive responses to integration services. Results have shown that patients feel they learn skills and strategies to assist with management of behavioral health difficulties, experiencing enhancement in quality of life, increased likelihood of following-through on referrals outside their clinic, and experiencing less stigma and increased comfort by being treated in primary care (Chomienne et al., 2010; Drainoni et al., 2014; Ede et al., 2015).

Turgesen (2010) explored patient perspectives of an integrated care program at two different primary care settings using questionnaires, surveys, and rating scales. Patients in this study completed the Patient Satisfaction Survey which assessed patients' experience of their direct interactions with their integrated primary care behavioral health provider (Turgesen, 2010). While this measure focuses on important areas of experience of behavioral health care, it fails to address other essential components of integration such as clinic workflow, communication between providers, and screening and referral processes.

Drainoni et al. (2014) conducted a mixed-methods study with patients receiving integrated primary care treatment for substance misuse. The authors conducted interviews with patients and asked them to complete a Patient Satisfaction Survey associated with the particular substance abuse treatment program offered. Results showed that patients believed the integrated services were more convenient, effective, and efficient than medical or specialty substance-use treatment alone. The interviews and survey results yielded useful data for evaluating impacts of the program and patient experience of care. However, this study focused solely on the delivery of

substance use services within integrated primary care rather than the full array of comprehensive behavioral health services offered within an integrated primary care practice.

Singer, Friedberg, Kiang, Dunn, and Kuhn (2013) developed an instrument called the Patient Perceptions of Integrated Care survey designed to assess the integration of care from the patient's experience. Through consultation with a panel of experts and testing with patients, the authors developed a conceptual model for integrated care and came up with various domains of questions to assess such care from the patient perspective. The resulting instrument was then piloted among various primary care clinics and underwent additional refinement. The results of the piloting indicated that while patients tended to report well-integrated care, certain areas of integration were also noted as needing improvement, such as communication of providers and coordination of resources. The authors suggest that measuring integrated care in this way, from the patient's perspective, provides opportunities for learning about ways to enhance care and information regarding certain patient characteristics that might influence their experience of such care and outcomes (Singer et al., 2013). As Singer et al. explained, this was the first measure of its kind to focus comprehensively on integration; however, it focused on patients receiving care for multiple chronic conditions, not the integration of behavioral health services into primary care. The process of using the input from experts and initial piloting with patients is a useful guide for creating a questionnaire more targeted towards integration of behavioral health and primary care.

Assessing patient satisfaction within the integrated primary care environment can yield clinically useful information to help aid care-improvement efforts. While measures that aim to do this are lacking, the ones currently in existence provide insight into important considerations regarding this type of measurement. For example, focusing measurement on domains specific to

integrated care characteristics can provide feedback about explicit aspects of care delivery within a particular practice. Consulting with experts in the field, as well as input garnered during interviews with patients themselves, can offer valuable information in understanding the construct of patient satisfaction in the realm of integrated primary care.

Leveraging the Wisdom of Patients to Develop a Patient-Experience Measure

Measuring patient experience and satisfaction with integrated care is an important and useful way to learn what is important to them and how care can be improved at the practice level. This is information that cannot be gathered solely from measuring integration via practice provider and staff report. Extant studies have used a combination of quantitative and qualitative data to assess the patient's perspective of integrated care. However, no measure up to this point has been created to directly and comprehensively assess patient experience and satisfaction specifically with integrated primary care. Such a measure would be helpful in comprehensively assessing and improving delivery of integrated primary care. The purpose of this study was to create a measure of patient satisfaction that assesses patient's experience with integrated primary care. Use of one of the already established measures for integration, the PIP, as a baseline, allowed for measurement of domains particularly relevant to integrated primary care. While collecting input on patient satisfaction about their practice, information was also learned about what is important to patients about integration. The specific research questions were:

1. Which domains of integrated primary care are most important to patients?
2. How satisfied are patients with the care they receive within each of these domains?

Method

Research Paradigm and Qualitative Method Strategy

This qualitative study investigating patient satisfaction with integrated primary care followed a pragmatic research paradigm. The pragmatic paradigm asserts that it is important to understand the multiple subjective realities experienced by individuals within an objective reality, and the research process often emphasizes interacting directly with individuals experiencing a particular phenomenon (Mertens, 2015). The qualitative methods of data collection and analysis in each phase of the study were used to gather information from patients that helped in the creation and refinement of a patient satisfaction questionnaire for integrated primary care. The questionnaire was titled: IPC Patient Satisfaction Questionnaire.

Qualitative Design

The current study used a phenomenological qualitative design to capture the essence of patients' experience and better understand patient satisfaction in integrated primary care and create a tool to measure this unique construct. Phenomenological research strives to understand the subjective experiences or perceptions of individuals of the phenomenon under consideration (Mertens, 2015). A report by the American Institutes for Research (AIR) highlighted several principles important to developing patient-centered measures in assessing quality of healthcare (AIR, 2017). The report identified the importance of patients being "equal partners in measure development and decision-making about how data is collected, reported, and used" (AIR, 2017, p. 6). This report also suggested that "patients' needs, goals, perspectives, and values—as expressed by patients themselves—inform decisions about what we measure, how we assess health outcomes for individuals, groups of patients, communities, and populations and how we evaluate health care performance" (p. 3).

The North American Primary Care Research Group (NAPCRG) also advocates for the inclusion of patient perspective early on in the research process and has summarized the literature highlighting this importance (Sand et al., 2017). They present evidence supporting the necessity of patient voice due to potentially differing understanding of medical or healthcare-related constructs and values about care that might differ among patients and providers (Sand et al., 2017). The current study used a sequence of two phases of semi-structured interviews allowing for focus on the patient voice.

In the first phase, qualitative data was gathered to explore how patients view the integrated care they are receiving and how they might assess their level of satisfaction with different aspects of their care. This information was then used to design a measure of patient satisfaction that captured all relevant domains that patients receiving integrated primary care were able to conceptualize and speak to. The measure asked patients about their satisfaction with such domains as well as an additional element asking about how important such areas of care are to them. The second phase aimed to elicit the patient voice in regards to the degree of readability, comprehensiveness, and ease of completion of the IPC Patient Satisfaction Questionnaire from their perspective.

This two-step qualitative approach has been used by other researchers also aiming to develop similar measures of patient satisfaction and experience of care (Wong et al., 2013). Wong et al. conducted a study in which they utilized both focus groups and individual interviews to utilize patient input in developing a questionnaire assessing patient experience of inpatient care. While the current study utilized individual interviews in both phases of data collection instead of focus groups, it followed this same progression of including patient input throughout the measure development process.

Participants

The target population for the interviews was adult primary care patients receiving integrated care services at two primary care clinics. The desired number of participants for each phase of interviews was between five and seven participants, accounting for between 10 and 14 participants overall. In the end, 11 patients in total participated in the study, five patients in the first phase and six patients in the second phase.

Study recruitment focused on patients with at least some exposure to behavioral health services as part of their primary care experience in the two aforementioned clinics. This included either (a) having an appointment with a behavioral health provider, (b) meeting a behavioral health specialist in one or more of their primary care appointments, and/or (c) being screened or treated for behavioral health concerns. Exclusion criteria included cognitive impairment or severe mental illness that could have made answering the interview questions particularly difficult or potentially burdensome for patients. The recruitment strategy included asking providers at each clinic to invite their patients to meet with me to discuss the study while patients were already at their primary care clinic for a visit. The AHRQ website discusses challenges with various strategies used in recruiting participants for human subjects research and noted that having someone introduce the study who already has a relationship with individuals, such as providers inviting their own patients, can be an especially useful approach to recruitment (AHRQ, n.d.).

Providers at the clinics were given a recruitment letter (see Appendix A) and were asked to provide patients with a flyer describing the purpose of the study (see Appendix B). Providers were asked to explicitly assure these individuals that participation in the study is completely voluntary and that their decision whether or not to do so will in no way affect the care they are

receiving at the clinic. This recruitment of participants occurred when patients were in the clinic for visits with their primary care providers, allowing for same-day participation and placing fewer burdens on participants. Patients were introduced to me to further discuss whether or not they were interested in participating. I was in the clinic to conduct the interview upon completion of informed consent (see Appendix C). Participants were made aware that their participation is not mandatory and that they could take a break or withdraw at any time. The informed consent process included discussion of the risks of harm via participation in this study, which were made explicitly clear so that individuals could make informed decisions about whether or not to participate. Because of the potentially sensitive nature of some of the material that participants could have discussed in the interviews, the study carried some risks that participants were made aware of. Thinking about and discussing with another individual certain aspects of their care related to behavioral health concerns could have had the potential to cause emotional distress for some participants. While no participant was explicitly asked to state what specific behavioral health concern they may have received care for in their clinic, discussing this topic even in general could have brought up painful memories or feelings for participants in the moment, depending on their individual circumstances. It was also possible that individuals who have had any negative experiences at their clinic could have experienced emotional distress while discussing these events.

Participants were also made aware of the potential benefits from this research. Participants could have benefited from talking about the care they received and how that has been helpful for them and their lives. If individuals had positive experiences in the clinic, it would likely feel good talking about those positive experiences, such as a good relationship with their provider or positive outcomes of their care. While it was not guaranteed that anyone would

personally experience benefits from participating in this study, there were numerous potential benefits of this study at large. The results from the study would lead to the creation of a patient satisfaction measure of integrated primary care that can be used to gather relevant, important information for staff and providers across primary care clinics about their patients' experience of their care. Providers from the two clinics where patient participants were recruited would be provided with a brief summary of results from the interviews to inform them of any feedback that may be of interest to their clinic and potential areas for improvement of services. The results from this study will also add to the larger body of research in the field related to patient satisfaction with integrated primary care services. At both levels, this information has the potential to lead to better-informed care and subsequently, improved patient outcomes.

To help avoid harm or drop-outs after the detailed informed-consent process, it was important for me to be aware of the potential sensitivity of the information being discussed and to adjust the process when necessary throughout the actual interviews. A small monetary reward was offered to increase willingness to participate in the study, but it was not so large so as to create undue pressure. A raffle for a \$25 Visa gift card was held for each phase of participants to incentivize participation. Participants were made aware that if they dropped out during any phase of the study they would still be entered in the raffle.

Confidentiality and security were maintained in a number of ways throughout the completion of this study. Numerical code identifiers were assigned to each individual participant to be used on all research notes, audio files, and documents. Informed consent forms were kept separate from coded ID numbers to further ensure identity protection of participants. A password was required to access any electronic raw data collected from the interviews as well as documents pertaining to analysis, and all audio files were destroyed upon completion of this

study. Any handwritten notes from either of the rounds of interviews were kept in a locked file cabinet in my personal possession. While some direct quotes from the interviews have been used in the research and publication of this study, such quotes have remained completely anonymous and the statements included do not contain any information that could potentially identify any individual participant.

Interview Protocol

Two phases of interviews were conducted, each phase occurring three months apart. I conducted these interviews personally and they occurred at the two primary care facilities from which patients were recruited. The interviews followed a semi-structured interview protocol that allowed for follow-up or clarification based on the responses of participants.

In the first phase, participants were asked a number of questions pertaining to their experience with integrated primary care in their practice. This aimed to allow the emergence of the patient voice at the very beginning of measure development in order to better understand the unique patient experience of integrated care. The development of the interview questions was guided by PIP domains, addressing issues relevant to the unique construct of patient experience and what patients themselves would likely be able to speak to in regards to their satisfaction with integrated primary care. If the domains included on the PIP are used to measure integration, it is also important to know how satisfied patients are with all these areas. An additional question asked participants to discuss any aspects of their care or experience that were not already addressed by the previous questions. Appendix D provides a list of the PIP domains and the corresponding questions. Participants were made aware that the topics covered by the questions were based on the individual domains of the PIP and they were asked to rank each of the topics discussed on a scale from highest level of importance to lowest level of importance in terms of

their care. This allowed for further focus on what was important to patients in the development of the IPC Patient Satisfaction Questionnaire. The interviews were audio-recorded for future analysis.

