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Providers' Perspectives on Women's Integrated Healthcare: An Exploratory Study

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Table of Contents

List of Figures and Tables

Appendices

Appendices A-J. Measures

Appendix A. Demographics Questionnaire

Appendix B. Patient Population

Appendix C. Provider Work Experience (Level of Integration)

Appendix D. Level of Administrative/Organizational Support

Appendix E. Inter-Professional Relationships

Appendix F. Patient-Provider Relationship

Appendix G. Providers' Perspectives on Patient Healthcare Disparities and Barriers

Appendix H. Providers' Perspectives on Patient Satisfaction and Well-Being

Appendix I. Provider Job Satisfaction

Appendix J. Provider Beliefs

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Abstract

Women of color, low socioeconomic status (SES) women, and other minority groups face healthcare disparities in the U.S. healthcare system, including lower quality care (Cook et al., 2009), dissatisfaction, and barriers to accessing care (Anderson et al., 2001; Avery et al., 2011). In recent years, within the healthcare field, there is an increased interest in integrated healthcare, specifically, the integration of mental health services in primary care. The current study uses a mixed method exploratory approach to investigate providers' perspectives on women's healthcare disparities from a relational and systems perspective. We included both psychologists and primary care physicians from three levels of healthcare integration (traditional/coordinated, co-located, and integrated). This study aimed to 1) examine both structural and relational factors that contribute to providers' experiences at various levels of integration and their perspectives on women's healthcare; 2) identify interrelationships among structural, relational, and provider factors; 3) explore differences in provider perspectives between provider types and levels of integration; 4) examine predictors of provider beliefs and job satisfaction; and 5) identify themes in narrative data on provider healthcare experiences with diverse women. As we hypothesized, results indicated that providers in integrated settings were the most satisfied with their collaboration with other providers. Providers' narratives revealed that healthcare integration is promising for improving patient-provider relationships and providers' knowledge and sensitivity to health disparities and provided insight into areas for further training and intervention. Implications of these findings highlight the need for in-depth understanding of various impact factors, experiences of providers, and potential benefits of integrating care for women of diverse backgrounds.

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CHAPTER ONE

Introduction

In the medicalized model of healthcare women's health issues have been historically undervalued and in recent years, this issue has become more critical. At the same time within the healthcare field, there is an increased interest in integrated healthcare, which may have unique benefits for the future of women's healthcare. The American Psychological Association (APA; American Psychological Association, 2014b) now endorses the practice of integrated healthcare. Though not directly promoting integrated healthcare, the World Health Organization (WHO) continues to advocate for a holistic perspective on health and well-being (World Health Organization, 1946). The integrated healthcare model increases collaboration and communication among providers from different disciplines, including psychology, psychiatry, and various medical disciplines. This study focuses specifically on integrated healthcare that includes the blending of mental health and primary medical care, sometimes referred to as *integrated behavioral health.* Integrated healthcare has been growing in its support and implementation and is an essential topic for education, research, training, and practice, as it may well be the future of our healthcare system. The WHO defines health as "the state of physical, mental, and social well-being." Yet, the U.S. traditional medical system continues to focus primarily on physical health. Integrated behavioral healthcare can help bridge this gap and incorporate mental and social well-being. The growing body of

research on integrated behavioral healthcare shows positive outcomes, though more research is needed, especially in the area of women's integrated healthcare specifically.

Theoretical conceptualizations of integrated healthcare have proposed its usefulness for potentially correcting healthcare disparities—the inequities in healthcare access, treatment, and outcomes for people from vulnerable groups including women, racial and ethnic minorities, the poor, and others. Primary care providers represent an underutilized potential gateway to mental healthcare and other social services. Access to mental healthcare, especially for vulnerable populations, is lacking. In previous studies, two-thirds of primary care physicians (PCPs) reported that they could not refer to a mental healthcare clinician when they felt it was needed (Cunningham, 2009). Additionally, there is evidence that primary care physicians on their own are only able to identify less than half of their patients that meet criteria for a mental health diagnosis (Kohn-Wood & Hooper, 2014). As a result, though PCPs are a great potential resource for coordinating their patients' mental healthcare, too many patients fall through the cracks. Integrated healthcare, though relatively new in its implementation, is expected to reduce healthcare disparities overall, especially in improving access to mental healthcare. Both the patient-provider and provider-provider relationships have been shown to impact patient care and satisfaction. The increased level of collaboration between providers in an integrated healthcare system may factor into improved health outcomes for marginalized communities, including women from diverse backgrounds (Butler et al., 2008). Lastly, an increased focus and training in holistic health may help correct health disparities related to provider beliefs, actions, and decisions. Studies (Butler et al., 2008; Reiss-Brennan et al., 2016) so far in the area of health disparities focus primarily on population level

outcomes or patient perspectives, despite the importance of providers in providing quality care. Providers are a key focus of intervention through training, education, and new models of care to improve health disparities (Smedley, Stith, & Nelson, 2002) To date, no qualitative studies integrate interdisciplinary providers' perspectives across varying levels of collaboration (from traditional medical settings through integrated care). Additionally, no known studies look at women's integrated healthcare specifically, which is essential given that historically women's health has been undervalued and under researched (American Psychological Association, 2007). Thus, this study focused specifically on providers' experiences delivering women's healthcare. This study used a mixed-methods design to examine providers' (mental health and primary care providers) experiences in their practice of women's healthcare across three levels of integration (traditional/coordinated, co-located, and integrated) from a relational and system perspective.

Integrated Healthcare

Integrated healthcare refers to the model of providing holistic, person-centered healthcare using an inter-professional and collaborative approach (American Psychological Association, 2014a). *Integrated behavioral health* often refers specifically to the integration of mental or behavioral health and medical care with medical care (Miller, B. F., Kessler, Peek, & Kallenberg, 2011; Miller, E., Lasser, & Becker, 2007). Given that these terms are often used interchangeably in the literature (American Psychological Association, 2014a; Heath, Wise Romero, & Reynolds, 2014; Miller, B. F. et al., 2011), we use the term, *integrated healthcare,* referring specifically to the integration of medical and mental health or behavioral health services. Integrated

healthcare may be found in specialty medicine, including pain management and end of life care, but this project focused on integrated behavioral health within primary care. There may be providers with different levels of education and roles working in both mental health and primary care. However, providers' educational and professional training are important considerations for their perception, beliefs, and use of healthcare modalities, including collaboration and integration. Thus, for the purpose of this study we used similar professional training levels for both mental health and primary care providers, This study is focused on mental health providers (psychologists) and medical providers (primary care physicians) and these terms are used interchangeably for this paper. The terms *patient* and *client* are also used interchangeably.

Integrated healthcare is also considered along a continuum, where different practice models exist from separated care through fully integrated and collaborative care. There are also models of integrated healthcare from several disciplines and perspectives, including medicine. This study utilized models of integrated care specifically coming from the field of psychology and mental health. Several terms are used interchangeably or overlap considerably with integrated healthcare and confusion of terms is often cited as a barrier to research and implementation in this area (Miller, B. F. et al., 2011). Some practitioners and researchers in the field use the term *collaborative care* as the umbrella term for various models of integrated healthcare. The World Health Organization (WHO) defines collaborative practice as "when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, caregivers, and communities to deliver the highest quality of care across settings" (World Health Organization, 2010). *Integrated healthcare* is often considered

the highest level of collaboration in a healthcare system between providers working with the same patient. Other terminology may include *consultation, coordinated care, shared care, primary care behavioral health, or care management.* At the lowest level of collaboration would be *co-located care* or *behavioral healthcare (*either outside or co-located). Lastly, *a patient-centered medical home is* a specific type of integrated care where providers work together using a personalized approach for each patient (Miller, B. F. et al., 2011). A related concept, *patient-centered care*, first introduced by Gerteis (1993) continues to gain popularity within the US healthcare system. *Patient-centered care* is defined by the Institute of Medicine (IOM) as care that is "respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (Baker, 2001). Specific models have also been presented for *patient-centered culturally sensitive health care* to use a patient-centered care model to provide culturally competent care (Tucker et al., 2007). Research on patient-centered care so far has found a positive impact on patient outcomes (Epstein, Fiscella, Lesser, & Stange, 2010). Additionally, teamwork among providers has been shown to be a key component of patient-centered care (Epstein et al., 2010).

The idea of integrated healthcare stems from the work of Dr. George L. Engel and his biopsychosocial model (Engel, 1977). The biopsychosocial model represented a huge shift from the traditional medical or *biomedical* model, which focused solely on biological factors found within the body. Engel (1977) suggested that we view problems as a combination of biological, psychological, and social factors. He maintained that the traditional model was too reductionist and no longer fit the needs of our healthcare system, especially for mental health conditions. The addition of non-biological factors

facilitates a more accurate and holistic perception of health. Psychologists agree that with the importance of the biopsychosocial model in their conceptualizations and treatment of patients (McDaniel, 1995). Many psychologists view integrated healthcare as a step forward in providing care from this perspective (McDaniel, 1995). Furthermore, there is considerable overlap between integrated and holistic models of care.

Though various models of integrated care exist, this study utilized an approach coming from the field of psychology and mental health focusing specifically on the integration of mental health services and primary care. According to the Substance Abuse and Mental Health Administration's (SAMHSA) guidelines (Heath et al., 2014), integrated healthcare is located along a spectrum with traditional medical care, with varying levels of collaboration from minimal collaboration through fully integrated care for the general population in the United States. The dominant descriptive model of integrated primary and behavioral healthcare in the U.S. comes from Doherty, McDaniel, and Baird (1996) and proposes five levels of collaboration from no collaboration (traditional care) to full collaboration and is adapted SAMHSA standard framework for integrated healthcare (Doherty, McDaniel, & Baird, 1996; Heath et al., 2014). Level 1 is minimal collaboration; this is the traditional medical model, where primary care providers and mental health providers have little interaction with each other and do not coordinate patient care. Level 2 is basic collaboration from a distance; providers may have more communication than Level 1, but they do not share an integrated space. Primary care providers may send referrals to off-site mental health clinicians. Level 3 is basic collaboration on site and Level 4 is close collaboration in a partly integrated system. Both Level 3 and Level 4 are examples of the Co-Location Model, which was

popular when integrated healthcare first started out from 1987 through around 1998 (Vogel, Kirkpatrick, Collings, Cederna-Meko, & Grey, 2012). In a co-located model of care, mental health services and primary care are located in the same facility. Thus, providers may have more interaction with each other and easier referrals, but maintain distinct office, roles, and patient care. Fully integrated healthcare has the highest level of collaboration (Level 5) (Vogel et al., 2012); healthcare providers from various disciplines would work together as a team providing care for the patient and sharing responsibility and decision-making (Doherty et al., 1996). In the fully integrated healthcare setting, primary care and mental health providers share space and patients. They collaborate and communicate regularly to provide care for their shared patients. Some models add in Level 6 or a transformed or merged practice (Heath et al., 2014). In this full collaboration model, medical and mental healthcare function as one unified healthcare system where all providers treat all patients holistically with shared language and professional cultures (Heath et al., 2014). Many researchers condensed this spectrum model to three levels of collaboration: traditional/coordinated (Level 1 and 2), co-located (Level 3 and 4), and integrated (Level 5 and 6) care (Heath et al., 2014). This three-level model was used in this project based on simplicity and the view of healthcare integration and collaboration on a continuum. The benefits and challenges of integrated healthcare models will be discussed.

Benefits of Integrated Healthcare. Overall, integrated healthcare has many theoretical and empirically supported benefits. Integrated healthcare provides holistic care for both the mind and body. This model of care shows improved outcomes within both domains (mental health and physical health care systems). Integrated healthcare also

demonstrates improvements in patient experiences, population health, and costs— "The Triple Aim." Lastly, the hope is that integrated healthcare will reduce health disparities for vulnerable populations by providing them with increased access to holistic care and preliminary research supports this idea.

The first benefit of integrated healthcare is its ability to provide holistic care for patients. Susan McDaniel, Ph.D.—one of psychology's most vocal proponents of integrated healthcare—argues that one of its greatest benefits is avoiding the separation of mental health and physical health, also known as *mind-body dualism* (McDaniel, 1995). The connection between mind and body is well documented. The mind can influence the body and the vice versa. As a result, integrated health care can help bridge this gap through three main types of care: treating mental health and psychosocial concerns within primary care, behavioral interventions to strengthen primary care, and primary care for individuals with mental illness (Pincus, 2003). Greater integration between different types of providers helps achieve more complete care and avoid this unnecessary differentiation. It would be very difficult, if not impossible, for providers to attend to all factors on their own. Working together allows all of the pieces to come together. Thus, the integrated healthcare model is extremely compatible with the biopsychosocial model.

Integrated healthcare shows demonstrated improvements over traditional care in both the biological and psychosocial domains. First, for mental health care, integrated health care improves access, satisfaction, and outcomes. Access to mental health care is a barrier to patients receiving this type of care, which can be overcome through integrating healthcare (Coons, Morgenstern, Hoffman, Striepe, & Buch, 2004; James, 2006). This is

essential given that up to 70% of primary care visits are related to mental health; yet, only a small portion of those patients will receive specific mental health services (American Psychological Association, 2014a). Barriers to getting services to those in need include: problems with physician identification of issues, referrals, as well as patient barriers such as stigma (Cunningham, 2009). Research also supports improvements in mental health care outcomes through integrated care. Randomly controlled studies (RCTs) show integrated interventions for specific diagnoses, such as depression, demonstrate improved patient outcomes (decreased depressive symptoms) and satisfaction (Kolbasovsky, Reich, Romano, & Jaramillo, 2005). The Agency for Healthcare Research and Quality (AHRQ) recognizes the lack of broad research, as most RCTs focus on specific diagnoses (Butler et al., 2008).

Integrating mental healthcare providers working alongside medical providers will help improve medical care as well. This is especially important within the changing landscape of our society's healthcare needs. Many healthcare utilizers in America have complex healthcare needs that would benefit from increased collaboration. The healthcare system has increasingly shifted toward treating chronic conditions and this trend is expected to continue (Anderson, G. & Horvath, 2004; Savage et al., 2016). Individuals with chronic conditions make up most of healthcare users and spending. These individuals often see multiple providers, including mental healthcare providers. Unfortunately, chronic care patients often report inadequate satisfaction with care, especially coordination between providers. Their lack of satisfaction negatively affects health outcomes, such as preventable hospitalizations. The healthcare system must change to accommodate the changing healthcare landscape and integrated healthcare is a

promising model to provide more efficient and effective care for individuals with more complex needs (Anderson, G. & Horvath, 2004; McDaniel & deGruy, 2014).

"The Triple Aim" is often used as a benchmark and tool in describing the benefits of any healthcare system changes, including integrated healthcare. The Triple Aim model suggests that improving the U.S. healthcare system needs to meet the following three goals: improve the patient healthcare experience, improve population health, and reduce the cost of healthcare (Berwick, Nolan, & Whittington, 2008). Many proponents of integrated healthcare believe that it has the potential to improve our current healthcare system in all three of these areas with empirical support (Berwick et al., 2008). The last large-scale review of the empirical literature on integrated healthcare is from 2008, by the Agency of Healthcare Research and Quality (AHRQ). The review found 33 randomly controlled trials with various levels of integration, examining patient outcomes based on the added integration of mental health providers into primary care (Butler et al., 2008). Research at this point focuses on outcomes of patients with depression. In these trials, patients overall show reduced mental health symptom severity, functional impairment, and rates of remission, with higher rated quality of life compared to traditional primary healthcare without mental health providers (Butler et al., 2008). At the level of population health, integrated care shows improvements for patients with depression, in particular for older adults with depression (Butler et al., 2008). It is still unclear how integrated healthcare impacts the population with various mental health condition and/or comorbidities. However, it is worth nothing that the majority of the research is on the use of the Collaborative Care Model of integration specifically. Other models with more generalist behavioral health approaches, such as the Primary Care

Behavioral Health (PCBH) model are promising, but are new and have little research at this time (Reiter, Dobmeyer, & Hunter, 2018).

Recent studies indicate improved outcomes with an integrated healthcare approach. Specific outcomes include quality of life and confidence in being able to handle their problems (Chomienne et al., 2010). Patients report positive experiences of integrated healthcare services in general (Reiss-Brennan et al., 2016). Improvements in patient experience include care quality (i.e. higher rates of screenings and greater treatment adherence) and reduced utilization (including lower emergency room visits and hospitalizations; (Reiss-Brennan et al., 2016). At the population level, more comprehensive primary care is associated with lower hospitalization rates overall (Kringos, Boerma, van der Zee, & Groenewegen, 2013). Countries with stronger primary care systems (more coordination and comprehensive services) show patterns of greater health outcomes for patients with a variety of chronic diseases (Kringos et al., 2013). Lastly, integrated healthcare in some studies, has lower costs overall for both patients and the system in comparison to traditional separated care (Reiss-Brennan et al., 2016). Other studies recognize the higher cost of building integrated care systems, at least at the start, though costs are expected to decline over time (Kringos et al., 2013).

Challenges of Integrated Healthcare. Though integrated healthcare demonstrates empirically supported and theoretical benefits, barriers need to be examined to understand effective implementation strategies. These barriers include: political, financial, and educational barriers. In the current political climate, changes to the healthcare system, especially movement toward what some might view as “socialized” medicine, is proving to be challenging. Other political barriers are more interpersonal.

For example, the redistribution of power may pose a threat to medical doctors who are used to being in charge (Berwick et al., 2008; Zwarenstein, Rice, Gotlib-Conn, Kenaszchuk, & Reeves, 2013). Financially, it may be difficult to secure funding for integrated care (Berwick et al., 2008) including the implementation of programs and insurance payments for services within this new system (Huang, Fong, Duong, & Quach, 2016). Additionally, training programs need to have a special focus for this new frontier. Current studies reveal that training is insufficient for working in multidisciplinary teams such as this across all types of providers (Hall et al., 2015). Providers also need continued cultural competence training to make this model more effective in reducing health disparities (Huang et al., 2016; Keegan et al., 2015; Tucker et al., 2007). Crucial to the success of this model is strong communication and collaborative practice among professionals. Both medical doctors (Powell, Doty, Casten, Rovner, & Rising, 2016) and mental health clinicians (Frohm & Beehler, 2010; Nash, McKay, Vogel, & Masters, 2012) will require shifts in their thinking and training to work together in this new way. Overall, true integrated healthcare and its benefits require more than just putting together two separate traditional systems. It requires collaboration and holistic thinking from providers involved (Ventevogel, 2014).

Another challenge is that integrated healthcare is an emerging field and models. As a result, more research is needed on the efficiency, benefits, and challenges of integration and collaboration. In 2010, AHRQ provided a follow up review paper on the areas of future research needed in integrated healthcare based on systematically identifying the gaps in the previous literature review (Carey et al., 2010). The top three research needs based on input from stakeholders in the field were: effective methods of

integration (for both mental and physical health outcomes), testing the effectiveness of more broad interventions (not just specifically for depression, etc.), and examining the use of technology and electronic health records (EHR). Additional research is also needed to overcome the funding challenges of integration including payment and reimbursement systems and cost-effectiveness. There is also a call for more in depth research on broader patient populations (beyond patients with depression) and analyses from multiple perspectives. As integrated healthcare continues to grow and emerge as an ideal model for our healthcare system, more research is needed to make it the best it can be for all stakeholders. Another closely related issue to integrated healthcare is healthcare disparities and the potential for integrated healthcare to reduce healthcare barriers for vulnerable populations, including women.

Healthcare Disparities

Healthcare disparities refers to the inequalities in access, treatment, and outcomes for patients based on sociopolitical factors such as race/ethnicity, gender, sexual orientation, disability status, religion, socioeconomic status (SES) and more (US Department of Health and Human Services, 2008). These inequities are considered a systemic problem and a matter of national and worldwide concern. These social factors can affect everything from a person's health status to the quality of care they receive. The World Health Organization (WHO) recognizes these social determinants of health driven by both differing levels of vulnerability (through social and physical environmental factors) and healthcare systems responses to prevention and disease (World Health Organization Commission on Social Determinants of Health, 2008). As a result, healthcare disparities exist for vulnerable groups at the population level where they have

higher rates of disease, lower quality care, less access, poorer outcomes. The same is true for both traditional medical and mental healthcare. Even as healthcare improves in providing person-centered care, few healthcare disparities among a variety of groups, including racial/ethnic minorities, have been eliminated (Agency for Healthcare Research and Quality, 2015). A variety of marginalized groups in the United States often face fragmented and lower quality care. Specific healthcare disparities for women will be discussed, with a focus on women's intersecting identities including gender, race/ethnicity, sexual orientation, disability status, and age. Addressing this issue is feasible through an integrated healthcare practice framework. This approach can facilitate best practice to understand the struggle and challenges experienced by oppressed/marginalized groups including women from diverse racial, gender, and other social/cultural backgrounds. Negative experiences of oppression are known to compound for individuals with multiple vulnerable social identities such as women of color (Crenshaw, 1991). Most of these health disparities are noticed at the intersections of multiple vulnerable identities in both physical (Parish, Swaine, Son, & Luken, 2013) and mental health (Jackson, Williams, & VanderWeele, 2016) areas.

Healthcare disparities among women. A large body of research highlights health disparities for a range of minority groups, including women. The history of both medical and mental healthcare systems is fraught with discrimination and bias against women (American Psychological Association, 2007). In present day, disparities endure. Women are less likely to receive specialty consultations and receive follow-ups than men with the same conditions (Cook, Ayanian, Orav, & Hicks, 2009). Women's focus groups in the U.S. identify themes of dissatisfaction with their healthcare and barriers to

receiving good healthcare include: not having enough time, lack of child care, financial barriers, experience of discrimination, frustration with lack of continuity of care, and feeling that their concerns were not taken seriously by their providers (Anderson, R. T. et al., 2001; Avery, Escoto, Gilchrist, & Peden-McAlpine, 2011). Overall, women feel that the healthcare system needs to be more holistic to better serve their needs, especially in mental health care areas (Anderson, R. T. et al., 2001; Avery et al., 2011). Women also express concern with being able to make health related behavior changes due to confusion, information overload, and lack of time for self-care (Avery et al., 2011). In terms of mental healthcare, women are more likely to have diagnoses like depression and experiences of trauma than men, but many of them do not receive adequate mental health treatment (Poleshuck & Woods, 2014). Health disparities compound for minority women and women with other marginalized identities. Thus, those specific areas of intersection and compounding oppression need to be further explored in depth.

Health disparities for racial and ethnic minority women are particularly important to explore, as gaps in health and healthcare are largest for many of these groups. Health disparities for racial and ethnic minorities exist for both physical and mental health beyond differences of socioeconomic status (Smedley et al., 2002). Physical health disparities include overall health, rates of disease, death rates, and quality of care (Anderson, G. & Horvath, 2004; Smedley et al., 2002). These differences may be attributed to bias, discrimination, and stereotyping at institutional *and* interpersonal levels. African Americans in particular are more likely to struggle with chronic disease (Anderson, G. & Horvath, 2004), have barriers to care access (Parish et al., 2013), and have worse outcomes and survival rates (Anderson, G. & Horvath, 2004; Keegan et al.,

2015). Compounding both race and gender, women of color are much more likely to have health problems, but are less likely to receive treatment (Anderson, G. & Horvath, 2004). Even with treatment, they show worse outcomes than their White counterparts (Anderson, G. & Horvath, 2004; Parish et al., 2013). Less is known about the health disparities of other racial and ethnic groups. Evidence suggests that Hispanics, Asians, and Native Americans also receive less preventative care and have worse outcomes than their White counterparts (Virnig et al., 2002). For non-English speaking immigrant women, language is an additional concern and barrier within healthcare (Lindsay et al., 2016). In focus groups of Brazilian immigrant women living in Massachusetts, they were overall very satisfied with the U.S. healthcare system, but have also struggled with a lack of interpreting services, cultural differences (including around childbirth), and some discrimination (Lindsay et al., 2016). English-speaking immigrant women may still perceive discrimination from their health providers resulting in disengagement from care, underutilization of mental health services, and dissatisfaction with the quality of healthcare they receive (Arntz & Ray, 2017). Despite federal initiatives, heath disparities remain for women of color including greater risk of serious conditions, higher infant mortality rates, and fewer preventative health care and screenings (Oleson & Ziegler, 2014).

Racial and ethnic minorities also face disparities in both incidence of mental health concerns and treatment disparities. Disparities also exist for racial and ethnic minorities in rates of mental health concerns and access and quality of mental health care. Experiences of discrimination are unfortunately common for many people of color in the U.S. and self-reported discrimination correlates with mental health disorders and

domestic violence (Gee, Spencer, Chen, Yip, & Takeuchi, 2007). Thus, these minorities are more likely to have mental health needs, but less likely to receive adequate treatment (Kohn-Wood & Hooper, 2014). In addition, prevalence of stigma attached to mental health care creates another layer of difficulties for these many racial and ethnic minority groups. Stigma is a top reason cited for unmet mental health needs and this effect is stronger for minorities, especially African Americans (Alang, 2015; Wafula & Snipes, 2014). Stigma is an important concern and barrier for many other ethnic groups including Latinos (Bridges et al., 2014) and Asian Americans (Han & Pong, 2015). In many cultures, mental health problem are not as acceptable as physical health problems. The integration of mental health services into primary care is expected to help reduce the effects of stigma as a barrier to access to mental health services because services are offered within a non-stigmatized setting (Alang, 2015; Bridges et al., 2014). Additionally, warm hand offs and same day appointments with mental and behavioral health providers have the potential to reduce the rate of patients lost due to lack of attending follow up appointments (Reiter et al., 2018). Overall, some disparities based on racial and ethnic group have begun to improve, but they are still present among many racial and ethnic minorities with lower SES backgrounds (Agency for Healthcare Research and Quality, 2015).

Although it is difficult for this overview to be exhaustive of all groups, other vulnerable groups include sexual minority women. Lesbian, gay, bisexual, transgender, and other individuals under this umbrella (LGBT+) often face both overt and covert discrimination in healthcare settings (Dean, Victor, & Guidry-Grimes, 2016). Sexual identity has also not been included in the WHO social determinants of health despite

disparities in physical and mental healthcare (Logie, 2012). Sexual minority individuals are more likely to die from diseases that are more preventable (Bränström, Hatzenbuehler, Pachankis, & Link, 2016). LGBT+ patients may receive unequal screening rates for these diseases contributing to some of the disproportionate outcomes. LGBT+ individuals are also more likely to have mental health concerns, including higher rates of mood disorders and suicidality (Logie, 2012). Transgender individuals are particularly vulnerable to health disparities and discrimination within the healthcare system (Hughto, Reisner, & Pachankis, 2015). Unfortunately, so far, diversity training has not been enough to combat the microaggressions and other negative experiences faced by the LGBT+ community in their healthcare (Dean et al., 2016).

Socioeconomic status (SES) in the U.S. often determines health status and treatment within the healthcare system. Women in the United States are also more likely than men to be living in poverty (U.S. Census Bureau, 2016). Regardless of other social identities, people with lower incomes and those living in poor neighborhoods experience less access and lower quality healthcare services (Agency for Healthcare Research and Quality, 2015). Individuals with low SES are more likely to have mental health problems and less likely to have access to care (Aneshensel, 2009). SES is a large factor in determining a person's access to services and outcomes; vulnerable populations (like ethnic minorities, etc.) living in poverty show the greatest health disparities (Parish et al., 2013). Survival and health outcomes for low SES individuals are one important area to consider. For women battling breast cancer, clear health disparities exist based on race and ethnicity; however, they also interact with the effects of SES. Non-Hispanic White women living in low-SES neighborhoods showed similar lower rates of survival than

their high-SES counterparts and around the same level as African American women at all SES levels (Parish et al., 2013). Additionally, low SES individuals are less likely to be satisfied with their care and on average receive shorter consultations from their medical providers (Videau, Saliba-Serre, Paraponaris, & Ventelou, 2010). They also report demeaning experiences with their health care provider that make it unlikely for them to seek care in the future (Allen, Wright, Harding, & Broffman, 2014). Compounding SES and mental health within primary care, low SES patients with mental health symptoms are also more likely to receive shorter appointments than their higher SES counterparts (Videau et al., 2010). Unfortunately, these inequalities for low-income individuals and families have not improved over time, despite some government interventions, and show signs of real crisis (Agency for Healthcare Research and Quality, 2015).