A draft of the IPC Patient Satisfaction Questionnaire was developed based on the first round of interviews. This draft was shared with patients in a second round of interviews to examine the feasibility and understandability of the measure. Participants were presented with the draft, asked to complete it, and then asked about the perceived ease of use of the questionnaire, readability of the items, comprehensiveness of the content, and any additional impressions of the measure. Participants in this phase were also informed of the PIP domains and associated elements of care and asked if they felt the items seemed to cover these elements from their perspective. Participants were asked if there were any aspects of their care or experience that they did not feel were included in the IPC Patient Satisfaction Questionnaire. Appendix E provides a list of specific questions that were utilized in this second round of interviews. These interviews were also audio recorded to allow for future analysis.

Analysis

This study used thematic analysis for data gathered in the two phases of interviews. Thematic analysis is a widely used qualitative approach for analyzing data that allows for identifying and reporting patterns and themes across data sets that results in a rich description of the data as it relates to the research question or topic (Braun & Clarke, 2006).

There are five phases of this process of analysis. In the first phase, I became familiar with the data that was transcribed from the audio recordings into written format. This included reading through the data several times and making note of early ideas about what is included in the data and anything that was of particular interest.

In the second phase, I generated an initial set of codes across the entirety of the data set. These codes referred to basic elements of the raw data that identified what I considered to be interesting or important features of the data set based on the research topic (Braun & Clarke, 2006). Specific data extracts, taken from the transcripts, pertaining to each code were organized so that all the raw data were grouped within relevant codes (Braun & Clarke, 2006).

The next phase is characterized by searching for broader themes across the data. This included analyzing the developed codes and combining any codes (and associated data extracts) that fit together to create a larger, overarching theme (Braun & Clarke, 2006). While the coding process entails organizing data into meaningful groupings, the interpretive analysis of the data occurred at the level of these broader themes. It is possible for codes that do not seem to fit in any particular larger theme category to be grouped on their own as miscellaneous (Braun & Clarke, 2006).

In the fourth phase, I reviewed and refined the identified themes, some of which were discarded, combined with others, or further separated into additional distinct themes. Braun and Clarke (2006) explained that important things to consider in this phase are (a) whether generated themes are supported by enough data to remain significant, (b) whether certain themes are particularly similar and can be joined together into a more encompassing theme, or (c) if a theme contains too much data or data that is too diverse and potentially needs to be broken down further. Themes are assessed based on additional review of the relation and fit of the coded data extracts within each of those themes, examining whether all the coded extracts within particular themes form a pattern of some sort, and allow for revision of themes or reorganization of coded data extracts if necessary (Braun & Clarke, 2006). The themes themselves are then considered as they relate to the overall data set, in order to assess whether they seem to portray an “accurate

representation” of what the data presents (Braun & Clarke, 2006, p. 91). This process entailed re-reading the data set to ensure that the thematic map I developed seemed to accurately reflect the meanings from the data set as a whole, as much as possible. This also required further revision of both themes and individual codes whenever the final thematic map created did not seem to sufficiently reflect the larger data set. Continuous theme refinement and additional coding are ongoing processes throughout thematic analysis (Braun & Clarke, 2006).

At this point, final refinement of themes occurred, which involved defining or naming individual themes and identifying any potential sub-themes within each larger theme. Braun and Clarke (2006) described this process as “identifying the ‘essence’ of what each theme is about (as well as the themes overall), and determining what aspect of the data each theme captures.” (p. 92). Within thematic analysis, the final analysis and subsequent report produced are intended to tell a concise, interesting, and understandable story based on what the data revealed—one that is not only descriptive in nature but also serves to provide an argument or informative message concerning the research question(s) under consideration (Braun & Clarke, 2006).

I wanted to maintain the essence of each individual’s experience as much as possible, so I limited the number of respondents necessary to create a theme. While most of the main themes and subthemes presented incorporate the data from all of the patient interviews, some subthemes in particular will only represent the data from two or three interviews. This offered the opportunity to maintain more personalized data points that provide valuable information but that might have otherwise been consolidated in the analysis process. Throughout the analysis process, I also kept notes about parts of the process that were particularly interesting or surprising to me, and used the process of bracketing to make memos of any of my own biases that arose. Additionally, I consulted an external auditor to confirm that the themes and cluster effectively

represented my data. This auditor reviewed the data analysis, which included all of the main themes, subthemes, and associated data extracts, and they provided both written and verbal feedback to ensure I remained true to the raw data as much as possible.

The analysis of the data from the first round of interviews was used to better understand how patients understand and consider the domains from the PIP relevant to their experience of care and ultimately support the inclusion of individual questions on the IPC Patient Satisfaction Questionnaire. The analysis from the second round of interviews informed specific wording of individual items on the IPC Patient Satisfaction Questionnaire as well as potential items to be modified or removed. This helped to better ensure patient comprehension and relevance of the questionnaire content.

Procedure

The first step involved having either primary care or behavioral health providers at the two identified primary care clinics recruit individual patients to participate in this study. Both phases of interviewing followed the same recruitment process outlined previously. The second phase of interviews occurred three months after the first round of interviews. This timeline was necessary to ensure for sufficient data analysis, drafting, and revision of the initial version of the questionnaire. All individual interviews were audio-recorded and I took notes throughout the interviews for review.

Preliminary data from the first round of interviews underwent a brief review, including any patient feedback about the process to ensure that any implementation issues were addressed before the next phase. The audio recordings of the first round of interviews were transcribed following the completion of all interviews in phase one. Data from these interviews were then analyzed according to the thematic analysis process outlined above, and initial questionnaire

items were developed based on the results. The audio recordings of the second round of interviews were also transcribed after their completion and the data was analyzed following the same thematic analysis process. Items on the IPC Patient Satisfaction Questionnaire were further revised and refined based on the results of this analysis. The draft of the questionnaire also underwent a brief review by my dissertation committee members and the original PIP team to allow for additional feedback and revision. A final draft of the IPC Patient Satisfaction Questionnaire was then developed.

Results

Demographic Information

Participants in this study identified as male, female, transgender, and genderqueer/genderfluid. Participants ranged between the ages of 18 and 64 years old. All of the 11 participants identified as Caucasian, one of whom also identified as Hispanic or Latino, and one of whom also identified as Hispanic or Latino and African American. Education levels of participants included some middle/high school education, GED or high school degrees, some college education, and Associate's Degrees and Bachelor's Degrees. Annual incomes reported by participants ranged from less than \$10,000 a year to between \$100,000 and \$149,000 a year. In terms of employment characteristics, participants were either unemployed or receiving disability, employed part-time, employed full-time, or were students at the time of the study. Complete demographic information is presented in Table 1.

Overview

A total of seven main themes emerged from phase one, with a total of 15 subthemes grouped under those main themes. A total of two main themes and five subthemes emerged from phase two. Reference tables listing all main themes, subthemes, and associated data extracts from

phase one and phase two have been provided in Appendix F and Appendix G, respectively.

Throughout the results section, behavioral health provider will be abbreviated as “BHP” and primary care provider will be abbreviated as “PCP.”

Phase One

Main theme 1: Satisfaction with BHPs and services. All five participants responded to the interview question “Please describe your experience receiving behavioral health services in the clinic.” Analysis of patients’ responses to this question resulted in the emergence of two subthemes: (a) Patients are typically satisfied with their BHP and the BH services delivered; and (b) the majority of patients were satisfied with the accessibility of BH services, while one patient desired more access.

Patients are typically satisfied with their BHP and the BH services delivered. All five patients described their satisfaction with their BHPs and services. Overall, patients had very positive feelings about their particular BHP and the individual services they were receiving. Patients described their BHPs as non-judgmental, good listeners, and helpful. One participant explained, “I mean it seems like [BHP] really cares about trying to help and give productive solutions to problems I have which is good” (Participant 3). Interestingly, one participant reported both positive and negative feelings about their experience with BH services. Specifically, they stated, “I find that the people, you got good counselors” (Participant 2) but followed this up by remarking on feelings of being judged and dismissed by their BHP at times. They reported, “And I find that it pisses me off that you have a right to categorize me, ‘she’s wearing a leather jacket, she’s got patches, got tattoos, she’s a druggie’” (Participant 2). However, this was the only negative impression reported throughout the interviews regarding patients’ feelings about their BHPs. While this an important differing opinion to highlight, it is

important to not allow this particular viewpoint overshadow the resounding positive impressions reported by all other participants evidenced by this subtheme.

The majority of patients were satisfied with the accessibility of BH services, while one patient desired more access. Four of the five participants remarked that they feel able to easily and quickly access BH services as often as needed within their clinic, while one patient felt there was too much time restriction on individual BH appointments within integrated primary care. For example, one patient described the flexibility of their BHP as helping them feel satisfied with their degree of access to services by stating, “He’s flexible in that regard, provided his schedule allows it” (Participant 1). Another patient reported, “I was surprised that I was able to get such a frequent appointment I guess” (Participant 3). The negative viewpoint evidenced in this theme focused on the shortened BH appointment time. This participant reported, “I don’t believe a half hour is long enough for anybody to spit their name out let alone start a conversation” (Participant 2). No other participant responses throughout the interviews reflected this view of desiring longer appointments.

Main theme 2: Scheduling appointments. All five participants elaborated on scheduling appointments within their clinic. The two subthemes that emerged were: (a) Scheduling BH appointments by phone or in person is typically quick and easy, and (b) scheduling issues include length of time to initial appointment and PCP and BH availability.

Scheduling BH appointments by phone or in person is typically quick and easy. All five participants discussed their positive experiences with scheduling BH appointments. Scheduling can be done either in-person or by calling into the clinic, and patients report feeling satisfied with the ease and speed of this process. One patient stated, “Yeah, I usually just schedule when I’m here (Participant 3)” referring to scheduling follow-up appointments while already in the clinic,

and another stated “It only takes a few minutes and I’m out the door” (Participant 1).

Scheduling issues include length of time to initial appointment, and PCP and BH availability. Despite the ease of the scheduling process that some patients described, four patients also discussed some of the difficulties they experienced with scheduling behavioral health appointments. Patients encountered difficulties scheduling initial BH appointments and scheduling appointments with their PCP and BHP on the same day. For example, one patient described the difficulty presented by their different providers’ schedules not lining up by stating, “Yeah, I’m supposed to set up an appointment with the doctor that’s here but with his schedule and the other doctor’s schedule it’s kind of hard to do that but it happens” (Participant 5). Two patients also discussed specific difficulty with scheduling with their PCP in a timely manner as compared to their BHP. One stated, “I know with primary care doctors it’s hard sometimes to get an appointment like as early as like two weeks or four weeks out” (Participant 3).

Main theme 3: BH referral process. All five patients spoke to their experience with the referral process to behavioral health services within their clinic. The two subthemes were: (a) Patients are either referred by PCP or request BH services themselves, and (b) patients have a limited understanding about the full range of options for BH services.