Lastly, elderly women and women with disabilities are two additional vulnerable populations that warrant inclusion in a discussion of health disparities. Women with disabilities include those with physical and/or mental disabilities. Health disparities and barriers exist for both elderly and disabled women in research, treatment, and outcomes. Overall, women with disabilities have poorer health, outcomes, and access than the general population (Krahn & Fox, 2014; Wisdom et al., 2010). In recent years, individuals with chronic pain make up a significant portion of those with physical disabilities, and they also experience worse outcomes and challenges within the patient-provider relationship (Matthias et al., 2010). Additionally, though the elderly, and in particular, elderly women, have many health concerns, they are often excluded from clinical trials (Lee, Alexander, Hammill, Pasquali, & Peterson, 2001). Thus, evidence-based practice may not specifically apply to them. Within the patient-provider

relationship, healthcare provider bias and stereotypes may prevent adequate care (Chapman, Kaatz, & Carnes, 2013). Both elderly women (Bynum, Braunstein, Sharkey, Haddad, & Wu, 2005) and women with disabilities (Parish et al., 2013) are less likely to have preventative screenings for diseases like breast cancer. Again, it is important to take an intersectional approach as issues for elderly and disabled women are compounded when they are also women of color or have other multiple marginalized identities (Parish et al., 2013; Reichard, Stolzle, & Fox, 2011).

Provider contributions to health disparities. Much of the focus in the area of health disparities has been on differing rates of disease and systemic issues such as access for vulnerable groups. A less explored, yet significant issue is provider contributions to health disparities. Differences in health provider treatment of patients based on social identity (including race, gender, etc.) have been found in past literature (Aronson, Burgess, Phelan, & Juarez, 2013; Blair, Steiner, & Havranek, 2011; Chapman, Kaatz, & Carnes, 2013; Dovidio & Fiske, 2012). Theoretical and empirical research posits that providers have a significant effect on known health disparities including access, quality of care, and prognosis (Aronson et al., 2013; Dovidio & Fiske, 2012; van Ryn & Fu, 2003). There are several mechanisms that may explain this effect including discrimination and perceived discrimination (Blair et al., 2011; Chapman et al., 2013; van Ryn & Fu, 2003), treatment decision-making (Dovidio & Fiske, 2012), and gate keeping access to services (van Ryn & Fu, 2003). Both implicit and explicit prejudices have been found among providers in regards to race, gender, and age (Chapman et al., 2013). For example, providers have been found to act less warm and collaborative with these groups of patients, including people of color, women, and the elderly (Chapman et

al., 2013). It is likely that providers may show similar patterns of behavior and bias with other marginalized groups that may not have been studied as of yet. Research also suggests that implicit bias significantly impacts providers' treatment and communication with patients from marginalized groups (Blair et al., 2011; Chapman et al., 2013). Additionally, perceived discrimination contributes to health disparities through patient behaviors (van Ryn & Fu, 2003). Patients who perceive discrimination or bias from their providers are more likely to avoid healthcare altogether, show patterns of ineffective communication in treatment and have lower adherence rates (Aronson et al., 2013).

Suggestions have been made in reducing provider contributions to health disparities including awareness of bias and other diversity trainings (Dovidio & Fiske, 2012). It is also important to preemptively counteract the potential for perceived discrimination in patients by focusing on strengths and empowering patients from marginalized backgrounds (Aronson et al., 2013). Despite its importance, there is a dearth of research on improving provider-related contributions to patient health disparities. In particular, alternative healthcare models, including integrated healthcare, have not been explored in terms of their impact on provider-related health disparities, including provider bias in their work with diverse patients.

Impact of Integrated Healthcare Practices on Disparities

A less researched—yet important—potential benefit of integrated healthcare is the hope that it will help alleviate issues of healthcare disparities in our society. Integrated healthcare is a promising change to the traditional medical system that may reduce these disparities in access, treatment, and outcomes for a large group of vulnerable populations. Many of these populations have chronic conditions that could more easily be followed

through integrated care (Anderson, G. & Horvath, 2004). From the start of theoretical models of integrated healthcare, the holistic focus should be better suited to deal with the complexity of today's healthcare needs, especially those from vulnerable populations (Anderson, G. & Horvath, 2004; McDaniel & deGruy, 2014). Mental health providers embedded within the primary care and others specialty health systems may facilitate patients' access to care (Coons et al., 2004; James, 2006), adherence, and other barriers that may be associated with health disparities (McDaniel, 1995). For women, integrating mental health clinicians into primary care seems most effective to address sensitive issues like miscarriages, and the screening, assessment, and treatment of mental health concerns (Poleshuck & Woods, 2014). Integrated healthcare will provide opportunities for better collaboration and communication, which contribute towards patient satisfaction and experience among vulnerable populations (Anderson, R. T. et al., 2001). A few studies on ethnic minority groups in integrated healthcare setting show increased access, quality of care, and psychotherapy outcomes for patients compared to traditional healthcare (Butler et al., 2008; Huang et al., 2016). Preliminary work on an integrated behavioral healthcare model focusing on Latino patients with mental health concerns showed that Latinos showed more comparable utilization and improvement rates as White patients, potentially correcting the disparity between the two groups in traditional care (Bridges et al., 2014). Continuity of care is found to improve health and reduce inequalities among different SES groups (Kringos et al., 2013). However, most of the benefits of integrated healthcare in reducing health disparities at this point are purely theoretical. More empirical research is needed to determine the effect of levels of healthcare integration on health disparities for a variety of at risk groups. Most importantly, the impact of integrated health care on

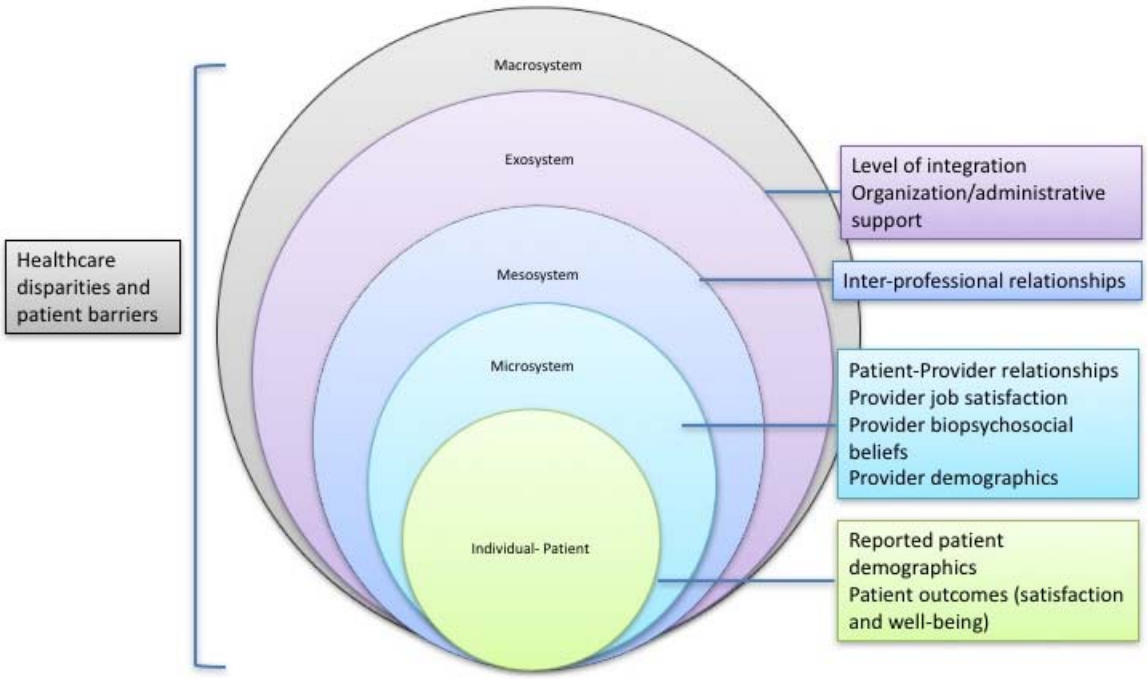
provider contributions to health care disparities has not been explored. Integrated health care proposes a new model of health care that may help providers in improving their communication and decision making with their patients from diverse backgrounds through the team-based and collaborative approach and the addition of behavioral health providers to the team.

CHAPTER TWO

Current Study

Relational and Systems Model

Figure 1 Adaptation of Bronfenbrenner's Ecological Systems Model



Integrated healthcare at its core is a holistic and systems model. Additionally, women identify a desire for more holistic and relational healthcare services (Anderson, R. T. et al., 2001; Avery et al., 2011). We are defining holistic health care in this study as care that focuses on physical and emotional well-being and recognizes each person in the care relationship, both the patient and the provider (Anderson et al., 2001; Thomas, Mitchell, Rich, & Best, 2018). Women's health and development are also tied to the relational domain, especially in terms of care and connectedness as supported by past

research and theory (Gilligan, 1982). Thus, it is important to take a holistic and relational systems perspective in conceptualizing and researching women's experience of integrated healthcare. This perspective is, thus far, not always explicitly used in research in this area. In this study, we define an ecological systems approach as one that recognizes the importance of context as well as the mutual interactions between individuals within a system. A systems approach aligns well with a feminist perspective in that they both recognize that nothing exists in isolation and context is essential to consider. Using an ecological systems approach (Bronfenbrenner, 1979), we can see the complex relationships between each level within the healthcare system (See Figure 1). However, few research studies so far on integrated healthcare have taken this approach, especially for women's healthcare.

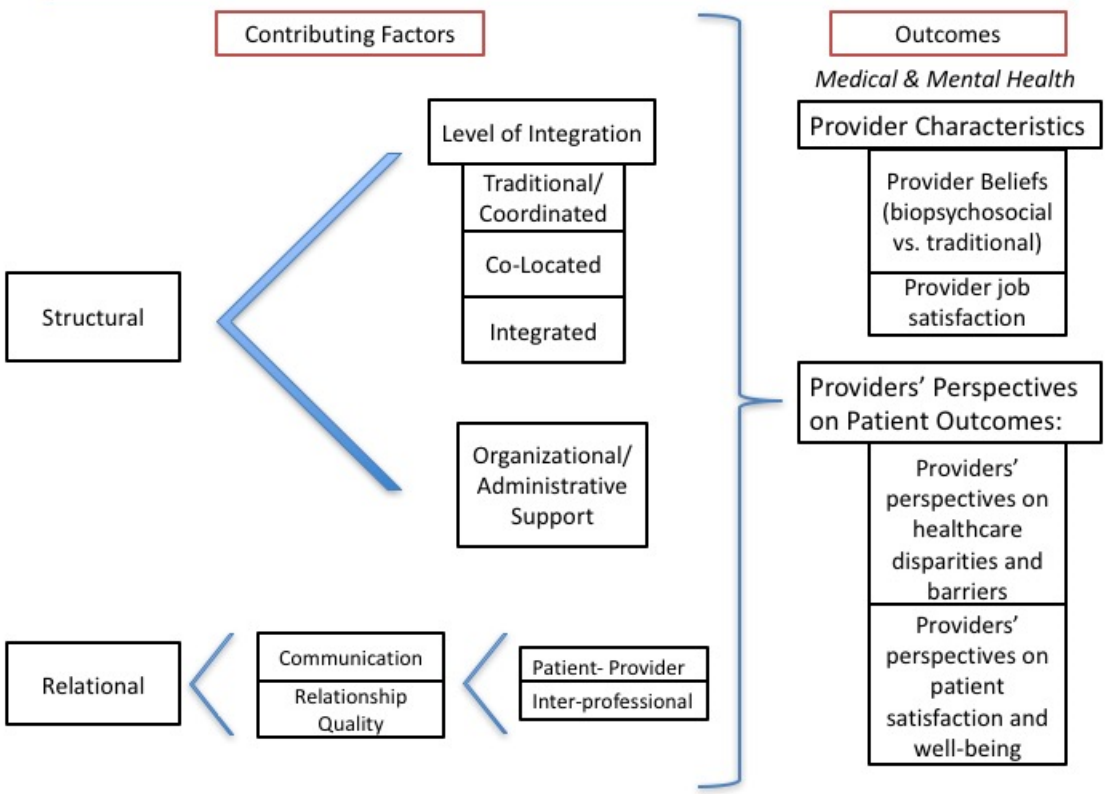
Most studies focus on patient outcomes (health and satisfaction) only when evaluating integrated healthcare, and usually for very specific populations like individuals with depression (Butler et al., 2008; Krause et al., 2006). Other studies may focus on providers' perspectives of patient barriers (Powell et al., 2016), but not providers' attitudes and beliefs about their own holistic experiences. No known studies integrate these two perspectives or go a step further adding organizational and administrative factors, which are all important in conceptualizing the healthcare experience as a whole. In this relational and systems model the individual or patient level includes characteristics of patients such as race, gender, personality, and diagnoses. It also includes patients' level of satisfaction and well-being. The next level, the microsystem, focuses on the relationships between the patient and their providers. In depth inquiry into relational dynamics and intersectionality issues is very much needed to

address healthcare disparities among women of diverse backgrounds. Providers' beliefs, job satisfaction, and demographics are also important to consider within the microsystem. The mesosystem describes the relationships between different microsystems. In this model, the focus is on inter-provider, particularly the relationship patterns among providers. The exosystem factors are the structural and organizational factors in which the healthcare experience takes place. This includes the type of setting (hospital, outpatient, etc.) and administration. Lastly, in the macrosystem we take into account broader factors of society and culture. This may include societal views on health and wellness, healthcare legislation, and insurance companies.

Providers' Perspectives on Healthcare Practice and Outcomes

This study focused on providers' (medical primary care and mental health) perspectives on women's healthcare practice and outcomes at various levels of healthcare integration. Given the importance of reducing healthcare disparities and the potential for intervention at the provider and systems levels, this study also looks at providers' perceptions of patient disparities, barriers, and other outcomes in addition to their own experiences. Contributing factors and outcomes of the healthcare practice from providers' perspectives are shown in Figure 2. This section discusses each factor and outcome in depth.

Figure 2 Providers' Perspectives on Women's Integrated Healthcare



Providers' Perspectives on Healthcare Outcomes

We focused on structural and relational domains and their impact on provider characteristics (providers' beliefs and job satisfaction) and perception of patient outcomes. Providers' perspectives on healthcare outcomes include perceptions of patient well-being and patient challenges and barriers.

Provider characteristics. Provider characteristics include provider beliefs and provider job satisfaction. Other provider characteristics, including providers' gender, may be of interest and may affect provider perspectives.