Patients have positive experience being referred to BH by PCP or requesting BH services themselves. All five participants remarked on speaking up themselves about their desire for BH services within their clinic, while three participants described direct involvement in the referral process by their PCP. Patients were all satisfied with the way their initial referral process occurred. In explaining their first clinical encounter at their clinic, one patient reported, “My first real, like, appointment with my PCP was just talking about the depression and anxiety and that’s when she referred me to behavioral health down here, and then I had to come back for a

physical” (Participant 3). That same participant also spoke to the benefits of having PCPs be engaged in helping with the referral process to BH, noting that, “There’s not as much effort required on the patient’s part so it’s probably more likely that they’ll follow through with the appointment” (Participant 3).

Patients have a limited understanding about the full range of options for BH services.

Four patients talked about what they were aware of in terms of types of BH services offered within their clinic. Overall, patients’ understanding about the types of difficulties that BH services can be useful for was limited. While patients spoke to their knowledge of mental health counseling and psychiatry treatment, there was no mention of other potential focuses of intervention such as substance use or health behavior change. All patients remarked on their lack of knowledge outside of the specific treatment they were receiving. One patient stated, “It seems like, I’m not a hundred percent sure but it seems like a lot of mental health problems” (Participant 3) and another noted, “I don’t really know, well therapy and psychiatry stuff” (Participant 4).

Main theme 4: BHP and PCP shared workspace. All five participants responded to questions regarding their perspective of having their BHP and PCP provide care in the same clinic workspace. The two subthemes in this theme were: (a) Patients were typically pleased with having a shared workspace within their clinic, although one patient felt this was intrusive and unnecessary; and (b) patients have both positive and negative experiences with same day appointments with BHP and PCP.

Patients were typically pleased with having a shared clinic workspace, although one patient felt this was intrusive and unnecessary. Four patients discussed their opinions on having their BHP and PCP providing care in the same clinic. Three patients had positive opinions of the

convenience of their providers all being in the same location, while one was strongly against it, feeling as though BH and medical services should be kept distinct from one another. One patient who had a favorable opinion reported, “It is very nice to have everything in one place” (Participant 3). The patient against this type of clinic environment stated, “I’m in a medical exam room, I can’t get comfortable” (Participant 2) and “We need to separate the doctor from the shrink” (Participant 2).

Patients have both positive and negative impressions of same day appointments with BHP and PCP. All five patients discussed their experience, or lack thereof, of having either separate or joint same day appointments with their BHP and their PCP. While not all patients interviewed had personal experience seeing their BHP and PCP on the same day, two participants specifically spoke to their impressions of being able to do so within the shared workspace of their clinic. The opinions of patients who had experienced this type of collaboration were both favorable and unfavorable. For instance, one participant remarked favorably on his BHP being brought in to his PCP appointment in the moment. However, another participant, who was also dissatisfied with having a shared workspace in general, reported disliking the idea of joint visits by stating, “No that’s never, I think there should be, unless you’re talking about putting someone on medication I think that’s a no-no” (Participant 2).

Main theme 5: Communication and collaboration among providers. All five participants discussed their awareness of their providers collaborating about their care. Three subthemes emerged in this category: (a) Patients can be uncomfortable with the communication and collaboration between their providers, (b) patients experience co-management of their behavioral health medications by their PCP and BHP positively, and (c) patients tended to be uncomfortable with shared EHR [Electronic Health Record] use while also acknowledging the

utility of doing so.

Patients can be uncomfortable with the communication and collaboration between their providers. All five patients indicated an awareness of their BHP and PCP communicating and working together on their care, but two patients had particularly negative feelings about this communication occurring. Patients don't always understand the need for their PCP to know the focus of their work with their BHP and can experience a decline in their trust of their BHP when they communicate with their PCP. One patient stated, "I don't mind him [BHP] knowing about broken bones or something but going the other way kind of irks me because somebody stitching up my hand doesn't necessarily need to know what's going on in my head" (Participant 1).

Patients tend to experience co-management of their behavioral health medications by their PCP and BHP positively. All five patients discussed their experience of both their BHP and PCP being involved in management of or decisions regarding psychiatric medications. Negative impressions of this collaboration were rare as most patients found this aspect of care to be helpful and important. One patient stated, "Yeah so [BHP] will ask me questions, like part of my medication is for sleep, um, so she'll ask me how sleep's going and stuff like that" (Participant 4). One patient did describe a negative opinion, however, and desired more of a separation between behavioral health and medication services. They remarked "Get out of the pill s***, get out of the medication and get with the mental health part that you're supposed to be treating" (Participant 2) in regards to their BHP focusing on their medication in their visit.

Patients can be uncomfortable with shared EHR use while also acknowledging the utility of doing so. While four patients reported being aware of their EHR being accessed by both their BHP and PCP, three patients spoke to their discomfort with this shared access. Patients felt uncomfortable with the permanence of behavioral health difficulties being noted in their

EHR and the knowledge that providers obtain even when patients haven't directly communicated about a specific topic or issue with them. However, two participants discussed understanding the necessity and utility of such coordination of care. One patient specifically discussed feeling comfortable with the fact that they can be directly involved in the documentation process within the shared EHR. Participant 4 stated:

But I also have some say in what goes into it like in therapy sessions and stuff like I can be like this is one thing I don't feel comfortable with but then if it's something that's a little more serious then I don't really have a say.

Main theme 6: Follow-up contact. All five participants responded to the interview question, "Please describe any follow-up communication you have had from clinic staff or your provider" making up the main theme regarding follow-up contact. The subthemes within this that emerged were: (a) Patients feel comfortable reaching out to their BHP directly, and (b) patients feel that follow-up contact from providers and clinic staff is sometimes lacking.

Patients feel comfortable reaching out to their BHP directly. Two patients discussed having contacted their BHPs directly before. These patients spoke about their providers encouraging them to contact them if needed to discuss their care or current difficulties they're encountering. One participant explained, "[BHP] has made it pretty clear to me on few occasions that if I find myself in a bad place I can pick up phone and call him" (Participant 1).

Patients feel that follow-up contact from providers and clinic staff is sometimes lacking. Four participants discussed the contact they receive from either staff or providers at their clinic regarding their care. Patients spoke of receiving follow-up contact about their appointments, test results, referrals, and general well-being. While patients reported experiencing varying degrees of contact from clinic providers and staff, the overall message was that this

follow-up contact is not as consistent as patients would prefer. One patient reported, “Am I always getting it? More often than not, but people are human and mistakes get made” (Participant 1).

Main theme 7: Screeners in clinic. All five patients discussed their experience being screened for behavioral health concerns in their clinic by responding to the interview questions, “To your knowledge, have you been screened or assessed for behavioral health concerns? What has been your experience with such screeners?” Two subthemes emerged here: (a) Patients feel that consistent screening for BH concerns can be redundant but can help to guide their care, and (b) patients discuss the results of their screeners with their providers.

Patients feel that consistent screening for BH concerns can be redundant but can help to guide their care. All five patients reported being screened for BH concerns on a regular basis. However, patient impressions of these questionnaires included feelings of redundancy and irrelevance. Some language used by patients to describe the consistent screening process included “repetitive,” “redundant,” “generic,” and “pointless.” One patient even spoke to their perspective of the impersonal nature of the screeners. They stated, “That should be your first question asked, ‘how you doing today?’ not a piece of paper” (Participant 2). Despite this, four patients also spoke to positive aspects of the process of being screened for behavioral health issues. Patient responses suggested that completing the screeners serves as a guide for appointments and overall treatment goals. To this point, one patient stated, “You know he [BHP] takes a look at it, gets an idea by looking at the numbers where I am that week” (Participant 1).

Patients discuss the results of their screeners with their providers. Three patients discussed their experience with their providers discussing the results of their completed screeners with them. Patients reported feeling that both their BHP and PCP are informative and

comprehensive in their discussions with them about their screening results. One patient responded by stating, “They’re pretty open about explaining the whole thing” (Participant 4). Another stated, “Well definitely with my primary care doctor that first appointment we talked about it a lot cause I brought it up and she, like, looked at my scores on it and everything (Participant 3).

Domain Ratings

Four out of the five participants rated their perceived importance of the six PIP domains described to them on a scale from 0–10 (0=not important at all, 10=extremely important) in terms of their care. Each of the six domains were rated fairly highly by the majority of participants; therefore, items related to all six domains were included in the draft of the IPC Patient Satisfaction Questionnaire. Table 2 presents participants’ individual ratings of each domain.

Initial Draft of Questionnaire

The IPC Patient Satisfaction Questionnaire consisted of items related to each of the six PIP domains. Individual items were created based on the individual items presented in the PIP and the information gathered from the individual interviews with patients in phase one. Items on the original PIP were considered as they relate to patient experience, and any items that did not seem feasible in their ability to be answered by patients were not included. For instance, there are some items on the original PIP that inquire about staff’s functioning behind the scenes that patients would not be aware of, such as maintaining a patient registry. Items covering these types of integrated care elements were not directly carried over to the IPC Patient Satisfaction Questionnaire, as they are clearly not topics that patients have direct experience with. However, the content of these items were not completely lost on the IPC Patient Satisfaction Questionnaire.

For example, clinic's maintenance of a patient registry may show up in patients' experience of receiving reliable follow-up contact by the clinic, this content is just captured differently to facilitate a patient's ability to respond.

Phase one results were intended to support the inclusion of PIP items that did appear to be feasible for patients to respond to from their experience. The results from phase one suggested that all of the PIP domains should in fact be included on the IPC Patient Satisfaction Questionnaire. There were no elements of care within the domains that patients reported feeling unable to speak to, and they all discussed their satisfaction with care within each of the domains covered. Because patients were able to speak to all six domains, individual items from each domain were included.

The IPC Patient Satisfaction Questionnaire contained 20 items on one page in landscape orientation, front and back. Nineteen of the items pertained to individual domains of integrated primary care, while the final item asked about patient overall satisfaction with the care they receive in their clinic. Each item, except for the final item, asked patients to rate their experience with the particular aspect of care discussed in the respective item, as well as how important they feel that aspect of care is to their overall healthcare. The response columns included Likert-scale rating options on a scale from 1 (Very Poor) to 5 (Very Good) and 1 (Not At All Important) to 5 (Very Important). Both the satisfaction and importance scales included "N/A" options as well. The initial draft of the IPC Patient Satisfaction Questionnaire is presented in Appendix H. This initial draft then served as the basis for the second phase of interviews.

Phase Two

Main theme 1: Structure of questionnaire. All six participants discussed the overall ease of completing the questionnaire based on their impressions of the format and content of the

items included. Two subthemes in particular emerged within this theme: (a) Format of the questionnaire made it easy to complete, and (b) questionnaire is comprehensive.

Format of the questionnaire made it easy to complete. Five patients described positive impressions of the format of the questionnaire. Patients felt the questionnaire was set up in a format that was compact and not overwhelming, and spoke to the ease of it being all on one page front and back. The questionnaire also felt familiar to them, as the format reminded patients of other forms that they are asked to fill out in their clinic. For example, one patient stated, “Yeah, it kind of continues on with the flow of what they have here, the questionnaires at the front and stuff” (Participant 9).

Questionnaire is comprehensive. All six patients commented on the comprehensiveness of the content covered by the questionnaire. Patients spoke to feeling as though every area covered by the questionnaire was important to them, covered everything they can think of having experienced in their clinic, and all patients denied there being anything else they could think of that should be covered based on their experiences. One patient remarked on the comprehensiveness by stating, “This pretty much covers from start to finish” (Participant 6). Additionally, patients were informed of the six PIP domains that were used to help create the items of the questionnaire. After explanation of these domains and being asked, “In your opinion, did the questionnaire capture all of these areas of care?” all six patients reported feeling as though the questionnaire successfully captured and represented these domains. Because the questionnaire was constructed with the aim of capturing the patient perspective of the various PIP domains, it’s important to know whether patients feel each of these elements was represented in a way they understood. Since all patients responded in support of this once the various domains were explained to them further, this suggests that patients did in fact feel the

content of the questionnaire sufficiently captured the characteristics of said domains.