Provider beliefs. Provider beliefs refer to the extent to which providers endorse a holistic or biopsychosocial model of patient care. Given the importance of utilizing the biopsychosocial model, it is also important to look at providers' beliefs surrounding

biological, psychological, and social factors (Ashworth, Williamson, & Montano, 1984). In relation to the biopsychosocial model, provider beliefs to be identified include: where problems come from, what should be treated, and providers' role in addressing problems from a biopsychosocial perspective. In past studies, both mental health and medical providers' beliefs align with the biopsychosocial model (Gavin et al., 1998). It is hypothesized that level of integration and collaboration in the work setting may impact providers' belief systems and vice versa (Gavin et al., 1998). Specifically, organizational factors such as encouragement of collaboration and time considerations can help or hinder a provider's belief in the usefulness of working from a biopsychosocial perspective. Other factors that have impacted provider beliefs include length of time in practice and gender. In a study by Gavin and colleagues (1998), medical providers with less experience (more recently trained) were more likely to endorse the biopsychosocial model, while the opposite was true for mental health providers. Additionally, female medical providers were more likely than males to subscribe to biopsychosocial beliefs. Patient outcomes in relation to provider beliefs have only been minimally studied within the chronic pain literature with mixed findings about the relationship between provider beliefs and patient outcomes (Sieben et al., 2009). However, some studies have shown a link between provider biopsychosocial beliefs and their patient recommendations (Domenech, Sánchez-Zuriaga, Segura-Ortí, Espejo-Tort, & Lisón, 2011). It is important to address the link between providers' beliefs and their perception of patient care outcomes. This study examines provider biopsychosocial beliefs in relation to structural and relational factors as well as providers' perspectives on patient outcomes.

Provider job satisfaction. Provider job or work satisfaction refers to their level of satisfaction with their current job and work. Provider job satisfaction relates to various structural and relational factors. For providers working in mental health and medical settings, job satisfaction is positively related to structural factors such as organizational and social support, managerial feedback, rewards, and supervision (Eklund & Rahm Hallberg, 2000; Scanlan & Still, 2013). Work environment has been found to be significant predictor of job satisfaction for providers, with primary care physicians focused on autonomy (Landon, Reschovsky, & Blumenthal, 2003), while mental health providers are most impacted by support, involvement, and caseloads (Ballenger-Browning et al., 2011; DeStefano, Clark, Gavin, & Potter, 2005). It has been suggested that in evaluating the healthcare system we should move from a triple to a "quadruple-aim," to recognize the importance of provider work satisfaction and well-being (Bodenheimer & Sinsky, 2014). Team-oriented supervision further increases providers' job satisfaction (Eklund & Rahm Hallberg, 2000). Relational factors impact provider job satisfaction through both the patient-provider and inter-professional relationships. The patient-provider relationship, or working alliance, is a significant positive predictor of provider job satisfaction (Osborn & Stein, 2016). Providers that perceive better working alliances with their patients generally have greater job satisfaction. Direct time with patients is important as well; many providers are happier with their jobs when they are spending time with their patients as opposed to other job areas such as paperwork (Mason et al., 2004; Scanlan & Still, 2013). Relating to providers' relationships with other providers, those providers with greater communication and cooperation with other providers report greater job satisfaction (Eklund & Rahm Hallberg, 2000). Provider job

satisfaction is important given its impact on patients in a variety of ways. Lower job satisfaction for medical and mental health providers is associated with higher turnover and lower quality care for patients (Scanlan & Still, 2013; Weng et al., 2011). It is also indirectly related to patient satisfaction ratings, through provider burnout, especially regarding depersonalization (Vahey, Aiken, Sloane, Clarke, & Vargas, 2004; Weng et al., 2011). Providers' job satisfaction is crucial to their perception of patient care outcomes. This study examines the effect of structural and relational factors on providers' job satisfaction as well its impact on provider's perspectives on patient outcomes.

Providers' perspectives on patient outcomes. The second area of healthcare outcomes is providers' perspectives on patient outcomes. Patient outcomes include providers' perception of healthcare disparities/barriers and patient satisfaction/well-being. Providers working in various levels of integration are an important focus for understanding and intervention to improve patient care, including correcting health disparities. Previous studies have elucidated patient outcomes and perspectives on health disparities (Keegan et al., 2015; Smedley et al., 2002) and integration (Rathert, Williams, McCaughey, & Ishqaidef, 2015). However, little is known of providers' understanding and perceptions of patient experiences with disparities and integration. This information may be an important piece in discovering differences in perspectives and areas of intervention at the provider level.

Providers' perspectives on healthcare disparities and barriers. Given the extensive documentation of health disparities for women based on patient outcome data and their own narratives, this study focuses on provider perspectives of patient healthcare disparities and barriers. Additionally, providers are an essential focus of intervention,

given that implicit bias is likely a component of health disparities for women, people of color, people from low SES backgrounds (Chapman et al., 2013; Zestcott, Blair, & Stone, 2016), and people who identify as LGBTQ (Sabin & Greenwald, 2012). Furthermore, providers, such as PCPs, have been used to elucidate healthcare system disparities and patient barriers within the healthcare system in past studies (Cunningham, 2009; Loeb, Bayliss, Candrian, deGruy, & Binswanger, 2016; Powell et al., 2016). Some studies looking at very specific populations have also been used to compare providers understanding of patient perspectives with actual patient perspectives (Hasnain, Connell, Menon, & Tranmer, 2011; Komaric, Bedford, & van Driel, 2012). In these studies, providers had, overall, a good understanding of patient concerns and barriers, with some gaps in their knowledge, which can be used to inform provider training and education. Additionally, other providers may not have this level of understanding of patient barriers and concerns, especially for minority populations and women. Other studies have found that providers are often unaware of the effects of social issues such as race and racism on patients' health and care (Delgado et al., 2013; Dovidio & Fiske, 2012). However, no known studies to date have looked at interdisciplinary provider perspectives in this area at various levels of healthcare integration. This information could illuminate differences in provider perspectives across provider type *and* level of integration. Providers and patients may perceive different types of barriers to care. Though studies have illuminated women's perspectives on their barriers to care (Anderson, R. T. et al., 2001; Avery et al., 2011), no studies have identified providers' perceptions of barriers to care for women from a variety of backgrounds. Barriers to quality care for patients exist at the individual, relational, and structural levels. Barriers at the individual level include insurance

coverage (Loeb et al., 2016; Powell et al., 2016) and mistrust of the healthcare system (Powell et al., 2016), especially for minority group patients (Benkert, Hollie, Nordstrom, Wickson, & Bins-Emerick, 2009; Morales, Cunningham, Brown, Liu, & Hays, 1999). At the relational level, patient satisfaction varies across ethnic minorities, with those from Hispanic, Latino, and Spanish-speaking backgrounds reporting the highest levels of dissatisfaction in their healthcare (Bova, Carol, Fennie, Watrous, Dieckhaus, & Williams, 2006; Morales et al., 1999). Inter-professional communication such as communication of PCPs with specialist providers is another potential barrier to providing high quality care for patients (Loeb et al., 2016). Structural and systemic barriers to healthcare are among the most commonly identified and a potential area for intervention within integrated healthcare systems. These barriers include billing and payment systems, poor access to care, productivity demands on care providers, and fragmented or uncoordinated care (Loeb et al., 2016; Powell et al., 2016). For example, barriers persist in patients' access to mental healthcare services. Insurance coverage and a shortage of providers represent some of the greatest obstacles to primary care mental health referrals (Cunningham, 2009). Barriers and challenges for diverse patients are important to consider at each of these levels. There is evidence so far that the relationship between barriers is complex and that removing one barrier or challenge may not improve disparities across all levels (Kohn-Wood & Hooper, 2014). It is the hope that integrated healthcare and increased collaboration between providers will alleviate many of these barriers to quality healthcare through improving access, reducing fragmentation of care, and improving both inter-professional and patient-provider relationships. Evidence so far suggests that though integrated healthcare is extremely useful in improving access to mental health services,

access and equity of services may still be impeded for certain groups including women, those with disabilities, and those with negative views of mental healthcare (Hailemariam et al., 2016). Attention should be paid to what barriers, challenges, and disparities remain at different levels of integrated care. Lastly, providers with less diversity training may be more likely to cite patient/individual level barriers (including using biology to explain racial and ethnic health disparities) as opposed to systemic, relational, and structural barriers to care and overall health (Nelson, Prasad, & Hackman, 2015). This study explores providers' perspectives on health disparities and patient barriers. Their perspectives are compared across levels of healthcare integration and provider type.

Providers' perspectives on patient satisfaction and well-being. This refers to patient outcomes, including satisfaction and overall well-being, as perceived by providers. Again, little is known about interdisciplinary providers' understanding of patient experience, which could be important in identifying gaps and mismatches with patient experience. Studies on women around the world identify that women's definitions and experiences of well-being often differ from dominant perspectives and include more relational components and desire for empowerment and control (Alex & Lehti, 2013; Juuso, Skr, Olsson, & Sderberg, 2013; Svensson, MÖrtensson, & Hellstrñm Muhli, 2012; White & Jha, 2014). In the healthcare system, better patient ratings on quality of care and healthcare satisfaction are associated with individual, relational, and structural factors. At the individual level, patients have better outcomes based on factors such as their own physical comfort (Rathert et al., 2015). The relationship with the provider will also be discussed in greater detail later, but has been shown to impact patient outcomes and satisfaction for both mental health (Mason et al., 2004) and medical care (Rathert et al.,

2015). Key factors within this relationship include respect for patient preferences, information, education, and communication provided (Rathert et al., 2015). The style of communication has been found to be more important than the content of the conversation for patient satisfaction (Freed, Ellen, Irwin, & Millstein, 1998). The patients' relationships with others also matter through emotional support and the involvement of family and friends in their care (Rathert et al., 2015). However, a systems perspective will provide a broader picture of patient outcomes, especially given that patient satisfaction does not always align with their actual health outcomes (Zgierska, Miller, & Rabago, 2012). Though patient satisfaction is related to some positive outcomes, it also correlates with greater healthcare costs overall, greater inpatient hospitalizations, and increased mortality rates (Fenton, Jerant, Bertakis, & Franks, 2012). It is sometimes difficult for providers in their view to balance providing evidence-based practice with values-based and person-centered care (de Hoyos, Monteón, & Altamirano-Bustamante, 2015). Therefore, it is important to further explore providers' understanding of patient outcomes and how they are measuring their own success with patients at various levels of healthcare integration. In integrated settings, physicians' perspectives have been used to assess patient outcomes including patient overall care (Miller-Matero et al., 2016) and collateral mental healthcare (Chomienne et al., 2010). Thus, it is essential to examine these areas from providers' perspectives on patient outcomes and quality of care. This study explores providers' perspectives on patient satisfaction and well-being, including how they assess success with their patients and are compared across levels of integration and by provider type.

Providers' Perspectives on Structural and Relational Factors

Contributing factors of healthcare practice and outcomes in this study include structural factors (level of integration and organizational/administrative support) and relational factors including communication and relationship quality for patient-provider and provider-provider relationships. These factors were chosen given their potential impact on patient care and health disparities.

Structural factors. Structural contributing factors include level of integration and organization or administrative support. Both level of integration and level of organizational support for providers is expected to impact providers' perspectives on healthcare experience and outcomes. Both level of integration and level of provider support from their administration may impact patient care.

Level of integration. Level of integration refers to the spectrum of integration and collaboration outlined in SAMHSA's model (Heath et al., 2014). This study utilizes the collapsed three-level model, including coordinated/traditional, co-located, and integrated levels. It is expected that both medical and mental health providers may have different experiences at various levels of integration. The level of integration clearly has a bidirectional relationship with organizational factors (Heath et al., 2014). The organization will determine the level of integration and in turn, level of integration impacts organizational factors such as location, setting, and electronic systems. The level of integration should have a direct effect on relationships between providers. Higher levels of integration increase communication and collaboration between inter-disciplinary providers (Heath et al., 2014). The level of integration is expected to impact providers' perspectives on health experience outcomes including their perspectives on health

disparities, patient well-being, and provider job satisfaction. In past studies, PCPs have identified better coordination of care to overcome patient barriers and fragmentation of care (Loeb et al., 2016). The patient experience overall will differ at various levels of integration with patients experiencing referrals and barriers to care access at lower levels and a unified, holistic experience at higher levels of integration (Heath et al., 2014). In studies so far, both patient and providers report satisfaction with increasing the level of integration of mental health services into primary care (Funderburk, Fielder, DeMartini, & Flynn, 2012; Miller-Matero et al., 2016). For medical providers specifically, increasing integration leads to more time and improved reports of working conditions (Chomienne et al., 2010). Level of integration is a key contributing factor in this study. All variables are assessed in relation to level of integration.

Organizational/administrative support. Other organizational and administrative factors may also impact healthcare experiences for both patients and providers. Thus, we focus on the level of institutional, organizational, and administrative support perceived by providers as this is related to other determinants as well as health experience outcomes. Providers working in various levels of integrated healthcare may experience organizational support differently. There may be providers who work in and value integrated care, but are finding it difficult to implement because of lack of support from higher up versus other providers whose experience of integration is smoother due to institutional support (Robinson & Strosahl, 2009). Providers' experience of support within their organization may include reimbursement, organization structure, credentialing, and record keeping (Pilgrim et al., 2010). Organizations can facilitate the development of healthcare integration in several ways including through policies and co-

locating facilities (Pollard et al., 2014). Organizational support for healthcare integration could also come in the form of training, supervision, incentives, and other areas of need that have been identified by both patients and providers. Support of the organization may impact both patient-provider and provider-provider relationships as well. Providers identify organizational factors as a key to facilitating or obstructing collaboration or communication with other providers (Bray & Rogers, 1995). For example, if the organization requires that you spend all your time trying to meet quotas of seeing patients and does not value collaboration with other providers, collaboration is less likely to happen. These same factors are also likely to impact the patient-provider relationship similarly, though this needs to be studied more in depth. Additionally, administrative factors and level of support are expected to impact health experience outcomes. As outlined before, providers who feel more supported by their organization have greater satisfaction with their jobs and are less likely to experience burnout (Eklund & Rahm Hallberg, 2000; Scanlan & Still, 2013). The level of institutional support is expected to relate to patient outcomes (both disparities and well-being) through the provider relationship and satisfaction. Lastly, organizational support is one way to connect providers with utilizing patient satisfaction reports, potentially improving healthcare delivery (Rozenblum et al., 2015). This study asks providers how supported they feel by their organization and administration in order to see its effects on provider characteristics and providers' perspectives on patient outcomes.