Main theme 2: Understanding of individual items. Throughout the interviews, all six patients commented on the wording of individual items. All six patients spoke about understanding what was meant by specific terms on the questionnaire, but also reported instances of having difficulty answering some of the items. Three subthemes emerged within this main theme: (a) Patients found it difficult to answer when they lacked experience with a certain aspect of care but patients tended to use N/A option at these times, (b) the wording of several items on the questionnaire caused confusion, and (c) patients understood what was meant by relationship with BHP.

Patients found it difficult to answer when they lacked experience with a certain aspect of care but patients tended to use N/A option at these times. All six patients described having a lack of awareness or lack of personal experience with some aspect of care included on the questionnaire. These areas of care included substance abuse treatment, joint visits with PCP and BHP, connection to external referrals and resources, communication between their PCP and BHP, and follow-up contact from clinic staff. This lack of experience made it challenging for patients to know how to rate their satisfaction or importance with such areas of care. One patient remarked “The first 3 questions kind of threw me off a bit. I mean I’ve never really been referred to anywhere outside of here” (Participant 9), referencing their lack of experience with external referrals. Despite this difficulty they encountered, three patients spoke about using the N/A option when their experience was not relevant or they did not understand based on their lack of awareness about certain aspects of care. However, not all patients utilized this N/A option when they did not understand based on their own experience. Although there are instructions at the beginning of the questionnaire telling patients when to use N/A, the inconsistent use of the N/A

option suggests the need for rewording of this response option.

The wording of several items on the questionnaire caused confusion. Four patients discussed having initial difficulty understanding the wording of particular items. Patients reported misreading or misinterpreting the item about provider EHR use, the item asking about referrals to community resources, and the item about referrals to specialty mental health. The wording of these individual items elicited confusion among patients about the aspect of care the item was referring to. For example, Participant 7 stated, “Access and use of electronic health record, I’m only as literate as my smart phone has allowed me to be with computer technology, I’m getting there but I don’t own a computer and have yet to send a successful email” indicating that they initially read this item to mean their own use and access of the EHR system. Another patient also interpreted this item in this same way. Another participant was initially confused about the first two items on the questionnaire asking about referral to community resources and specialty mental health services. After a brief explanation of the possibility of being referred to such resources outside of one’s clinic, the patient reported understanding. However, they did not understand what this question was asking about prior to such explanation, suggesting an issue with the way it is worded. While not all patients misunderstood these items, these incidences of misunderstanding that did occur required adjustments to be made in order to increase readability for all patients.

Patients understood what was meant by relationship with BHP. Upon questioning about their understanding of the term “relationship” in the fifth item, all six patients responded. They went on to describe the qualities of their relationship with their BHP that helped inform their decision about their satisfaction with that relationship. Patients considered the quality of communication, the strength of the rapport, their level of trust, and feeling comfortable with their

BHP as important indicators of relationship satisfaction. Their responses indicated that not only did they understand what was meant by “relationship” in this particular item, but also that they each thought of specific characteristics about that relationship based on their unique experience when answering it. For example, Participant 6 noted:

I mean, the importance of being able to communicate with your therapist and direct back and forth, feeling comfortable, that’s pretty much the most important part of the whole thing. Because I’ve had a couple therapists that did the old sit and take notes, you know, and that never worked for me.

While this was one item in particular that I was unsure about in terms of readability given the potential vagueness of the term “relationship,” patients tended to understand this wording largely similarly and all use their unique experience to consider how satisfied they were.

Final Refinement of Questionnaire

After analysis of the data from the phase two interviews several changes were made to the IPC Patient Satisfaction Questionnaire. Edits included changing the wording of the prompt for the importance column items to “How important is this to your overall care at the clinic (1 being *Not Important At All* and 5 being *Very Important*)?” This helped to shorten and simplify this prompt for increased readability by patients. I also defined “primary care provider” on the IPC Patient Satisfaction Questionnaire given that there are multiple individuals within a patient’s care team that can fill such a role. The intent was to make this clearer for patients completing the questionnaire regarding what role particular items are asking about when mentioning a PCP.

Following this same reasoning, I also chose to define “behavioral health provider” based on the fact that patients could refer to individuals who fill this role as multiple terms such as therapist, psychologist, counselor, etc. I placed these two definitions in the initial instructions at the top of

the first page of the questionnaire.

I changed item 15 to “My provider discussing questionnaire results with me.” Following this same logic, I also decided to adjust the wording on items 11 and 12. These now read, “Discussion with my behavioral health provider about my medical care” and “Discussion with my PCP about my behavioral health needs and care,” respectively. Additionally, to shorten the length and wordiness of the fourth item, this was changed to “What my behavioral health provider and I work on together (i.e., trouble with my mood).”

Additional changes were made to the wording of individual items based on the responses from participants highlighting confusion about particular items. I attempted to simplify the wording for such items in an effort to clarify the meaning of the particular aspect of care that patients reported not initially understanding. Part of this refinement included making terms more consistent throughout the questionnaire, such as “behavioral health” instead of “mental health” in the second item and sixth item. I also took out the specification of “non-clinical” and added “outside of my clinic” in the first item to instead read “Being referred to community resources outside of my clinic” while also clarifying the examples by saying “assistance with housing, transportation, food, etc.” to clarify what is meant by community resources.

The confusion indicated on the eighth and ninth items led to a wording shift to “My behavioral health provider’s use of my electronic health record during visits” and “My PCP’s use of my electronic health record during visits.” By placing the mention of the behavioral health provider and PCP at the beginning of the item, the aim was to clarify that this item is not asking about the patient’s own use, which was how it was interpreted before, but rather their provider’s use. Due to the inconsistent use of the N/A option, and the confusion experienced by multiple participants due to lack of experience with certain items, I chose to instead use “I don’t know or I

haven't experienced this" in the column that previously offered the N/A option. The hope was that this change would more specifically provide patients with a choice to acknowledge their lack of awareness or experience, hopefully increasing use of that response choice rather than patients simply not answering based on confusion. The final draft of the IPC Patient Satisfaction Questionnaire is presented in Appendix I.

Discussion

This study examined the patient perspective of integrated primary care in an effort to create a patient satisfaction measure of integrated primary care. Through qualitative analysis of two phases of semi-structured interviews with patients, this study aimed to capture the essence of the patient experience as much as possible within a phenomenological research paradigm. The first phase of interviews elicited information about patient experience and satisfaction with various aspects of care. The second phase provided insight into the IPC Patient Satisfaction Questionnaire from the patient perspective in terms of readability, ease of completing, and comprehensiveness.

Results from this study indicated that patients do in fact have awareness of many of the domains that are unique to integrated primary care, and that patients were largely satisfied with the particular aspects of care within such domains. While future research is needed to continue to examine the validity and reliability of the IPC Patient Satisfaction Questionnaire, responses from patients suggested that the current draft is likely a useful foundation for assessing patient satisfaction in integrated primary care.

Implications

Patients have awareness of unique elements of integrated primary care. One of the most important findings of this study was that fact that patients appear to be aware of the

different aspects of integrated primary care. Because the efforts of developing more integration in primary care practices are still fairly new, it was important to learn whether patients could actually speak to these specific efforts, from their own experience, to make possible patient input in implementation and improvement of integrated care. The results from the patient interviews in phase one suggest that as a whole, patients were able to speak to all of the domains of integrated care specific to the AHRQ Lexicon. This means that in terms of the content of the questionnaire, patients' experience prepares them well to conceptualize and rate their level of satisfaction with and perceived importance of the various areas of care.

Research suggests many potential benefits of focusing on patient satisfaction in healthcare improvement efforts, such as improved clinical outcomes and greater medical adherence by patients (Alazri & Neal, 2003; Hall et al., 1998; Hirsh, 2004; Sherbourne et al., 1992). The results of this study suggest that using the domains of the PIP as a guide in the IPC Patient Satisfaction Questionnaire can be an effective way to learn about patient's satisfaction with the essential elements of integrated primary care to improve clinical practice. Results also suggested that patient satisfaction with these elements of care varied. While some of the results of this study are in line with the favorable opinions highlighted in the existent literature on the patient experience of integrated primary care (Chomienne et al., 2010; Drainoni et al., 2014; Ede et al., 2015), there were also a fair number of negative impressions reported. For example, some patient responses indicated dissatisfaction with (a) access to services and access to medical providers, (b) scheduling challenges, (c) management of medication by both the PCP and BHP, (d) joint visits between PCP and BHP, (e) EHR access by both the PCP and BHP, (f) communication occurring between PCP and BHP about patient care, and (g) the use of behavioral health screeners. Therefore, use of the IPC Patient Satisfaction Questionnaire will

likely allow for an emergence of these types of patient perspectives that may differ from what is in the existing literature, and can provide new insights for clinics and providers about their patients' experience.

Use of the patient satisfaction measure in integrated primary care. It seems reasonable to conclude that the IPC Patient Satisfaction Questionnaire is a solid draft of a measure that can be utilized in integrated primary care clinics to help assess levels of patient satisfaction with care. The lack of a specific measure to assess patient satisfaction particularly with the domains unique to integrated primary care suggested a gap in the field of measuring integration efforts. The creation of this measure aimed to fill that gap. However, due to the confusion of particular items highlighted in the results of phase two of the present study, further research is necessary in order to more confidently gauge how effective this questionnaire actually is at accurately assessing patient satisfaction. The goals of phase two of the study were (a) to evaluate the quality and representativeness of the content of the IPC Patient Satisfaction Questionnaire, and (b) to assess whether or not items were presented in a clear and concise way that patient's are able to understand.

While the results suggested decent comprehensiveness of content of the IPC Patient Satisfaction Questionnaire and an easy format, there was not enough support to claim good readability, which is essential if the questionnaire is to be used in a meaningful way to improve practice. Of note is the fact that initial wording of the IPC Patient Satisfaction Questionnaire included consideration of the individual items on the original PIP. As with findings from cognitive interviews on the original PIP, it is clear that many individuals are having difficulty interpreting some of the terms (Martin et al., 2018). Therefore, it is likely that the initial wording of the PIP that was used in the development of this current measure contributed to some of the

patients' misunderstandings of particular items.

If wording issues are sufficiently addressed, use of this questionnaire can potentially provide a great deal of information to clinics about how satisfied their patients are with particular areas of care and highlight any potential areas for improvement. The inclusion of both a "satisfaction" and "importance" response column on the questionnaire allows for clinics to evaluate where possible improvement efforts should focus. For example, if patients rate particular areas of care lower on the satisfaction scale, but also rate them as lower on the importance scale, then this may mean clinic staff and providers don't need to focus immediate improvement efforts on that area. Instead, attention can be given to items that are rated low on satisfaction but high on importance to overall care. Patient responses on the IPC Patient Satisfaction Questionnaire will also highlight areas of integration efforts that are currently being implemented effectively within a clinic and are experienced positively by patients.

An important consideration is that in some instances, it may be unclear about what particular aspect of care a patient finds dissatisfying. For this reason, when implementing the IPC Patient Satisfaction Questionnaire, follow-up conversations with patients in regards to any responses that are unclear in this way could allow for clarification and additional feedback on potential areas for clinic improvement.