Relational factors. Relational contributing factors include communication and relationship quality for both the patient-provider and provider-provider (inter-professional) relationships. Relational factors are a key component of both patient and

provider experiences with the healthcare system. It is expected that different types of providers at different levels of integration will have different experiences in both patient-provider and inter-professional relationships.

Patient-provider relationships. The patient-provider relationship is the relationship between the patient/client and their provider (medical or mental health). Patient-provider relationship and therapeutic alliance are considered essential components of healthcare and patient outcomes in both mental health (Mason et al., 2004; Osborn & Stein, 2016) and medical care (Matthias et al., 2010). Relational factors within the patient-provider relationship including communication (Gill & Cowdery, 2014), trust (Bova, Carol et al., 2006; Mason et al., 2004), and non-verbal behaviors of providers (Levine & Ambady, 2013) influence patients' satisfaction with and quality ratings of their care. Other important factors impacting the strength of the patient-provider relationship include collaboration, the discussion of health information, and feeling valued in the relationship as a patient (Campbell, Auerbach, & Kiesler, 2007). Female providers may have more positive attitudes than male providers towards aspects of the patient-provider relationship, including communication (Löffler-Stastka et al., 2016). Relational factors have been shown to be of particular importance for women (Fox & Chesla, 2008; Schmittdiel, Grumbach, Selby, & Quesenberry, 2000; Trudel, Leduc, & Dumont, 2013). For example, women with chronic diseases, in multiple studies (Fox & Chesla, 2008; Trudel et al., 2013), feel that their health is significantly impacted by their relationship with their health care provider, especially through a sense of control over their health. Female patients are also more likely to value physician communication skills and prevention efforts (Schmittdiel et al., 2000). The patient-provider relationship may be

impacted by a variety of factors including gender, race, and ethnicity. For example, female patients are more likely to have open communication with their medical providers, especially regarding sensitive topics (Emmers-Sommer et al., 2009). Ethnic minority patients report less trust in their healthcare providers (Levine & Ambady, 2013). Non-verbal cues may be important with minority patients and cultural background mismatches between patients and providers (Levine & Ambady, 2013). Additionally, African American women identified gender as more important than race in choosing a provider and feeling comfortable with them (Dale, Polivka, Chaudry, & Simmonds, 2010). Patient-provider relationships are especially important to explore in conjunction with health disparities as previous research has shown that PCPs are more negative and contentious with their Black patients (Street Jr, Gordon, & Haidet, 2007). For mental health workers, the quality of the patient-provider relationships is a significant positive predictor of provider job satisfaction, while controlling for other factors like workload and setting (Osborn & Stein, 2016). On the structural level, greater patient-centered care, such as in an integrated health system, is related to better patient-provider relationships (Matthias et al., 2010). This study explores providers' perspectives on their patient-provider relationships across levels of integration and provider type.

Inter-professional relationships. For this study, we use the term *inter-professional* relationship to refer to the provider-provider relationship between mental health providers and primary medical providers. The relationship between interdisciplinary providers working together to provide care for a patient is a key component in patient care identified by both patients and providers (Aguirre-Duarte, 2015; Miller, E. et al., 2007; Sampson, Barbour, & Wilson, 2016). Though it is an

essential first step, it is not enough to simply put the providers together; the relationships between interdisciplinary providers must be cultivated due to their different roles and practices. Increased communication and collaboration between providers has the potential to improve mental health screening and outcomes (Bray & Rogers, 1995). Poor inter-professional collaboration, however, may bring harm to patients through fragmented care and decision-making (Zwarenstein et al., 2013). Areas for interdisciplinary provider relationship improvement identified by providers include: communication gaps (e.g. lack of access, in efficient back and forth, and poor listening), professional behavior and conduct (e.g. dumping work on others and resisting collaboration), and other areas of relationship building (e.g. unrealistic expectations of each other; Sampson et al., 2016). Power in the relationship is another key factor as physicians are used to being at the top of a hierarchy as opposed to collaborating (Kirschbaum et al., 2015; McDaniel, 1995). In observational studies, physicians' interactions with allied professionals are often "rare and terse"; they work less with other professionals and may prefer to make decisions on their own (Zwarenstein et al., 2013). However, the provider-provider relationship, and therefore, patient outcomes, can be improved through increased training for providers working together (Bray & Rogers, 1995; Funderburk, Levandowski, Wittink, & Pigeon, 2018; Kirschbaum et al., 2015). Factors that increase the effectiveness of this relationship include regular contact, opportunities for structured direct communication, and proximity to each other (Bray & Rogers, 1995; Bruner, Davey, & Waite, 2011). Thus, it is expected that inter-professional provider relationships will improve with increased levels of integration within the healthcare system. Specifically, improved inter-professional relationships, collaboration, and communication may help correct health disparities

through reducing fragmented care and dissatisfaction (Bruner, Waite, & Davey, 2011). This study examines inter-professional relationships including communication, collaboration, and relationship quality across levels of integration.

The Current Study

The current available literature on the benefits of integrated health care, provider related healthcare disparities, the need for access to mental health services, and care specific to women are limited and thus, warrant further exploration. Specifically, in-depth inquiry into levels of collaborative care and various correlates of integrated healthcare practice and outcomes for women are extremely vital for our field today. This is especially true to strategize implementation of integrated healthcare practice for effective outcomes. This study focused on providers' (both mental health and medical primary care) perspectives on healthcare at various levels of integration. Given the importance of health disparities, this study examines providers' perceptions of health disparities and patient barriers. A large body of research exists on health disparities based on patient objective outcomes, narratives, and perspectives. However, provider-related health disparities are an understudied area, despite their impact on patient care. Additionally, little is known about providers' knowledge and their understanding of health disparities for diverse women, especially at various levels of healthcare integration. Some studies have found that providers are largely able to identify patient disparities and barriers (Hasnain et al., 2011; Komaric et al., 2012), while others show that providers with little diversity training are less able to do so (Nelson et al., 2015). In particular, research on providers' knowledge of women's healthcare needs and disparities are extremely rare. Thus, it is important to examine providers' understanding of women's health disparities

and barriers at various levels of integration. This may illuminate factors that influence providers' insight into of patient experiences. Gaps in provider understanding can also be used for training, education, and systems interventions to improve patient care, particularly for women across diverse backgrounds.

This study takes a system and relational approach given the importance of relationships in patient care and the holistic nature of integrated healthcare. At the individual level, we focus on providers' job satisfaction, beliefs about care, and perceptions of patient outcomes including satisfaction and well-being. We collected data on providers' demographics and their report of their patients' characteristics. Relationships within the healthcare system, especially for integrated healthcare, and even more so for vulnerable populations, have already been highlighted as an essential component of healthcare outcomes (McDaniel & LeRoux, 2007). The relational component between providers within the integrated healthcare system has also been compared with family systems theory in that all providers must work together to facilitate better care for their patients (McDaniel & LeRoux, 2007; Thomson, Outram, Gilligan, & Levett-Jones, 2015). Providers' perspectives on both the patient-provider and provider-provider relationships are explored. Lastly, this study focuses on structural factors, primarily the level of integration of the healthcare system from traditional medical systems to fully integrated practice to compare outcomes. Other organizational and administrative factors are examined at the exosystem level, specifically organizational support received by providers. This model is conceptualized within the macrosystem, considering societal views and expectations along with professional and social identities (medical/mental health providers and gender of providers).

Objective measures of patient outcomes in integrated care exist in the literature, while few narrative studies have been conducted (Butler et al., 2008; Peek, Cohen, & deGruy III, 2014) so far. However, in investigating health disparities in relation to integrated healthcare, it is essential to take a qualitative approach. Research in the area of diversity and social justice, particularly research with the goal of understanding the needs of marginalized populations is better understood using qualitative approaches such as grounded theory, consensual qualitative research (CQR), and participatory-based research (Fassinger & Morrow, 2013). Additionally, this approach is helpful given that there is little research already on provider perspectives on their knowledge and relationship domains across clients and providers provide us with better insight into various correlates of healthcare impact on health disparities. Thus, a mixed method perspective was used to explore these dynamic areas in women's healthcare, integrated health care, and provider perspectives on overall health disparities in our system. Narrative (qualitative) data have the potential to illuminate themes in provider experiences and views working in different levels of integration. These themes are important to consider in light of what we already know about patient healthcare experiences and disparities. In addition, we address the impact of fragmentation and experiences of frustration across providers and patients (Colombini, Mayhew, Mutemwa, Kivunaga, & Ndwiga, 2016). Given the holistic approach used in integrated healthcare, the scope of this research includes a systemic perspective. The few narrative studies on the experience of primary care providers (Chomienne et al., 2010; Miller-Matero et al., 2016) or mental health clinicians (Powell et al., 2016) have indicated the close link between providers' perception of patient care and their structural and relational factors. Moreover, relationships between patients and

providers and among multidisciplinary teams of providers improve healthcare satisfaction and outcomes (Miller, E. et al., 2007). However, very few studies address providers' perspectives and their integrated healthcare experiences together. To date, no systematic studies have examined interdisciplinary providers' perspectives across varying levels of integration in healthcare. Additionally, providers' perspectives on women's healthcare services have not been fully examined. Given the need for research on women's unique healthcare needs and experiences, this research bridges the gap in the existing literature.

This exploratory study provides information and insight into patient-provider and inter-professional relationships and their impact on providers' perspectives on patient outcomes. We take a social justice and multicultural perspective in the hopes of examining provider perspectives in comparison to what is already known about diverse women's health experiences and outcomes. Recent shifts in the service sector towards integrated healthcare support the need to explore further the complexity involved in structural and relational domains, and their impact as perceived by practitioners today. Thus, the present study bridges the gap in the literature and offers the scope to obtain providers' perspectives across medical and mental health disciplines. This study examines the impact of varying levels of collaboration and integration, as well as other provider characteristics, on their perspectives of health disparities for women's health issues. Providers' perspectives on the role of levels of collaborative care, relationship dynamics across inter-professionals and with patients, and the impact of these factors on providers' beliefs, and job satisfaction are explored. Furthermore, we examined providers' perceived healthcare barriers and their impact on female patient healthcare outcomes, across levels of integration (traditional, co-located and integrated).

Goals and Hypotheses

1. **Explore differences in providers' perspectives on women's healthcare outcomes across varying levels of healthcare integration.** We expect that providers at varying levels of healthcare integration (traditional/coordinated, co-located, and integrated) will have differing perspectives on all aspects of the healthcare experience including level of organizational support, patient-provider and inter-professional relationships, job satisfaction, provider beliefs, and providers' perspectives on patient outcomes (patient disparities and barriers and patient satisfaction and well-being).
    a. We expect providers working in higher levels of integration to have more holistic beliefs and greater job satisfaction.
    b. We expect providers working in higher levels of integration to perceive greater patient satisfaction and well-being and fewer patient healthcare disparities and barriers.
    c. We expect providers working in higher levels of integration to experience greater organizational support and rate higher levels of communication and relationship quality with other providers and their patients.
2. **Identification of interrelations among structural and relational factors with providers' characteristics and their perceptions of women's healthcare outcomes.** Includes the interrelations among contributing factors: structural factors (level of integration and organization/administrative support) and relational factors (patient-provider and provider-provider relationships). As well as the interrelationships between these factors and health experience outcomes

including: provider characteristics (beliefs and job satisfaction) and providers' perspectives on patient outcomes (healthcare disparities, barriers, satisfaction, and well-being).

a. We hypothesize that structural factors including level of integration and administrative/organizational support will positively correlate with provider characteristics including provider holistic beliefs and job satisfaction.
b. We hypothesize that structural factors including level of integration and administrative/organizational support will negatively relate to perception of patient disparities and barriers, but positively related to perception of patient satisfaction and well-being.
c. Providers' collaborative relational style (communication and quality) with interdisciplinary providers will positively relate to provider characteristics (holistic beliefs and job satisfaction).
d. Providers' collaborative relational style (communication and quality) with interdisciplinary providers will negatively relate to perception of patient disparities/barriers and positively related to perception of patient satisfaction/well-being.
e. Providers' collaborative relational style (communication and quality) with their patients will positively relate to provider characteristics (holistic beliefs and job satisfaction).
f. Providers' collaborative relational style (communication and quality) with their patients will negatively relate to perception of patient

disparities/barriers and positively related to perception of patient satisfaction/well-being.

g. We expect level of integration to positively relate to perceived organizational/administrative support and more collaborative inter-professional and patient-provider relationships.

h. We expect more collaborative inter-professional relationships to positively relate to more collaborative patient-provider relationships.

i. We hypothesize that provider characteristics (holistic beliefs and job satisfaction) will positively correlate with providers' perspectives of patient satisfaction and well-being, but negatively correlated with providers' perspectives of patient healthcare disparities and barriers.

3. **Evaluate significant predictors of providers' characteristics.** The role of structural (level of integration and organizational/administrative support) and relational (communication and relationship quality in patient-provider and provider-provider relationships) factors in predicting provider characteristics (beliefs and job satisfaction) will be examined.

    a. We hypothesize that increased level of integration, organizational/administrative support, more collaborative patient-provider and inter-professional relationships will predict more holistic provider beliefs and greater job satisfaction for providers.

4. **Evaluate significant predictors of providers' perception of women's healthcare outcomes.** The role of structural (level of integration and organizational/administrative support) and relational (communication and

relationship quality in patient-provider and provider-provider relationships) factors in predicting providers' perspectives on patient outcomes (disparities/barriers and satisfaction/well-being) will be examined.

   a. We hypothesize that increased level of integration, organizational/administrative support, more collaborative patient-provider and inter-professional relationships will predict decreased perceived patient disparities and barriers and increased perceived patient satisfaction and well-being.

5. **Identification of themes in narrative data on providers' perspectives on women's' healthcare practice and outcomes.** The qualitative methods of conceptual analysis was used to identify themes in provider narratives on relational factors, job satisfaction, and patient outcomes (disparities, barriers, satisfaction, and well-being). Themes from narratives are used to compare perspectives on contributing factors and outcome variables.