Limitations

Transferability. Transferability is the extent to which results of a qualitative study can be compared to other situations and settings (Mertens, 2015). While readers of this research can make some reasonable judgments about whether or not they may find similar results with patients in other integrated primary care clinics, there are some characteristics that would likely limit the transferability of these results in other contexts. Patients were recruited from two

primary care clinics within the same healthcare system in Massachusetts with similar levels of integration. This means that results may not be transferable to other integrated primary care clinics within different health systems, clinics in different geographic locations, or clinics with varying levels of integration. Unfortunately, I was unable to gather additional data on the current level of integration of the two primary care clinics where this research was conducted for the current study. Richer descriptions of these contexts in terms of integration level would have provided more opportunity for transferability consideration.

The fairly homogenous demographic information of participants in this study also limits transferability. Within the 11 patients who volunteered to participate, there was a fairly wide range of demographic factors such as education level, income, employment status, gender, and age, but the majority of the participants were either unemployed or on disability, had an education level below a bachelor's degree, and had an annual income of less than \$10,000. The inclusion of several participants who had an education level of associate's degree or above may also have influenced the overall perception of readability and comprehension of parts of the IPC Patient Satisfaction Questionnaire. The items on the questionnaire may not be equally understandable by patients with varying education levels, and results from a similar qualitative study with different patient populations could potentially differ from what was learned here. There was also a lack of racial and ethnic diversity in this study. It's possible that results would have differed if there were a greater range of ethnic and racial backgrounds represented in the sample. This study had a limited sample size overall, and a larger number of participants would have likely led to greater transferability of results by offering more variety in participant characteristics.

It's possible that the recruitment process itself may also limit transferability of the results.

Every attempt was made to reduce any undue pressure for patients to participate in order to please their providers by (a) my giving only a study flyer to providers to hand out, (b) providers directing patients to me if they were interested in participating, and (c) carrying out the informed consent with the patient. Patients were also informed that their decision to participate in the study or not would not affect their relationship with their provider or the care they receive but it's possible that patients still felt that not participating could have impacted their care in some way. It is also a possibility that patients were driven to participate due to having particularly positive or negative experiences of care within their clinic and therefore, such perspectives were over-represented in the results from the interviews. Any positive responses could have also been influenced by patients wanting to avoid any negative impacts on their care.

Despite the fact that the informed consent process included reassurance of anonymity and that patients' specific responses to the interview questions would not affect the care they receive in their clinic in any way, participants may have worried about their provider (or other clinic staff) learning of any negative impressions they may have reported. This could have potentially led to more positively skewed themes emerging in the results. It will be necessary for consumers of this research to consider the results within the context of their individual sites and with their own patient populations to gauge potential transferability of the conclusions drawn.

Lack of depth of information. The experience of patients with the text of the first iteration of the questionnaire could have been captured in more detail. Despite the intentional decision to use semi-structured interviews in order to allow for further exploration of individual participant responses, patients tended to focus more on the content of the questionnaire rather than provide information about actual measure development or how to improve upon any challenges. Patients are not trained in measure development, and asking them to remark on

specific ways to make a questionnaire more comprehensible is not the most effective avenue for obtaining such valuable information.

Future Research

Psychometric testing. While this study successfully created a measure of patient satisfaction applicable to integrated primary care environments, there was no inclusion of specific testing of psychometric properties or official piloting of the developed measure. Although the current study seems to demonstrate face validity based on the participant responses from the interview questions covering the content of the questionnaire, there was no attention given to other measures of reliability and validity. While the draft of this measure is a step in the direction of a validated and reliable instrument to assess patient satisfaction, more research specific to these psychometric properties is needed. Future research should examine the internal consistency, content, criterion, and construct validity. Future research should also include official piloting of this measure with a wide variety of patients from various backgrounds. Additional research in this area would allow for the IPC Patient Satisfaction Questionnaire to be more reliably used as a measure of patient satisfaction with integrated primary care.

Further research to support rewording of items on questionnaire. Future research might go more deeply into patient understanding of the wording in the measure by asking how they interpreted each item or what they thought of when reading it. This additional research could yield information that would help to more specifically adapt the wording of items on the IPC Patient Satisfaction Questionnaire, allowing for increased confidence about readability and ultimately, accurate interpretation of patient responses to the items.

Exploration with clinics in different health systems and with varying levels of integration. Because of the potential lack of transferability of the results of this study due to the

sample population coming from just two clinics within the same health system, future research should focus on exploring patient satisfaction with the elements unique to integrated primary care within a variety of primary care clinics. Obtaining data from established patients in other practices within different integrated healthcare systems in different states across the country, in the form of individual interviews and/or use of the IPC Patient Satisfaction Questionnaire, would yield results that are more informative to the field of integrated primary care as a whole. It might be interesting to examine the results of this measure along with results of the PIP of various sites to explore the relationship between different levels of integration and patient satisfaction.

Potential exploration of provider satisfaction with specific domains. While many healthcare institutions continue to focus heavily on the three dimensions of the Triple Aim, the newly developed Quadruple Aim proposed adding a fourth dimension to consider in health care optimization—provider and staff satisfaction (Bodenheimer & Sinsky, 2014). Therefore, it seems reasonable to suggest future research focus on this as well. While there is literature examining the experience of providers in integrated primary care via both quantitative and qualitative means (Chomienne et al., 2010; Torrence et al., 2014), it would be beneficial to learn more about their levels of satisfaction with the elements unique to integrated primary care domains just as this study examined for patient populations using the concepts defined in the AHRQ Lexicon as a guideline. Perhaps it would also be interesting to develop a similar measure of provider satisfaction with the specific aspects of integrated care within their clinic in order to compare this to responses on patient satisfaction measures. This may allow clinics to dive even deeper into care improvement efforts—learning not only about what the patient experience is like within particular domains of care but also the unique experience of providers.

Conclusion

Primary care is a common first stop for individuals with behavioral health needs. Despite this, behavioral health needs are continuing to go unmet within the primary care environment. The solution is integrated primary care. Adding a behavioral health provider to the primary medical team has been shown to be widely efficacious in a number of ways. As the field of integrated primary care continues to evolve, it is important for providers and other healthcare stakeholders to better understand the patient experience of such developing care efforts.

This dissertation aimed to elicit the patient perspective of integrated primary care to help develop a patient satisfaction measure focusing on the specific domains that are unique to such integration. Ultimately, 11 patients from two primary care clinics participated in this study. Semi-structured interviews were conducted to learn more about individual patient experience and impressions of integrated primary care, as well as to gather input from the patient perspective on the created measure of patient satisfaction. Thematic analysis was used to analyze the collected data from the 11 interviews. The analysis resulted in a number of main themes and subthemes that highlighted unique aspects of the patient experience of integrated primary care, patient satisfaction with elements of their care and impressions of the IPC Patient Satisfaction Questionnaire.

Results from this study indicated that, while patients appear to be highly satisfied with integrated care services in their clinics and find the specific elements of integration important to their overall care, satisfaction with particular aspects of care varies. Results also suggested that the IPC Patient Satisfaction Questionnaire that was ultimately created requires more assessment of readability and validity, but can yield important information about patient experience of care. This information can likely help clinics understand and improve their integrated care efforts.

References

- Agency for Healthcare Research and Quality (AHRQ). (n.d.). *Participant Recruitment for Research*. Retrieved from <https://healthit.ahrq.gov/ahrq-funded-projects/emerging-lessons/participant-recruitment-research>
- Alazri, M. H., & Neal, R. D. (2003). The association between satisfaction with services provided in primary care and outcomes in Type 2 diabetes mellitus. *Diabetic Medicine*, 20(6), 486-490. doi:10.1046/j.1464-5491.2003.00957.x
- American Institutes for Research (AIR). (2017). Principles for making health care measurement patient-centered. Retrieved from <https://aircpce.org/projects/developing-principles-patient-centered-measurement>
- Anhang Price, R., Elliott, M. N., Zaslavsky, A. M., Hays, R. D., Lehrman, W. G., Rybowski, L., & ... Cleary, P. D. (2014). Examining the Role of Patient Experience Surveys in Measuring Health Care Quality. *Medical Care Research & Review*, 71(5), 522-554. doi:10.1177/1077558714541480
- Barber, J. A., Frantsve, L. M., Capelli, S., & Sanders, K. A. (2011). Implementation and evaluation of an integrated care program in a VA medical center. *Psychological Services*, 8(4), 282-293. doi:10.1037/a0026158
- Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems & Health: The Journal Of Collaborative Family Healthcare*, 21(2), 121-133. doi:10.1037/1091-7527.21.2.121
- Blount, A., & Bayona, J. (1994). Toward a system of integrated primary care. *Family Systems Medicine*, 12, 171-182. doi:10.1037/h0089151
- Bluestein, D., & Cubic, B. A. (2009). Psychologists and primary care physicians: A training model for creating collaborative relationships. *Journal Of Clinical Psychology In Medical Settings*, 16(1), 101-112. doi:10.1007/s10880-009-9156-9
- Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: Care of the patient requires care of the provider. *Annals of Family Medicine*, 12(6), 573-576. doi:10.1370/afm.1713
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research In Psychology*, 3(2), 77-101. doi:10.1191/1478088706qp063oa
- Chomienne, M., Grenier, J., Gaboury, I., Hogg, W., Ritchie, P., & Farmanova-Haynes, E. (2010). Family doctors and psychologists working together: doctors' and patients' perspectives. *Journal Of Evaluation In Clinical Practice*, 17(2), 282-287. doi:10.1111/j.1365-2753.2010.01437.x

- Cleary, P. D., & McNeil, B. J. (1988). Patient satisfaction as an indicator of quality care. *Inquiry*, 25, 25-36. doi:10.1177/106286060001500303
- Coventry, P., Lovell, K., Dickens, C., Bower, P., Chew-Graham, C., McElvenny, D., ... Gask, L. (2015). Integrated primary care for patients with mental and physical multimorbidity: cluster randomised controlled trial of collaborative care for patients with depression comorbid with diabetes or cardiovascular disease. *BMJ: British Medical Journal*, 350(7996). doi:10.1136/bmj.h638
- Dane, A., & Schneider, B. (1998). Program integrity in primary and early secondary prevention: Are implementation effects out of control? *Clinical Psychology Review*, 18(1), 23-45. doi:10.1016/S0272-7358(97)00043-3
- Day, J., Scammon, D. L., Kim, J., Sheets-Mervis, A., Day, R., Tomoaia-Cotisel, A., & ... Magill, M. K. (2013). Quality, satisfaction, and financial efficiency associated with elements of primary care practice transformation: preliminary findings. *Annals Of Family Medicine*, 11 Suppl 1S50-S59. doi:10.1370/afm.1475
- Doyle, C., Lennox, L., & Bell, D. (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open*, 3(1). doi:10.1136/bmjopen-2012-001570
- Drain, M. (2001). Quality improvement in primary care and the importance of patient perceptions. *The Journal Of Ambulatory Care Management*, 24(2), 30-46. doi:10.1097/00004479-200104000-00005
- Drainoni, M., Farrell, C., Sorensen-Alawad, A., Palmisano, J. N., Chaisson, C., & Walley, A. Y. (2014). Patient perspectives of an integrated program of medical care and substance use treatment. *AIDS Patient Care And Stds*, 28(2), 71-81. doi:10.1089/apc.2013.0179
- Ede, V., Okafor, M., Kinuthia, R., Belay, Z., Tewolde, T., Alema-Mensah, E., & Satcher, D. (2015). An examination of perceptions in integrated care practice. *Community Mental Health Journal*, 51(8), 949-961. doi:10.1007/s10597-015-9837-9
- Engel, G. L. (1997). From biomedical to biopsychosocial: Being scientific in the human domain. *Psychosomatics: Journal Of Consultation And Liaison Psychiatry*, 38(6), 521-528. doi:10.1016/S0033-3182(97)71396-3
- Fan, V. S., Burman, M., McDonell, M. B., & Fihn, S. D. (2005). Continuity of care and other determinants of patient satisfaction with primary care. *Journal Of General Internal Medicine*, 20(3), 226-233. doi:10.1111/j.1525-1497.2005.40135.x
- Fauth, J. & Tremblay, G. (2011). *The Integrated Care Evaluation Project: Full Report*. Unpublished report, Anitoch University New England, Keene, NH.