CHAPTER THREE

Method

Participants and Procedure

Participants were mental health providers (psychologists) and medical providers (primary care physicians) working in varying levels of healthcare integration. Data was collected from 60 participants across different levels of integration—traditional/coordinated (20), co-located (20), and integrated (20). Participants included both psychologists (30) and primary care physicians (30). Participants were recruited through advertisements, healthcare organizations, and social media around the Boston, Massachusetts, and Greater New England areas. The survey was conducted online using Qualtrics. Informed consent was obtained from all participants (online) prior to the study. Participants were informed that the study takes approximately 30-40 minutes to complete and were compensated with $10 electronic Starbucks gift cards upon completion of the survey.

Study Design

The study is a mixed method survey design utilizing quantitative and qualitative questions. Quantitative outcomes include healthcare experience contributing factors and outcomes. Contributing factors include structural factors (level of integration, and other organizational/administrative support) and relational factors (inter-professional relationships). The quantitative outcome factors are provider characteristics including provider beliefs and provider job satisfaction. Qualitative data was used to identify themes pertaining to healthcare experiences relating to both contributing factors (patient-provider and inter-professional communication and relationship quality) and outcomes

(provider job satisfaction, and providers' perspectives on patient health disparities, barriers, satisfaction, and well-being.) Consensual Qualitative Research (CQR) was used as the primary qualitative paradigm in both study design and analysis. CQR utilizes a research team and consensus in order to account for biases and varying perspectives (Hill, Thompson, & Williams, 1997).

Measures

Two survey forms were used: one for psychologists and one for primary care physicians. The appendix includes examples from the primary care physicians' form. The form for psychologists is comparable and contains only small changes in language including the replacement of "patient" with "client." Survey measures were created using the Consensual Qualitative Research (CQR) approach. First, a literature review was conducted. Second, research team members (including doctoral program faculty, this doctoral student, another doctoral student lab member, and two undergraduate research assistants) met in person to create, review, and edit survey measures. Group consensus was reached for each question. The entire survey was sent to two community members—one primary care and one mental health provider—for their feedback and consensus on items. Lastly, the survey was edited based on this feedback through consensus of the research team.

Demographics (see Appendix A). Information regarding providers' age (optional), gender, race/ethnicity, primary language, other languages, work setting, occupation, years of experience, and level of employment was collected in this questionnaire.

Patient/client population (see Appendix B). Information regarding providers' patient population was collected in this questionnaire, including approximate percentage breakdown by group in terms of: age, race/ethnicity, gender, socioeconomic status, sexual orientation, disability status, and languages spoken. Providers were asked about their use of interpreters in working with patients/clients, what languages they usually use them for, and what language(s) they usually speak when working with patients/clients. Providers were asked to describe in their own words their patient population.

Provider experience. Providers were asked about their perceptions and experience working in healthcare through quantitative and qualitative questions. These questions were created for this survey based on healthcare contributing factors (structural and relational) and outcomes (provider characteristics and providers' perspectives on patient outcomes). Contributing factors include structural and relational domains. Structural questions include the following:

Level of integration (Appendix C). Providers were asked to choose the level of integration (traditional/coordinated, co-located, and integrated) from descriptions of each of these levels. Each level of integration was defined for providers to choose from. Providers selected their current and ideal work settings from these three options. They were also asked about the types of providers they work with.

Level of organizational/administrative support (Appendix D). Providers were asked how supported they feel by their upper administration and management and asked to rate it on a five-point scale.

Relational factors include the following:

Inter-professional relationship (Appendix E)**.** Providers were asked about their experience working with interdisciplinary providers, including communication and relationship quality.

Patient-provider relationship (Appendix F). Providers were asked to describe their experience within the patient-provider relationship, including communication and relationship quality. Outcome factors include providers' perspectives on patient outcomes (disparities/barriers and satisfaction/well-being) and provider characteristics (beliefs and job satisfaction).

Providers' perspectives on patient outcomes included the following:

Patient healthcare disparities and barriers (Appendix G). Providers were asked about their experience working with diverse patients. They were also asked about their experience and perception of health disparities, challenges, and barriers.

Patient satisfaction and well-being (Appendix H). Providers were asked about their perception and experience of patient outcomes, satisfaction, and well-being.

Outcomes related to provider characteristics included the following:

Provider job satisfaction (Appendix I). Providers were asked to rate their level of satisfaction with their current job on a seven-point scale and explain their rating. One-question measures of provider job satisfaction have been verified in other studies (Scanlan & Still, 2013).

Provider beliefs (Appendix J). The Physician Belief Scale was originally designed to measure primary care physicians' beliefs on the psychosocial aspects of care (Ashworth et al., 1984). It measures the extent to which primary care physicians subscribe to a biopsychosocial model over the traditional biomedical model. The original

self-report measure included 32 items. Questions include statements such as: *My role is to work collaboratively to provide care for the patient*. Respondents are asked to select their level of agreement with the self-description statements. Responses are measured on a 5-point Likert scale from *disagree* to *agree*. Higher scores indicate greater collaboration and alignment with the biopsychosocial model. This scale was reduced to 10 questions for this study. It was also adapted for use with mental health providers, which has been done in past studies (Gavin et al., 1998). The consensual qualitative research approach was used to shorten the scale and adapt for use with mental health providers in a systematic way. Agreement was reached within the research team on the final sets of questions. The original scale showed high internal consistency (0.88) measured by the Kuder-Richardson Formula (Ashworth et al., 1984). In a later study with an adapted version with mental health providers, internal consistency measured by Cronbach's alpha ranged from 0.65 to 0.93 for physicians and from .76 to .77 for mental health providers (Gavin et al., 1998). For this current study, Chronbach's alpha equaled .75 for the physician scale and .66 for the adapted psychologist version.

Qualitative Approach

We used the Consensual Qualitative Research (CQR) approach for coding of narrative data of providers including contributing factors, followed by analysis of narrative themes of providers' perceptions of patient outcomes (Hill et al., 1997). Williams and Morrow (2009) identify three key components of trustworthiness in qualitative research: integrity of the data, balance of participant meaning and research interpretation, and clear and applicable interpretation of results. Integrity of the data was ensured through clear explanation of methods and systematic analysis of data (Williams

& Morrow, 2009). Data was analyzed through the utilization and continuing review of a coding rubric created via consensus of the research team. Themes assigned to participant narratives were coded using consensus of the research team followed by appropriate statistical analyses of these themes. Researchers under the CQR paradigm argue that the team of researchers and consensus method serves to balance researcher interpretations with participant meaning (Williams & Morrow, 2009). A coding team of four (including this author, one other graduate student, one undergraduate student, and one faculty member) used the consensual qualitative research (CQR) method to arrive at qualitative themes. A coding rubric was created and agreed upon before examination of the data. Small changes (primarily clarifications) were made to the coding rubric throughout the process as needed and agreed on by the entire coding team. Two primary coders (an undergraduate and a graduate student) coded the data based on the coding rubric. This author and the faculty member were used as support and to resolve disagreements. For the first few rounds of coding the coding team met all together to examine coding done by the two primary coders. Patterns of disagreements were identified and resolved and/or clarified by group consensus. Any disagreements on codes for individual statements were discussed until group consensus was reached.

CHAPTER FOUR

Results

To examine providers' perceptions of healthcare experience including contributing (structural and relational) and outcome factors (provider job satisfaction and providers' perspectives on patient experience), a series of univariate and multivariate statistical analyses were conducted. Multiple correlation analyses were conducted to assess the interrelations among structural factors (level of integration and administrative/organizational factors), relational factors (patient-provider and provider-provider relationships), and healthcare outcomes (provider beliefs, provider job satisfaction, and providers' perceptions of patient outcomes). We used multiple regression analysis to identify significant predictors of providers' characteristics and their perception of patient outcomes. Additionally, multiple analyses of variance (MANOVA) were conducted to explore differences in healthcare experiences across levels of integration (traditional/coordinated, co-located, and integrated). Finally, qualitative coding methods were used to explore themes of provider experiences and perspectives on patient outcomes (health disparities, barriers, satisfaction, and well-being).

Prior to conducting quantitative analyses, study variables were examined for outliers and missing data. All variables were found to be acceptable and no participants had to be excluded. Preliminary analyses were conducted to check for normality, linearity, multicollinearity, and homoscedascity and were found suitable for further analysis. An a priori power analysis was conducted using G*Power Software to determine the necessary sample size for the proposed analyses (correlation, analysis of variance). Power was determined with an alpha level of .05, assuming a small effect size (f2) of .25 and, a

power level of .95 for analysis. Results indicated that a sample size of at least 48 participants should be included; 60 participants were included in the final results. Descriptive results are presented first, followed by specific study aims and hypotheses, and narrative results.

Quantitative Results

Overview of provider demographic characteristics.

Years of experience. Participants' years of experience can be found in Table 1. Providers of both types had around or over 10 years of experience. Physician participants had significantly more experience than psychologists in this study t (58) =2.096, p <0.05. Mean difference is 5.92 with CI of 0.27 to 11.57. On average, physicians in this study had 15.6 years of experience, with a range of 0-37 years. Psychologist participants had 9.68 years of experience on average, ranging from 1-41 years. Providers tended to have less experience with higher levels of integration, but the differences between groups were not significant.

Table 1.

Provider Years of Experience

Level of Integration	Physicians	Psychologists
	Mean Experience (Yrs.)	Mean Experience (Yrs.)
Coordinated/Traditional	20.20	12.45
Co-Located	12.40	10.50
Integrated	14.20	6.10

Age. Providers had the option of choosing their age from eight categories, ranging from 18-24 through 85 and older. Though this question was optional, all participants provided a response. There were no significant differences in age based on provider type or level of integration. Most physicians were aged 25-34 and psychologists were of similar ages. Age ranges were similar across levels of integration. The average age overall of both psychologists (American Psychological Association, 2018) and physicians overall (Data USA, 2018) is somewhat older, 49.4 and 46.7, respectively. The full breakdown of providers' age is included in Table 2.

Table 2.

Provider Age Ranges

	Provider Type			
	Psychologists		Physicians	
Age Range	N	%	N	%
25-34	11	36.7%	12	40%
35-44	11	36.7%	4	13.3%
45-54	6	20%	5	16.7%
55-64	1	3.3%	7	23.3%
65-74	1	3.3%	2	6.7%
Total	30	100%	30	100%

Gender. Providers' gender did vary by provider type and across levels of integration. Psychologists in this study were more likely to be female, while the gender of physician participants was divided more evenly. Male psychologists in this study were

only located in integrated settings. The full breakdown of provider gender is included in Table 3. According to the US census, 63.2% of physicians are male (Data USA, 2018) and only 33.3% of psychologists (American Psychological Association, 2018).

Table 3.

Provider Gender

	Physicians							
	Coordinated		**Co-located**		**Integrated**		**Total**	
Gender	%	N	%	N	%	N	%	N
Male	60%	6	30%	3	50%	5	46.67%	14
Female	40%	4	70%	7	50%	5	53.33%	16
	Psychologists							
	Coordinated		**Co-located**		**Integrated**		**Total**	
Gender	%	N	%	N	%	N	%	N
Male	0%	0	0%	0	30%	3	10%	3
Female	100%	10	100%	10	70%	7	90%	27

Note: N=60, Percentages are for each level of integration.

Race. Both physician and psychologist participants were primarily White, but other races and ethnicities were also present. The full breakdown of provider race is included in Table 4. On a national level, 85% of psychologists are White, 6% Hispanic, 4% Black, 3% Asian, and 2% other ethnicities (American Psychological Association, 2018), which was similar to our psychologist participant demographics. Physicians in our study had slightly less diversity in racial/ethnic backgrounds than national demographics where 68.2% of physicians are White, 22.6% Asian, and 5.7% Black (Data USA, 2018).

Table 4

Provider Race/Ethnicity

	Physicians							
	Coordinated		**Co-located**		**Integrated**		**Total**	
Race/Ethnicity	%	N	%	N	%	N	%	N
White	80%	8	70%	7	100%	10	83%	25
Black	0%	0	10%	1	0%	0	3.33%	1
Asian	10%	1	10%	1	0%	0	6.67%	2
Other	10%	1	10%	1	0%	0	6.67%	2
	Psychologists							
	Coordinated		**Co-located**		**Integrated**		**Total**	
Race/Ethnicity	%	N	%	N	%	N	%	N
White	80%	8	60%	6	70%	7	70%	21
Black	20%	2	0%	0	10%	1	10%	3
Asian	0%	0	10%	1	10%	1	6.67%	2
Latino/Hispanic	0%	0	20%	2	0%	0	6.67%	2
Other	0%	0	10%	1	10%	1	6.67%	2

Note: N=60, Percentages are for each level of integration.

Level of Employment. The majority of providers in this study worked full-time. For physicians, 83.3% (25 out of 30) worked full-time, while 16.7% (5 out of 30) worked part-time. Almost all of psychologists (90%, 27 out of 30) worked full time, with only 3 (10%) working part-time.

Language and Use of Interpreters. All providers in this study spoke primarily English with their patients. Physicians were more likely to use interpreters in their practice. Twenty physicians (66.7%) had used interpreters when working with patients, while ten (33.3%) had not used interpreters. Most psychologists do not use interpreters in their work, with only 11 (36.7%) using interpreters and 19 (63.3%) that do not.

Patient demographics. Participants in this study provided estimates of their client/patient demographics (Table 5). Providers varied widely in their client/patient demographics overall.

Table 5.