- Glasgow, R. E., Wagner, E. H., Schaefer, J., Mahoney, L. D., Reid, R. J., & Greene, S. M. (2005). Development and validation of the Patient Assessment of Chronic Illness Care (PACIC). *Medical Care*, 43(5), 436-444. doi:0.1097/01.mlr.0000160375.47920.8c
- Grogan, S., Conner, M., Willits, D., & Norman, P. (1995). Development of a questionnaire to measure patients' satisfaction with general practitioners' services. *The British Journal Of General Practice: The Journal Of The Royal College Of General Practitioners*, 45(399), 525-529. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1239403/>
- Hall, J. A., Milburn, M. A., Roter, D. L., & Daltroy, L. H. (1998). Why are sicker patients less satisfied with their medical care? Tests of two explanatory models. *Health Psychology: Official Journal Of The Division Of Health Psychology, American Psychological Association*, 17(1), 70-5. doi:10.1037/0278-6133.17.1.70
- Heath, B., Wise Romero, P., and Reynolds, K. (2013). *A Standard Framework for Levels of Integrated Healthcare*. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. Retrieved from: http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf
- Hine, C. E., Howell, H. B., & Yonkers, K. A. (2008). Integration of medical and psychological treatment within the primary health care setting. *Social Work In Health Care*, 47(2), 122-134. doi:10.1080/00981380801970244
- Hirsh, A. T. (2004). *Patient satisfaction with treatment for chronic pain: predictors and relationship to compliance* (Master's Thesis). Retrieved from http://etd.fcla.edu/UF/UFE0004222/hirsh_a.pdf
- Hojat, M., Louis, D. Z., Maxwell, K., Markham, F. W., Wender, R. C., & Gonnella, J. S. (2011). A brief instrument to measure patients' overall satisfaction with primary care physicians. *Family Medicine*, 43(6), 412-7. Retrieved from <https://www.stfm.org/fmhub/fm2011/June/Mohammadreza412.pdf>
- Hunter, C., Funderburk, J., Polaha, J., Bauman, D., Goodie, J., & Hunter, C. (2018). Primary care behavioral health (PCBH) model research: Current state of the science and a call to action. *Journal of Clinical Psychology in Medical Settings*, 25(2), 127-156. doi:10.1007/s10880-017-9512-0
- Institute for Healthcare Improvement. (n.d.). *The IHI Triple Aim*. Retrieved from <http://www.ihl.org/engage/initiatives/tripleaim/pages/default.aspx>
- Katon, W. Von Korff, M., Lin, E., Simon, G., Walker, E., Unützer, J.,...Ludman, E. (1999). Stepped collaborative care for primary care patients with persistent symptoms of depression. *Archives of General Psychiatry*, 56(12), 1109-1115. doi:10.1001/archpsyc.56.12.1109.

- Kessler, R. S., Auxier, A., Hitt, J. R., Macchi, C. R., Mullin, D., van Eeghen, C., & Littenberg, B. (2016). Development and validation of a measure of primary care behavioral health integration. *Families, Systems, & Health*. doi:10.1037/fsh0000227
- Kessler, R. C., Demler, O., Frank, R. G., Olfson, M., Pincus, H. A., Walters, E. E.,... Zaslavsky, A. M. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. *New England Journal Of Medicine*, 352(24), 2515-2523. doi:10.1056/NEJMsa043266
- Korsen, N., Narayanan, V., Mercincavage, L., Noda, J., Peek, C. J., Miller, B. F.,... Christensen, K. (2013). *Atlas of Integrated Behavioral Health Care Quality Measures*. Agency for Healthcare Research and Quality, Rockville, MD. AHRQ Publication No. 13-IP002-EF. Retrieved from <https://integrationacademy.ahrq.gov/resources/ibhc-measures-atlas>
- Kringos, D. S., Boerma, W. W., Hutchinson, A., van der Zee, J., & Groenewegen, P. P. (2010). The breadth of primary care: a systematic literature review of its core dimensions. *BMC Health Services Research*, 10, 65-77. doi:10.1186/1472-6963-10-65
- Kroenke, K. & Mangelsdorff, D. (1989). Common symptoms in ambulatory care: Incidence, evaluation, therapy, and outcome. *JAMA: Journal of the American Medical Association*, 262(9), 1236. doi:10.1016/0002-9343(89)90293-3
- Macchi, C. R., Kessler, R., Auxier, A., Hitt, J. R., Mullin, D., van Eeghen, C., & Littenberg, B. (2016). The Practice Integration Profile: Rationale, development, method, and research. *Families, Systems, And Health*. doi:10.1037/fsh0000235
- Martin, M., Macchi, C. R., Brennhof, S., Trembath, F., Mullin, D., & Kessler, R. S. (2018, October). *The practice integration profile improvement study*. Poster session presented at the meeting of the Collaborative Family Healthcare Association, Rochester, NY.
- Mechanic, D. (2014). More people than ever before are receiving behavioral health care in the United States, but gaps and challenges remain. *Health Affairs (Project Hope)*, 33(8), 1416-24. doi:10.1377/hlthaff.2014.0504
- Mertens, D. (2015). *Research and evaluation in education and psychology*. California: SAGE Publications.
- Park-Lee, E., Lipari, R. N., Hedden, S. L., Copello, E. A. P., & Kroutil, L. A. (2016). Receipt of services for substance use and mental health issues among adults: Results from the 2015 National Survey on Drug Use and Health. *NSDUH Data Review*. Retrieved from <https://www.samhsa.gov/data/sites/default/files/NSDUH-ServiceUseAdult-2015/NSDUH-ServiceUseAdult-2015/NSDUH-ServiceUseAdult-2015.htm>
- Pascoe, G. C. (1983). Patient satisfaction in primary health care: a literature review and analysis. *Evaluation And Program Planning*, 6(3-4), 185-210. doi:10.1016/0149-7189(83)90002-2

- Peek, C. J. & The National Integration Academy Council. (2013) *Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus*. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from <http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>
- Press Ganey. (2011). 2011 Press Ganey pulse report: Perspectives on American health care. Retrieved from https://helpandtraining.pressganey.com/Documents_secure/Pulse%20Reports/2011_Press_Ganey_Pulse_Report.pdf
- Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto US mental and addictive disorders system: Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 50, 85–93. doi:10.1001/archpsyc.1993.01820140007001
- Robinson, P. J., & Reiter, J. T. (2016). *Behavioral health consultation and primary care: A guide to integrating services* (2nd ed.). Cham, Switzerland: Springer International Publishing Switzerland.
- Roblin, D. W., Becker, E. R., Adams, E. K., Howard, D. H., & Roberts, M. H. (2004). Patient satisfaction with primary care: does type of practitioner matter? *Medical Care*, 42(6), 579-90. doi:10.1097/01.mlr.0000128005.27364.72
- Roy-Byrne, P., Craske, M. G., Sullivan, G., Rose, R. D., Edlund, M. J., Lang, A. J., & ... Stein, M. B. (2010). Delivery of Evidence-Based Treatment for Multiple Anxiety Disorders in Primary Care. *JAMA: Journal Of The American Medical Association*, 303(19), 1921-1928. doi:10.1001/jama.2010.608.
- Sand, J., Felzien, M., Haeme, R., Tapp, H., Derkowski, D., & Westfall, J. (2017). The North American primary care research group's patient and clinician engagement program (pace): Demystifying patient engagement through a dyad model. *Family Practice*, 34(3), 285-289. doi:10.1093/fampra/cmz027
- Sans-Corrales, M., Pujol-Ribera, E., Gené-Badia, J., Pasarín-Rua, M. I., Iglesias-Pérez, B., & Casajuana-Brunet, J. (2006). Family medicine attributes related to satisfaction, health and costs. *Family Practice*, 23(3), 308-16. doi:10.1093/fampra/cmi112
- Scheirer, M. A., Leonard, B. A., Ronan, L., Boober, B. H. (2010). *Site Self Assessment Tool for the Maine Health Access Foundation Integrated Care Initiative*. Retrieved from: https://integrationacademy.ahrq.gov/sites/default/files/measures/8_MEHAF_SSA.pdf
- Sebo, P., Herrmann, F. R., Bovier, P., & Haller, D. M. (2015). What are patients' expectations about the organization of their primary care physicians' practices?. *BMC Health Services Research*, 15328. doi:10.1186/s12913-015-0985-ysebo

- Sherbourne, C. D., Hays, R. D., Ordway, L., DiMatteo, M. R., & Kravitz, R. L. (1992). Antecedents of adherence to medical recommendations: Results from the medical outcomes study. *Journal Of Behavioral Medicine*, 15(5), 447-468. doi:10.1007/BF00844941
- Shikiar, R., & Rentz, A. M. (2004). Satisfaction with medication: An overview of conceptual, methodologic, and regulatory issues. *Value In Health*, 7(2), 204-215. doi:10.1111/j.1524-4733.2004.72252.x
- Singer, S. J., Friedberg, M. W., Kiang, M. V., Dunn, T., & Kuhn, D. M. (2013). Development and preliminary validation of the Patient Perceptions of Integrated Care survey. *Medical Care Research And Review: MCRR*, 70(2), 143-164. doi:10.1177/1077558712465654
- Speight, J. (2005). Assessing patient satisfaction: Concepts, applications, and measurement. *Value In Health: Supplement 1*, 8, S6-S8. doi:10.1111/j.1524-4733.2005.00071.x
- Strosahl, K. (1998). Integrating behavioral health and primary care services: the primary mental health care model. In A. Blount, (Ed.). *Integrated primary care: the future of medical and mental health collaboration* (pp. 139-166). New York: W.W. Norton.
- Torrence, N. D., Mueller, A. E., Ilem, A. A., Renn, B. N., DeSantis, B., & Segal, D. L. (2014). Medical Provider Attitudes About Behavioral Health Consultants in Integrated Primary Care: A Preliminary Study. *Families, Systems & Health: The Journal Of Collaborative Family Healthcare*, 32(4), 426-432. doi:10.1037/fsh0000078
- Turgesen, J. N. (2010). *Program evaluation of integrated primary care in two primary care clinics* (Doctoral Dissertation). Retrieved from <http://digitalcommons.georgefox.edu/cgi/viewcontent.cgi?article=1094&context=psyd>
- Unützer, J., Harbin, H., Schoenbaum, M., & Druss, B. (2013, May). *The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes* (Issue Brief). Retrieved from <https://aims.uw.edu/resource-library/collaborative-care-model-approach-integrating-physical-and-mental-health-care>. Centers for Medicaid and Medicare Services.
- van Campen, C., Sixma, H., Friele, R. D., Kerssens, J. J., & Peters, L. (1995). Quality of care and patient satisfaction: A review of measuring instruments. *Medical Care Research & Review*, 52(1), 109-133. doi:10.1177/107755879505200107
- Walley, A. Y., Tetrault, J. M., & Friedmann, P. D. (2012). Integration of substance use treatment and medical care: A special issue of JSAT. *Journal Of Substance Abuse Treatment*, 43(4), 377-381. doi:10.1016/j.jsat.2012.09.002

- Wang, P. S., Berglund, P., & Kessler, R. C. (2000). Recent care of common mental disorders in the United States. *JGIM: Journal Of General Internal Medicine*, 15(5), 1. doi:10.1046/j.1525-1497.2000.9908044.x
- Waxmonsky, J., Auxier, A., Romero, P. A., Heath, B. (2014). *IPAT: Integrated Practice Assessment Tool*. Retrieved from SAMHSA-HRSA Center for Integrated Health Solutions website: http://www.integration.samhsa.gov/operations-administration/IPAT_v_2.0_FINAL.pdf
- Weisner, C., Mertens, J., Parthasarathy, S., Moore, C., Lu, Y. (2001). Integrating primary medical care with addiction treatment. *JAMA*, 286(14), 1715–1723. doi:10.1001/jama.286.14.1715
- Wong, E. L., Coulter, A., Cheung, A. W., Yam, C. H., Eng-Kiong, Y., & Griffiths, S. (2013). Item generation in the development of an inpatient experience questionnaire: a qualitative study. *BMC Health Services Research*, 13(1), 265-277. doi:10.1186/1472-6963-13-265
- Young, A. S., Klap, R., Sherbourne, C. D., Wells, K. B. (2001). The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry*, 58(1):55-61. doi:10.1001/archpsyc.58.1.55.