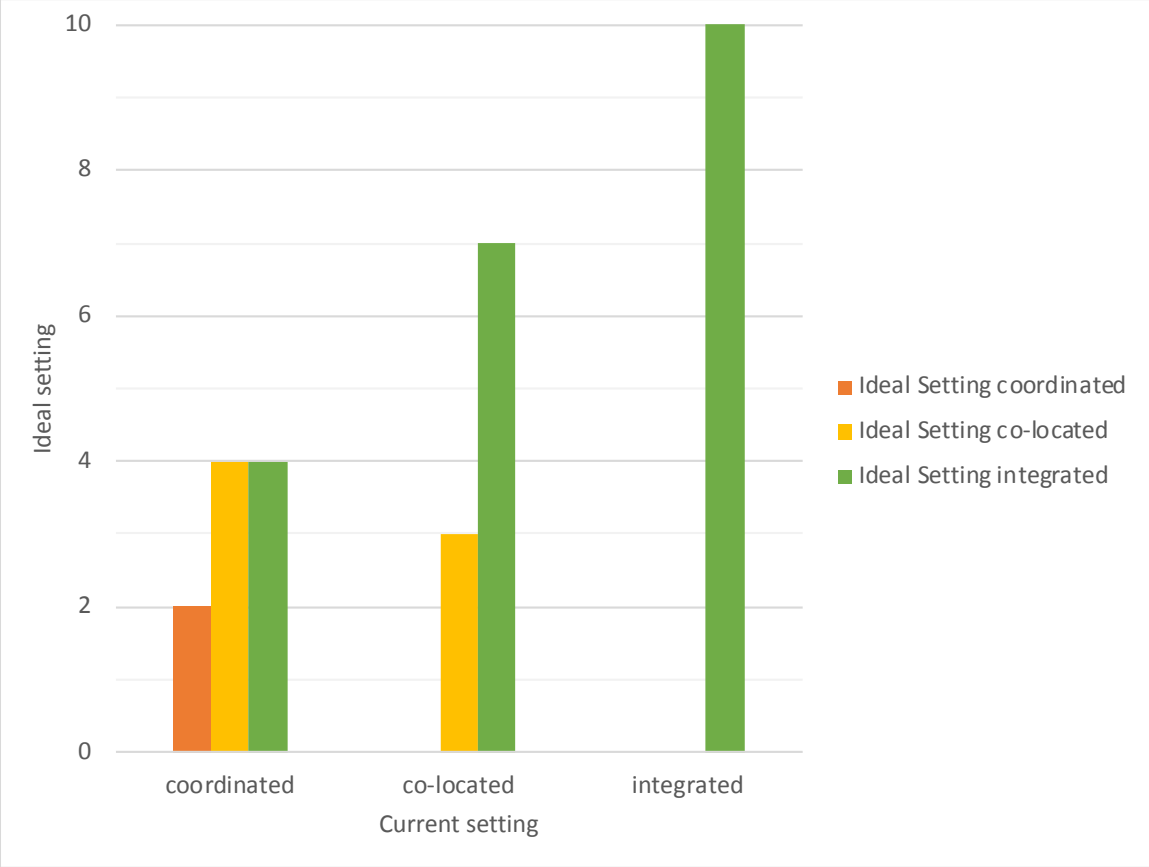
Patient Demographic Estimates

	Provider Type			
	Psychologists		Physicians	
	Range	Mean %	Range	Mean %
Gender				
Female	2-100%	58.6%	3-100%	54.84%
Age				
18-34	0-70%	43.18%	0-70%	24.56%
34-65	0-70%	41.38%	0-80%	46.63%
65+	0-70%	15.44%	5-100%	28.81%
Race				
White	0-100%	57.46%	5-100%	65.95%
Black	0-90%	15.59%	0-60%	11.02%
Native American	0-40%	2.53%	0-20%	1.09%
Asian	0-40%	4.76%	0-30%	4.22%
Latina/Hispanic	0-80%	13.04%	0-90%	14.47%
Other	0-50%	3.58%	0-30%	2.88%
SES/Income				
Low Income	0-100%	51.82%	5-100%	49.47%
Middle Income	0-100%	39.1%	0-80%	38.81%
High Income	0-66.7%	11.76%	0-80%	11.72%
Sexual Orientation				
Heterosexual	10-98%	71.89%	0-99%	77.19%
Homosexual	0-70%	16.85%	0-30%	10.69%
Bisexual	0-25%	5.62%	0-40%	2.66%
Other	0-66.7%	2.9%	0-20%	3.48%
Disability Status				
Able bodied	0-100%	54.67%	0-98%	60.16%
People w/physical disabilities	0-100%	21.5%	0-40%	14.64%
People w/psychological disabilities	0-100%	22.56%	0-80%	21.30%

Ideal Work Setting/Level of Integration. Providers were asked to choose their ideal work setting from the same level of integration options they rated their current setting (coordinated, co-located, or integrated). A series of chi-square tests were conducted to determine if providers in each setting had different preferences for their

ideal work setting. For physicians, a chi-square test indicated a significant association between current and ideal work settings, X^2 (4, n=30) =10.29, p=0.04, *Cramer's V*= 0.42. Physicians in integrated settings were the most likely to also choose integrated as their ideal work setting. See Figure 3 for a full breakdown of physician ideal work setting preferences by current work setting.

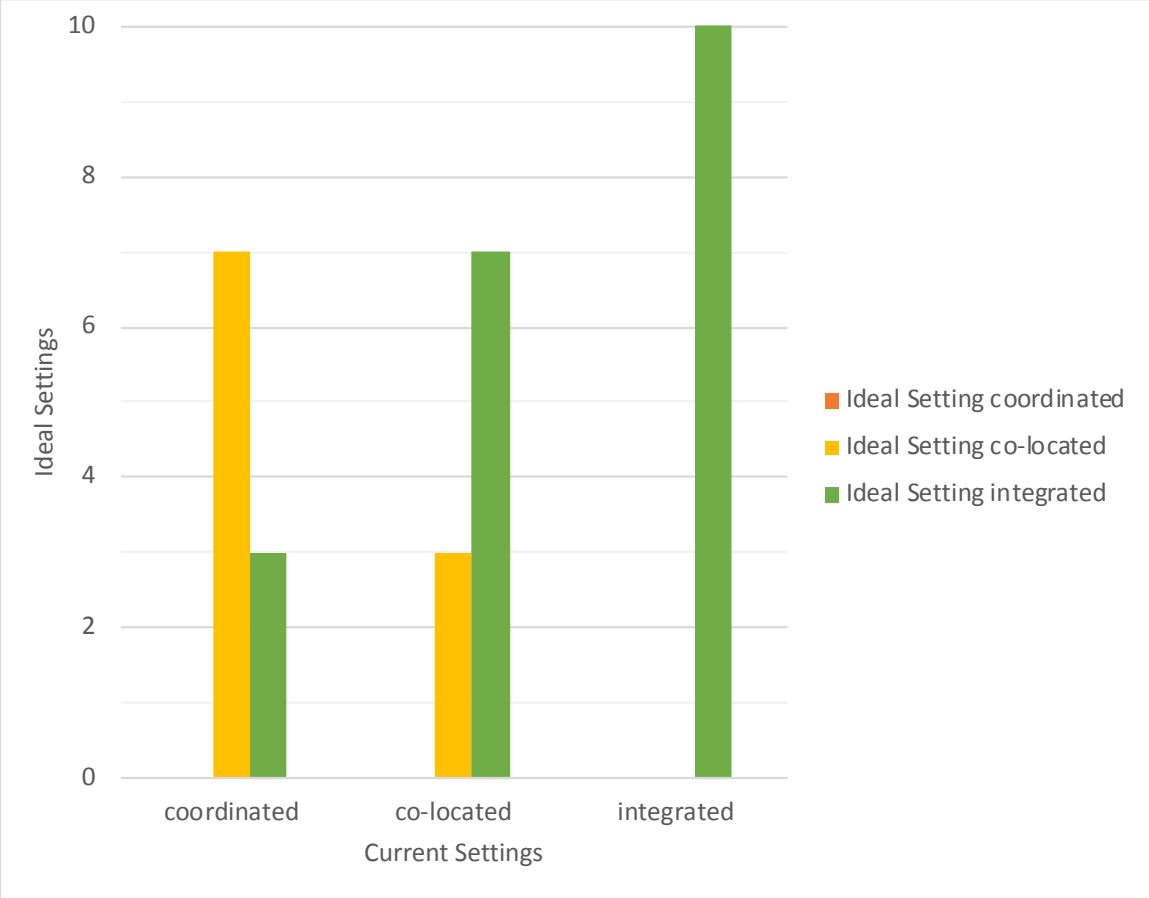
Figure 3 Physician Ideal Work Setting



For psychologists, a chi-square test also indicated a significant association between current and ideal work settings, X^2 (2, n=30) =11.1, $p < 0.01$, *Cramer's V*= 0.61. No psychologists chose coordinated/traditional settings as their ideal work setting. Interestingly, psychologists in coordinated settings were more likely to choose co-located as their ideal setting, while psychologists in co-located settings were more likely to

choose integrated as their ideal work setting. Again as with physicians, all psychologists currently working in integrated settings chose integrated as their ideal work setting. For both types of providers, these *Cramer's Vs* indicate a large effect size (Pallant, 2013). See Figure 4 for a full breakdown of psychologist ideal work setting preferences by current work setting.

Figure 4 Psychologist Ideal Work Setting



Differences Across Level of Integration and Provider Type. A one-way between-groups multivariate analysis of variance (MANOVA) was performed to investigate differences in provider perspectives based on provider type (physician or psychologist) and level of integration (coordinated, co-located, or integrated). Four dependent variables were used: level of administrative support, satisfaction with inter-

professional collaboration, job satisfaction, and provider holistic beliefs. Independent variables were provider type and level of integration. Preliminary assumption testing was conducted to check for normality, linearity, univariate and multivariate outliers, homogeneity of variance-covariance matrices, and multicollinearity. One violation was noted: homogeneity of variance-covariance could not be assumed for the variable of job satisfaction. There was a statistically significant difference between physicians and psychologists on the combined dependent variables, F (4, 49) = 3.28, p = .018; *Wilks' Lambda* = .79; *partial eta squared* = .21. There was also a statistically significant difference between providers working at different levels of integration on the combined dependent variables, F (8, 98) = 2.65, p = .011; *Wilks' Lambda* = .68; *partial eta squared* = .18. When the results for the dependent variables were considered separately, for providers differences, the only difference to reach statistical significance, using a Bonferroni adjusted alpha level of .0125, was provider holistic beliefs, F (1, 58) = 8.12, p = .006, *partial eta squared* = .135. An inspection of the mean scores indicated that psychologists reported slightly higher levels of holistic beliefs (M = 42.54, SD = 1.01) than physicians (M = 38.57, SD = 0.97). By level of integration, the only difference to reach statistical significance, using a Bonferroni adjusted alpha level of .0125, was satisfaction with inter-professional relationships, F (2, 58) = 8.86, $p < 0.001$, *partial eta squared* = .25. Post hoc analyses revealed a statistically significant difference for providers in integrated settings compared with other providers (both coordinated and co-located) in their satisfaction with inter-professional relationships (p=0.001). An inspection of the mean scores indicated that providers in integrated settings had the highest rates of satisfaction with inter-professional relationships (M = 4.45, SD = .22)

above those in coordinated (M = 3.31, SD = .23) and co-located settings (M= 3.35, SD= .22). See Table 6 for differences between the two types of providers and Table 7 for differences by level of integration.

Table 6

Mean Scores for Provider Type Differences in Healthcare Experiences (N=60)

	Provider Type				
	Physicians		Psychologists		
Healthcare Experiences	**M**	**SD**	**M**	**SD**	**Range**
Admin. Support	4.00	.91	3.82	1.02	1-5
Inter-Professional	3.77	.97	3.68	1.19	1-5
Provider Belief Scale	38.57*	6.05	42.71*	4.64	10-50
Job Satisfaction	5.90	1.39	5.82	1.42	1-7

***Significant difference, p < 0.0125 (Bonferroni adjusted alpha level)*

Table 7

Mean Scores for Provider Healthcare Experiences by Level of Integration (N=60)

	Level of Integration					
	Coordinated		Co-Located		Integrated	
Healthcare Experiences	**M**	**SD**	**M**	**SD**	**M**	**SD**
Admin. Support	4.00	.84	3.80	1.06	3.95	.99
Inter-Professional	3.33*	.84	3.35*	1.18	4.45*	.76
Provider Belief Scale	37.94	5.88	41.50	4.55	42.00	6.19
Job Satisfaction	5.89	1.71	5.90	1.12	5.80	1.39

***Significant difference, p < 0.0125 (Bonferroni adjusted alpha level)*

Interrelationships Among Variables. To further assess the experience of providers within the healthcare system, we investigated the interrelationships between level of integration, level of administrative support, satisfaction with inter-professional relationships/collaboration, job satisfaction, and provider holistic beliefs. A Pearson correlation analysis (*r)* was conducted and data met parametric assumptions for this analysis providing partial support for our hypotheses (see Table 8).

Level of Integration. Providers' level of integration in their current work setting was significantly positively correlated with their satisfaction with inter-professional collaboration, $r = .44$, $p < 0.001$. This represents a medium strength relationship between the two variables. As expected, providers working in more integrated settings are more satisfied with their relationships and collaboration with the other disciplines (mental health or physicians). Level of integration did not have significant relationships with other aspects of providers' healthcare experiences including administrative support, job satisfaction, and holistic beliefs.

Job Satisfaction. Providers' level of administrative support had a significant medium positive relationship with their job satisfaction, $r = .45$, $p < 0.001$. As expected, providers who felt more supported by their upper administration and management were more likely to express feeling more satisfied with their jobs overall. In addition to the relationship with administrative support, job satisfaction also had a significant positive relationship with provider holistic beliefs, $r = .37$, $p < 0.001$. The effect size of this relationship is medium. Providers expressing higher job satisfaction had more holistic beliefs.

Provider Holistic Beliefs. In addition to the relationship between provider holistic beliefs and job satisfaction, provider holistic beliefs also had a significant positive relationship with inter-professional relationships, $r = .28$, $p = .03$, though the effect was small. Providers that were more satisfied with their relationships and collaboration with other types of providers were more likely to have holistic health beliefs.

Table 8.

Interrelationships Among Provider Healthcare Experience Variables (N=60)

Healthcare Experiences	1	2	3	4	5
1. Level of Integration	--	-.02	.44**	-.05	.24
2. Administrative Support		--	.22	.45**	.13
3. Inter-Professional			--	.04	.28*
4. Job Satisfaction				--	.37**
5. Provider Beliefs					--

* $p < 0.05$, ** $p < 0.01$

Predictors of provider beliefs. A standard multiple linear regression was used to assess the ability for healthcare structural (provider type, level of integration, and administrative support) and relational (inter-professional relationships) factors to predict provider beliefs on the Provider Belief Scale (see Table 9). Preliminary analyses were conducted and there were no violations of assumptions for this analysis. The overall model was significant and explained 20.8% of the variance in provider beliefs ($R^2 = 0.21$, F (4, 53) = 4.75, $p < 0.01$). Provider type (psychologist or physician) was the only significant predictor of provider beliefs within the model, *beta* = .41, $p = 0.001$. Thus, our hypotheses were partially supported.