Appendix A: Provider Recruitment Letter

Dear [Primary Care Provider at Health Center],

My name is Sarah Pearson and I am a 4th year doctoral student at Antioch University New England and I am conducting a study on patient experience and satisfaction with integrated primary care.

Project Purpose

The ultimate goal of this research is to develop a patient satisfaction questionnaire. The resulting questionnaire will help inform the future of integrated primary care practice by highlighting the patient perspective of integrated care. I am writing to ask whether you might be willing to participate in this study by helping to recruit patients either directly or via other members of your team.

Who is eligible?

Patients in your clinic may be eligible to participate in the study if they have had at least some exposure to behavioral health services as part of their primary care treatment in the clinic. This could include having an appointment with a behavioral health clinician, meeting a behavioral health specialist in one or more of their primary care appointments, and/or being screened or treated for behavioral health concerns. Participation of the patients in your clinic is completely voluntary and all answers they provide will be anonymous. You do not have to respond if you are not interested in this study. If you do not respond, no one will contact you.

What participation is involved?

If you are interested and think your patients would be too, you will be asked to pass along the attached flyer to your patients and introduce them to this researcher. I will then meet with the recruited patients in your clinic to conduct the research, and will provide them with the necessary informed consent document. Patients would be asked to engage in individual interviews with this researcher, each lasting about 15-20 minutes, and asked to speak about their experience with various aspects of their care and their levels of satisfaction with such care. Some patients will be asked to complete a draft of the developed questionnaire along with a brief interview about the questionnaire. If desired, anonymous data surrounding patients' degrees of satisfaction and overall experience of care can be provided to you.

Thank you for your time and consideration. If you have any questions, please do not hesitate to contact me (XXXX@XXXXX or XXX-XXX-XXXX) or Kevin Lyness, the HSRO Associate Director of Antioch University New England (XXXX@XXXXX; XXX-XXX-XXXX). We look forward to hearing from you.

Sincerely,
Sarah Pearson, M.S.
Psy.D. Candidate
Antioch University New England

Appendix B: Patient Recruitment Flyer

Hello!

I am a doctoral student conducting a research study on **patient experience and satisfaction** with the way that your health center combines medical and behavioral health services to meet more of the needs of their patients. Your participation in this research will help us better understand the patient perspective on healthcare delivery in integrated primary care settings. It will also help us create a patient satisfaction questionnaire of integrated primary care, which can be used by practices to *improve upon the care they are delivering* to their patients.

This study involves participation in a brief interview, which will last about **15-20 minutes** and will be easily completed **today!** If you choose to participate, you will be given a chance to enter a raffle and win a **\$25 Visa gift card!**

All interview responses will be **anonymous** and your information will be kept **confidential**. No identifiable responses will be shared with your doctor or your medical team. Please refer to the attached informed consent document for further details as to how we will accomplish this.

Are you interested in participating? Your provider will inform you of where to find me in your clinic today, so that if you choose to participate or would like to learn more, I can go over additional details of the study with you and have you sign an informed consent document. This document will give you more information about the nature and purpose of the study, including the risks and benefits to participation, confidentiality, and your rights as a participant. Your provider will **NOT** be made aware of whether or not you choose to participate.

If you are interested in entering the raffle as well, you can send an email to XXXX@XXXXX with the subject line "Raffle."

Thank you so much for your consideration. If you have any questions or concerns, please do not hesitate to contact me (XXXX@XXXXX or XXX-XXX-XXXX) or Kevin Lyness, the HSRO Associate Director of Antioch University New England (XXXX@XXXXX; XXX-XXX-XXXX).

Sincerely,
Sarah Pearson, M.S.
Psy.D. Candidate
Antioch University New England

Appendix C: Description of Project and Informed Consent Document

Study Title: Integrated Primary Care: Development of a Patient Satisfaction Measure

Principal Investigator: Sarah Pearson, B.A. **Co-Investigator:** Alexander Blount, Ed.D.

Sponsor: Antioch University New England

Purpose

You are invited to participate in a research study. This study is exploring patient experience and satisfaction with integrated primary care services. You have been identified as a possible participant for this research as an adult patient in an integrated primary care practice.

What is Involved in the Study?

If you decide to participate, you will be asked to participate in a brief interview regarding your experience with care in your clinic. It will last about 15-20 minutes. The interview will take place today in your clinic.

Risks

There may be some risk involved. Talking about your care has the potential to cause emotional distress. You will not be asked to state any behavioral health concern that you have received care for in your clinic. However, talking about this in general could bring up painful memories or feelings depending on your experience. You may want to stop the study or take a break. You may do so at any time.

Benefits

There are also potential benefits from this research. You may benefit from talking about your care and how it has been helpful for you and your life. You will likely feel good talking about any positive experiences you have had. We cannot guarantee that taking part in this study will personally help you. Others may be helped by the information you share. These people could be other patients and providers in your clinic and other clinics.

Confidentiality

Steps will be taken to keep your information confidential and protect it from disclosure or damage. You will be assigned a numerical code. This code will be used on all research notes, audio files, and documents. A password will be required to access any data. Only my research advisor, Dr. Alexander Blount, and I will have access to this password. This consent form will be kept separate from data with coded ID numbers. Handwritten notes and transcripts from interviews will be kept in a locked file cabinet. Only the researcher will have access to this cabinet. Audio files will be destroyed after the study. Anonymous direct quotes from the interviews will be used in the research and publication. The quotes will not include any information that might identify you.

Your Rights as a Research Participant

Participation is voluntary. You have the right not to participate or to leave the study at any time. Deciding not to participate or choosing to leave the study will not result in any consequence. It will not harm your relationship with [Primary Care Clinic Name].

Incentive

If you choose to participate in this study, you will be entered to win a \$25 Visa gift card. You will still be entered into the raffle if you leave the study.

Contact Information

Please contact Sarah Pearson at XXX-XXX-XXXX or at XXXX@XXXXX if you have any questions or concerns. You can also contact Dr. Alexander Blount at XXX-XXX-XXXX or at XXXX@XXXXX.

Please contact Kevin Lyness, Chair of the Antioch University New England Institutional Review Board, at XXX-XXX-XXXX or XXXX@XXXXX if you have any questions or concerns about your rights as a research participant.

Documentation of Consent

Signing on the line below states that I have read this form and consent to participating in the study described above. The general purposes, details of participation, and possible risks have been explained. I understand that I can leave the study at any time.

Participant Name _____ Date _____

Participant Signature _____ Date _____

Appendix D: PIP Domains and Phase One Interview Questions

1. PIP Domain: Workflow
 - a. Please describe the process of your getting referred to the BHC (i.e. did your provider talk with you about this, did you get a phone call, etc.).
2. PIP Domain: Clinical Services
 - a. Please describe your experience receiving behavioral health services in the clinic.
 - b. What is your understanding of the difficulties or issues for which you could be seen by a behavioral health clinician (i.e. substance abuse, mental health concerns, complex medical conditions, etc.)?
 - c. If you are currently prescribed or have been prescribed medication, can you elaborate on your experience with how your medication has been managed by your team?
 - d. Do you have any experience with being referred to specialty mental health or other community resources?
3. PIP Domain: Workspace
 - a. Have you seen both your primary care provider and the BHC in the same day? Have you ever had a joint appointment?
 - b. What is your understanding of who has access to your medical chart? Have you experienced any of your providers referencing your medical chart regarding visits with other providers you have seen?
4. PIP Domain: Shared Care and Integration
 - a. How much do you think your PCP communicates with the BHC at your clinic regarding your care? Are you aware of any collaboration between them regarding your treatment plan and goals?
5. PIP Domain: Case Identification
 - a. To your knowledge, have you been screened for behavioral health concerns? What has been your experience with such screeners? (Can provide examples for clarification).
 - b. Please describe your experience with your provider sharing results of such screenings with you, i.e. how were you made aware of such results and any treatment recommendations?
6. PIP Domain: Patient Engagement
 - a. Please describe any follow-up communication you have had from clinic staff or your provider since your first behavioral health visit and future appointments.
 - b. Are you satisfied with the number of behavioral health visits you have had? How would you describe your degree of access to the behavioral health provider you have seen here?
 - c. How would you go about making an appointment for behavioral health if you needed one?

Appendix E: Phase Two Interview Questions

1. How easy or difficult does this questionnaire seem to be to complete and why?
2. How would you describe the wording of the questions, or is anything worded in a manner that is especially unclear?
3. Are there any questions that you feel you would not be able to answer from your experience?
4. Do you feel there is anything that should be included in a questionnaire that captures patient experience and satisfaction of care that is not currently included?
5. Please describe any other impressions of this questionnaire.

Appendix F: Phase One Interview Results

Main Theme	Subtheme	Data Extract(s)
Satisfaction with BHPs and Services	Patients are typically satisfied with their BHP and the BH services delivered.	I mean it seems like [BHP] really cares about trying to help and give productive solutions to problems I have which is good. (Participant 3)
		I find that the people, you got good counselors. (Participant 2)
		And I find that it pisses me off that you have a right to categorize me, "she's wearing a leather jacket, she's got patches, got tattoos, she's a druggie." (Participant 2)
	The majority of patients were satisfied with the accessibility of BH services, while one patient desired more access.	He's flexible in that regard, provided his schedule allows it. (Participant 1)
		I was surprised that I was able to get such a frequent appointment I guess. (Participant 3)
		I don't believe a half hour is long enough for anybody to spit their name out let alone start a conversation. (Participant 2)
Scheduling Appointments	Scheduling BH appointments by phone or in person is typically quick and easy.	Yeah, I usually just schedule when I'm here. (Participant 3)
		It only takes a few minutes and I'm out the door. (Participant 1)
	Scheduling issues include length of time to initial appointment, and PCP and BH availability.	Yeah, I'm supposed to set up an appointment with the doctor that's here but with his schedule and the other doctor's schedule it's kind of hard to do that but it happens. (Participant 5)
		I know with primary care doctors it's hard sometimes to get an appointment like as early as like two weeks or four weeks out. (Participant 3)
BH Referral Process	Patients have positive experience being referred to BH by PCP or requesting BH services themselves.	My first real, like, appointment with my PCP was just talking about the depression and anxiety and that's when she referred me to behavioral health down here, and then I had to come back for a physical. (Participant 3)

		There's not as much effort required on the patient's part so it's probably more likely that they'll follow through with the appointment. (Participant 3)
	Patients have a limited understanding about the full range of options for BH services.	It seems like, I'm not a hundred percent sure but it seems like a lot of mental health problems. (Participant 3)
		I don't really know, well therapy and psychiatry stuff. (Participant 4)
BHP and PCP Shared Workspace	Patients were typically pleased with having a shared clinic workspace, although one patient felt this was intrusive and unnecessary.	It is very nice to have everything in one place. (Participant 3)
		I'm in a medical exam room, I can't get comfortable. (Participant 2)
		We need to separate the doctor from the shrink. (Participant 2)
	Patients have both positive and negative impressions of same day appointments with BHP and PCP.	No that's never, I think there should be, unless you're talking about putting someone on medication I think that's a no-no. (Participant 2)
Communication and Collaboration Among Providers	Patients can be uncomfortable with the communication and collaboration between their providers.	I don't mind him [BHP] knowing about broken bones or something but going the other way kind of irks me because somebody stitching up my hand doesn't necessarily need to know what's going on in my head. (Participant 1)
	Patients tend to experience co-management of their behavioral health medications by their PCP and BHP positively.	Yeah so [BHP] will ask me questions, like part of my medication is for sleep, um, so she'll ask me how sleep's going and stuff like that. (Participant 4)
		Get out of the pill s***, get out of the medication and get with the mental health part that you're supposed to be treating. (Participant 2)

	Patients can be uncomfortable with shared EHR use while also acknowledging the utility of doing so.	But I also have some say in what goes into it like in therapy sessions and stuff like I can be like this is one thing I don't feel comfortable with but then if it's something that's a little more serious then I don't really have a say. (Participant 4)
Follow-up Contact	Patients feel comfortable reaching out to their BHP directly.	[BHP] has made it pretty clear to me on few occasions that if I find myself in a bad place I can pick up phone and call him. (Participant 1)
	Patients feel that follow-up contact from providers and clinic staff is sometimes lacking.	Am I always getting it? More often than not, but people are human and mistakes get made. (Participant 1)
Screeners in Clinic	Patients feel that consistent screening for BH concerns can be redundant but can help to guide their care.	That should be your first question asked, "how you doing today?" not a piece of paper. (Participant 2)
		You know he [BHP] takes a look at it, gets an idea by looking at the numbers where I am that week. (Participant 1)
	Patients discuss the results of their screeners with their providers.	They're pretty open about explaining the whole thing. (Participant 4)
		Well definitely with my primary care doctor that first appointment we talked about it a lot cause I brought it up and she, like, looked at my scores on it and everything. (Participant 3)

Appendix G: Phase Two Interview Results

Main Theme	Subtheme	Data Extract(s)
Structure of Questionnaire	Format of the questionnaire made it easy to complete.	Yeah, it kind of continues on with the flow of what they have here, the questionnaires at the front and stuff (Participant 9).
	Questionnaire is comprehensive.	This pretty much covers from start to finish. (Participant 6)
Understanding of Individual Items	Patients found it difficult to answer when they lacked experience with a certain aspect of care but patients tended to use N/A option at these times.	The first 3 questions kind of threw me off a bit. I mean I've never really been referred to anywhere outside of here. (Participant 9)
	The wording of several items on the questionnaire caused confusion.	Access and use of electronic health record, I'm only as literate as my smart phone has allowed me to be with computer technology, I'm getting there but I don't own a computer and have yet to send a successful email. (Participant 7)
	Patients understood what was meant by relationship with BHP.	I mean, the importance of being able to communicate with your therapist and direct back and forth, feeling comfortable, that's pretty much the most important part of the whole thing. Because I've had a couple therapists that did the old sit and take notes, you know, and that never worked for me. (Participant 6)

Appendix H: Initial Draft of IPC Patient Satisfaction Questionnaire

Please rate your experience with the following aspects of your care as well as how important each aspect is to your overall care (Please choose N/A if you don't know or if the question is not applicable to your care or you haven't experienced it):

Item	Please rate your experience from 1 (Very Poor) to 5 (Very Good)						On a scale from 1 (Not At All Important) to 5 (Very Important), how important or helpful is this to your overall care that you receive at the clinic?					
	1	2	3	4	5	N/A	1	2	3	4	5	N/A
1. Being referred to non-clinical community resources (i.e. housing, transportation)	1	2	3	4	5	N/A	1	2	3	4	5	N/A
2. Being referred to specialty mental health services outside of my clinic	1	2	3	4	5	N/A	1	2	3	4	5	N/A
3. Being referred to a behavioral health provider in my clinic (or offered the option)	1	2	3	4	5	N/A	1	2	3	4	5	N/A
4. The focus of my behavioral health visits (related to my concerns and/or goals, i.e. trouble with my mood, losing weight, etc.)	1	2	3	4	5	N/A	1	2	3	4	5	N/A
5. Relationship with my behavioral health provider	1	2	3	4	5	N/A	1	2	3	4	5	N/A
6. Medication management for mental health or substance use concerns	1	2	3	4	5	N/A	1	2	3	4	5	N/A
7. The presence of my behavioral health provider and PCP in the same clinic	1	2	3	4	5	N/A	1	2	3	4	5	N/A
8. Access and use of my electronic health record by my behavioral health provider during visits	1	2	3	4	5	N/A	1	2	3	4	5	N/A
9. Access and use of my electronic health record by my PCP during visits	1	2	3	4	5	N/A	1	2	3	4	5	N/A
10. The communication and collaboration between my behavioral health provider and PCP about my care	1	2	3	4	5	N/A	1	2	3	4	5	N/A

Item	Please rate your experience from 1 (Very Poor) to 5 (Very Good)						On a scale from 1 (Not At All Important) to 5 (Very Important), how important or helpful is this to your overall care that you receive at the clinic?					
11. Communication to me from my behavioral health provider about my medical care	1	2	3	4	5	N/A	1	2	3	4	5	N/A
12. Communication to me from my PCP about my behavioral health needs and care	1	2	3	4	5	N/A	1	2	3	4	5	N/A
13. Joint visits with both my PCP and behavioral health provider present	1	2	3	4	5	N/A	1	2	3	4	5	N/A
14. Completing a questionnaire to detect mental health and/or substance use concerns	1	2	3	4	5	N/A	1	2	3	4	5	N/A
15. My provider's communication to me of questionnaire results	1	2	3	4	5	N/A	1	2	3	4	5	N/A
16. Availability of behavioral health providers (i.e. frequency of visits)	1	2	3	4	5	N/A	1	2	3	4	5	N/A
17. Ease of scheduling behavioral health appointments (booking appointment by phone or in person)	1	2	3	4	5	N/A	1	2	3	4	5	N/A
18. Follow-up communication from providers between visits	1	2	3	4	5	N/A	1	2	3	4	5	N/A
19. Follow-up communication from clinic staff around my behavioral health care (i.e. if I miss an appointment)	1	2	3	4	5	N/A	1	2	3	4	5	N/A
20. Overall care received at the clinic (medical and behavioral health care)	1	2	3	4	5	N/A						

Appendix I: Final Draft of IPC Patient Satisfaction Questionnaire

Please rate your experience with the following aspects of your care as well as how important each aspect is to your overall care.

*PCP or primary care provider may include any of the following: family physicians, general internists, medical advanced practice nurses or clinical nurse specialists or medical physician assistants (Peek, C. J. & The National Integration Academy Council, 2013, p. 16).

*Behavioral health provider may include: clinicians and health coaches of various disciplines or training, including but not limited to mental health professionals (Peek, C. J. & The National Integration Academy Council, 2013, p. 44).

Item	Please rate your experience from 1 (Very Poor) to 5 (Very Good)						How important is this to your overall care at the clinic (1 being Not Important At All and 5 being Very Important)?						
1. Being referred to community resources outside of my clinic (assistance with housing, transportation, food, etc.)	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
2. Being referred to behavioral health services outside of my clinic	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
3. Being referred to a behavioral health provider in my clinic (or offered the option)	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
4. What my behavioral health provider and I work on together (i.e. trouble with my mood).	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
5. Relationship with my behavioral health provider	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
6. Medication management for behavioral health or substance use concerns	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
7. The presence of my behavioral health provider and PCP* in the same clinic	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
8. My behavioral health provider's use of my electronic health record during visits	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
9. My PCP's use of my electronic health record during visits	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
10. The communication and collaboration between my behavioral health provider and PCP about my care	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this

Item	Please rate your experience from 1 (Very Poor) to 5 (Very Good)							How important is this to your overall care at the clinic (1 being Not Important At All and 5 being Very Important)?					
11. Discussion with my behavioral health provider about my medical care	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
12. Discussion with my PCP about my behavioral health needs and care	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
13. Joint visits with both my PCP and behavioral health provider present	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
14. Completing a questionnaire to detect mental health and/or substance use concerns	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
15. My provider discussing questionnaire results with me	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
16. Availability of behavioral health providers (i.e. frequency of visits)	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
17. Ease of scheduling behavioral health appointments (booking appointment by phone or in person)	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
18. Follow-up communication from providers between visits	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
19. Follow-up communication from clinic staff around my behavioral health care (i.e. if I miss an appointment)	1	2	3	4	5	I don't know or I haven't experienced this		1	2	3	4	5	I don't know or I haven't experienced this
20. Overall care received at the clinic (medical and behavioral health care)	1	2	3	4	5	I don't know or I haven't experienced this							

Table 1*Participant Demographic Information.*

	Phase One (<i>n</i> = 5)	Phase Two (<i>n</i> = 6)	Total (<i>N</i> = 11)
Gender			
Female	2 (40%)	3 (50%)	5 (45.45%)
Male	2 (40%)	2 (33.33%)	4 (36.36%)
Transgender	0 (0%)	1 (16.67%)	1 (9.09%)
Genderqueer/ Genderfluid	1 (20%)	0 (0%)	1 (9.09%)
Age Range			
18-25	2 (40%)	4 (66.67%)	6 (54.55%)
26-49	1 (20%)	0 (0%)	1 (9.09%)
50-64	2 (40%)	2 (33.33%)	4 (36.36%)
Ethnicity			
Caucasian	5 (100%)	6 (100%)	11 (100%)
Hispanic or Latino	0 (0%)	2 (33.33%)	2 (18.18%)
African American	0 (0%)	1 (16.67%)	1 (9.09%)
Education Level			
Some High School	1 (20%)	0 (0%)	1 (9.09%)
GED/High School Degree	1 (20%)	2 (33.33%)	3 (27.27%)
Some College	1 (20%)	2 (33.33%)	3 (27.27%)
Associate's	1 (20%)	1 (16.67%)	2 (27.27%)
Bachelor's	1 (20%)	1 (16.67%)	2 (27.27%)
Annual Income			
0-\$10,000	3 (60%)	3 (50%)	6 (54.55%)
\$10,000-\$19,000	1 (20%)	1 (16.67%)	2 (27.27%)
\$20,000-\$29,000	0 (0%)	1 (16.67%)	1 (9.09%)
\$60,000-\$69,000	1 (20%)	0 (0%)	1 (9.09%)
\$100,000-\$149,000	0 (0%)	1 (16.67%)	1 (9.09%)
Employment			
Unemployed/Disability	3 (60%)	3 (50%)	6 (54.55%)
Part-time	0 (0%)	2 (33.33%)	2 (27.27%)
Full-time	1 (20%)	0 (0%)	1 (9.09%)
Student	1 (20%)	1 (16.67%)	2 (27.27%)

Table 2*Phase One PIP Domain Ratings.*

	Workflow	Clinical Services	Workspace	Shared Care & Integration	Case Identification	Patient Engagement
Participant 1	7	10	8	1	5	10
Participant 2	-	-	-	-	-	-
Participant 3	8	8	6	7	6	7
Participant 4	10	10	7	10	9	9
Participant 5	9	9	10	10	10	10