Table 9

Summary of Standard Multiple Linear Regression Analysis for Predictors of Provider Beliefs (N=60)

Predictor	Unstandardized *Beta*	SEB	Standardized *Beta*
Level of Integration	1.02	0.92	0.15
Provider Type	4.62	1.35	0.41**
Inter-Professional	1.13	0.72	0.21
Administrative Support	0.75	0.73	0.13

* $p < 0.05$, ** $p < 0.01$

Predictors of providers' job satisfaction. A standard multiple linear regression was used to assess the ability for healthcare structural (provider type, level of integration, and administrative support) and relational (inter-professional relationships) factors to predict job satisfaction (see Table 10). Preliminary analyses were conducted and there were no violations of assumptions for this analysis. The overall model was significant and explained 14.6% of the variance in job satisfaction ($R^2 = 0.15$, F (4, 53) = 3.43 p = 0.01). Perceived administrative support was the only significant predictor of job satisfaction within the model, *beta* = .46, p = 0.001. Thus, our hypotheses were partially supported.

Table 10

Summary of Standard Multiple Linear Regression Analysis for Predictors of Job Satisfaction (N=60)

Predictor	Unstandardized *Beta*	SEB	Standardized *Beta*
Level of Integration	-0.03	0.23	-0.02
Provider Type	0.08	0.34	0.03
Administrative Support	0.66	0.18	0.46**
Inter-Professional	-0.06	0.18	-0.05

* $p < 0.05$, ** $p < 0.01$

Qualitative Results

A major goal of this study was to identify themes within providers' narrative data on their perspectives on women's healthcare practice and outcomes. We explored provider narratives and defined themes. A total of 60 provider survey responses were used, with a total of 1,320 coded statements. Each of these providers answered a series of open-ended response questions. Using the CQR method, two independent coders were used. The overall inter-rater agreement was high (90.5%). The research team identified themes in provider narratives in in the following system domains: patient overall well-being, provider job satisfaction, patient-provider relationships, inter-professional relationships, organizational/administrative support, and health disparities and barriers. Narratives were also examined for similarities and differences across provider groups and

care setting (level of integration). Table 11 provides an overview of all domains and themes found in the qualitative analysis.

Table 11

Qualitative Analysis Overview

Domains	Themes	Psychologists			Physicians		
		Traditional	Co-located	Integrated	Traditional	Co-located	Integrated
Patient Well-being (factors) *62 statements*	1. Physical	0%	0%	0%	10%	0%	9%
	2. Psychological	40%	40%	45%	30%	0%	27%
	3. Holistic	50%	60%	36%	30%	50%	27%
	4. Other	10%	0%	18%	30%	40%	27%
Job Satisfaction *111 statements*	Satisfied (total)	79%	60%	79%	69%	41%	73%
	Reasons for satisfaction						
	1. Administration	9%	13%	13%	9%	0%	27%
	2. Patient-Provider	18%	20%	33%	36%	44%	18%
	3. Inter-professional	18%	13%	20%	18%	22%	9%
	4. Provider personal	45%	40%	27%	36%	33%	36%
	5. Financial	0%	0%	7%	0%	0%	0%
	6. Other	9%	13%	0%	0%	0%	9%
	Dissatisfied (total)	21%	40%	21%	31%	59%	27%
	Reasons for dissatisfaction						
	1. Administration	33%	40%	50%	20%	38%	25%
	2. Patient-Provider	0%	0%	0%	40%	8%	25%
	3. Inter-professional	0%	20%	0%	0%	0%	0%
	4. Provider personal	0%	0%	25%	20%	23%	0%
	5. Financial	33%	20%	0%	0%	0%	0%
	6. Other	0%	20%	25%	0%	15%	50%
	7. N/A	33%	0%	0%	20%	15%	0%
Patient-Provider Relationships *205 statements*	1. Consumer-driven	44%	72%	69%	38%	53%	32%
	2. Expert Model	35%	21%	14%	35%	22%	35%
	3. Ambiguous	18%	6%	17%	24%	25%	32%
	4. N/A	3%	0%	0%	3%	0%	0%

Table 11 (Cont.)

Domains	Themes	Psychologists			Physicians		
		Traditional	Co-located	Integrated	Traditional	Co-located	Integrated
Inter-professional Relationships *109 statements*	Current relationships						
	1. Satisfied	50%	35%	88%	20%	29%	53%
	2. Dissatisfied	42%	65%	11%	73%	64%	47%
	Value						
	1. Professionalism	13%	0%	7%	42%	32%	36%
	2. Power & Respect	27%	35%	20%	5%	5%	9%
	3. Trust	0%	12%	0%	11%	11%	0%
	4. Collaboration	60%	30%	73%	32%	37%	45%
	5. Other	0%	0%	24%	11%	11%	0%
Organizational/ Administrative Support *83 statements*	1. Satisfied	25%	33%	40%	46%	53%	55%
	2. Dissatisfied	33%	60%	60%	23%	47%	27%
	3. N/A	42%	7%	0%	31%	0%	18%
Health Disparities an Barriers *750 statements*	Factors						
	1. Patient	29%	22%	26%	26%	23%	25%
	2. Provider	19%	18%	17%	20%	22%	22%
	3. Relational/dyad	18%	21%	29%	12%	18%	12%
	4. System	16%	16%	19%	15%	21%	12%
	5. Other	6%	3%	8%	4%	6%	3%
	6. N/A	13%	21%	1%	23%	10%	26%
	Sensitivity						
	1. Sensitive	45%	34%	45%	25%	25%	27%
	2. Insensitive	10%	16%	11%	39%	21%	24%
	3. Ambiguous	45%	50%	44%	36%	54%	49%
1,320 total statements							

Providers' perspectives on patient satisfaction and well-being. Providers were asked how they assess the well-being of their female patients and what specific indicators they use. A total of 62 responses were made related to providers' perspectives on patient satisfaction and well-being (Table 12). We coded provider responses as related to one of the following factors: physical, psychological, holistic, power differential, other, or n/a.

The most common category across providers was holistic definitions of patient well-being (42%), where the provider incorporates both physical and psychological aspects, often through multiple means of assessing well-being. This was true across both psychologists (48%) and physicians (35%). However, psychologists were also likely to describe purely psychological definitions of well-being (40%), in which a provider would only look for a reduction of psychological symptoms, such as feeling less anxious. Many physician descriptions of patient well-being fell into the other category (32%). These were typically responses that did not fit within our coding rubric, but usually focused on patient self-report or rapport to assess patient well-being.

Table 12

Providers' Perspectives on Patient Well-Being Participant Response Examples

	Provider	
Setting	**Psychologists**	**Physicians**
Traditional	"Symptom reduction, self report of wellbeing – physical, emotional, spiritual, social." (*Holistic)*	"Self-report Physician observation." (*Other)*
Co-located	"Employ a feminist ecological model that looks not only at symptoms but the context negotiated by the client." (*Holistic)*	"I ask them! And have more frequent visits so they establish trust and open up to me. Symptom reduction. How they look, act. How they tell me they are feeling. How their health/vitality/wellbeing is or is not impacting their lives (are they feeling too bad to go to work?)." (*Holistic)*
Integrated	"Rating scales for depressive and anxiety symptoms; questions about role functioning and functional impairment." (*Psychological)*	"Questions about stress and functionality and use of dangerous coping strategies (alcohol, etc.)." (*Psychological)*

Note: Provider themes include holistic, physical, psychological or other perspectives on assessing patient well-being.

Provider job satisfaction. Providers were asked how satisfied they were with their jobs and their reasons for their level of job satisfaction/dissatisfaction. Participants made a total of 111 statements about their job satisfaction (Table 13). These responses were coded as satisfied or dissatisfied. They were also coded by the reason for the satisfaction or dissatisfaction. The majority of providers overall described being satisfied with their jobs (65%). The reasons for job satisfaction were provider personal reasons (36%), patient-provider factors (28%), inter-professional factors (17%), administrative/organizational factors (13%), other (6%), and financial factors (1%). Reasons for provider job dissatisfaction included administrative/organizational factors (36%), other (18%), provider personal factors (13%), patient-provider factors (10%), financial factors (8%), and inter-professional factors (5%). Across provider type and settings, psychologists in all settings were the most satisfied with their work (71% satisfied) compared to physicians (58% satisfied). PCPs in integrated settings were also highly satisfied with their jobs (73%). Both psychologists (60% satisfied) and physicians (41% satisfied) in co-located settings were the most negative in their job satisfaction narratives. PCPs in co-located settings were the only group that had more dissatisfied responses than satisfied.

Table 13

Provider Job Satisfaction Participant Response Examples

	Provider	
Setting	**Psychologists**	**Physicians**
Traditional	"I love the patients I work with. And hopefully making a difference."	"Love my coworkers, boss. Patients are the same everywhere—some are great, some not so great. "
Co-located	"I love this work, it is meaningful and the clients are amazing. The providers, that's a different story, so I just have to do the best I can and focus on my clients."	"Burnout is a real problem, I feel like I am always on the clock, and I work hard for my patients and still they can't always get what they need."
Integrated	Very satisfied by my work with patients and the opportunity to work with women who likely wouldn't get services elsewhere; very dissatisfied by lack of organizational support for high-quality integrated care"	"I am able to practice the full scope of primary care in an integrated environment with an underserved population. Check, check, check."

Providers' perspectives on patient-provider relationships. Providers were asked about their patient-provider relationships including: 1. The successful components, 2. The challenges and how they overcome these challenges, and 3. Trust in the patient-provider relationship. Participants made a total of 205 responses regarding the patient-provider relationship (Table 14). Providers' responses regarding the patient-provider relationship were coded as either consumer-driven or expert-model. A consumer-driven patient-provider relationship (or patient-centered) is one with mutual communication, an equalized power differential, collaboration, and trust that is built, required, and mutual.

An expert-mode patient-provider relationship has one-way communication, provider hierarchy and power over the patient, non-collaborative, and trust that is assumed and unidirectional (patient must trust the provider). Responses could also be coded as not falling into one of these two categories, but this was not the case for most responses. Overall about half of providers (51%) were clearly consumer-driven in their responses to these three areas of the patient-provider relationship. Psychologists tended to be more consumer-driven (62%) than physicians (41%). Co-located providers (both PCPs and psychologists) had the most consumer-driven responses relating to the patient-provider relationship (53% and 73%).

Table 14

Patient-Provider Relationships Participant Response Examples

	Provider	
Setting	**Psychologists**	**Physicians**
Traditional	"Trust and creating a safe space." (*Consumer-Driven)*	"Empathy and trust. Trust that the patient can be completely open and honest with me and trust me to really listen and do act in their best interest." (*Consumer-Driven)*
Co-located	"They are open and honest, including talking about ruptures in our relationship or things that elicit a feeling of shame." (*Consumer-Driven)*	"Most of my patients I have been seeing for 20+ years. Especially for younger women (20-30) I often have seen them through adolescence. Trust is built over time. I show respect and let them tell their story." (*Consumer-Driven)*
Integrated	"Building rapport, informed consent, and reviewing confidentiality are successful component to these relationships. Patient understanding that there is a full healthcare team on their side also make these relationships successful." (*Consumer-Driven)*	"I feel especially happy/successful when I can counsel them on healthy sexual health and female specific health maintenance that no one had explained to them in a way before of why it is good to do and what we look for." (*Expert Model)*

Note: Provider themes are consumer-driven or expert model perspectives on patient-provider relationships.

Providers' perspectives on inter-professional relationships. Providers were asked to comment on their current experience in inter-professional relationships and also what they value in inter-professional relationships.

Current Experience. Providers were asked to explain their satisfaction ratings for collaboration with interdisciplinary providers (either primary care or mental health

providers). Providers' responses were categorized as satisfied (46%) or dissatisfied (51%) or N/A (3%). Participants made a total of 93 statements regarding their experience with inter-professional relationships (see Table 15). Narrative responses in the area of inter-professional relationships indicated differences between levels of integration and provider type. Physicians overall were more dissatisfied with inter-professional relationships (61%) than psychologists (40%). Physicians in traditional settings were the most dissatisfied of any other group (73%), while psychologists in integrated settings were the most satisfied (88%). Overall, integrated providers stood out as much more satisfied with inter-professional relationships (72%) compared to their peers in other settings (32-33%). Many physicians in traditional settings felt that mental health providers were too busy to communicate or to see their patients. Communication was often the main concern for providers who were dissatisfied with their interactions with other providers.

Table 15

Satisfaction with Inter-Professional Collaboration Participant Response Examples

	Provider	
Setting	**Psychologists**	**Physicians**
Traditional	"I always hear back when I reach out. They do not often initiate contact with me, though." (*satisfied/dissatisfied)*	"They are too busy to communicate, they are spread too thin." (*dissatisfied)*
Co-located	"Care is often conducted in silos with poor communication between providers." (*dissatisfied)*	"Would like more time to have meetings to discuss challenging issues. They happen, but coordinating my time and the MH providers' time can be difficult." *(dissatisfied)*
Integrated	"It is easy to communicate with my PCPs and they are open to my feedback/suggestions about patient care. The culture in general at the health center highly values the role of behavioral health in caring for patients." (*satisfied)*	"We have integrated care for many of our patients. That is a very satisfying experience. Communicating with community MH providers is very challenging and is not satisfying." (*satisfied/dissatisfied)*

Note: Provider themes are satisfied or dissatisfied with inter-professional relationships.

Values. Providers were asked "What do you value in your relationship with other providers?" Provider responses regarding what they value in inter-professional relationships were coded into five categories: professional behavior and conduct, power and respect, collaboration, and other. Participants made a total of 96 statements regarding their values in inter-professional relationships (Table 16). Collaboration was overall the most important factor for providers in their inter-professional relationships (45%),

followed by professionalism (22%). Other themes included power and respect (17%), trust (6%), and other factors (8%). Differences emerged between psychologists and physicians in their values. Psychologists in all settings were more likely to value collaboration and power/respect. Physicians also valued collaboration, but were more likely to mention professionalism and not power and respect.

Table 16

Provider Values in Inter-Professional Relationships Participant Response Examples

Setting	Provider: Psychologists	Provider: Physicians
Traditional	"Being able to coordinate care, being able to check in with other provider on their observations and thoughts about a client." (*Collaboration)*	"Trust that they will not blow off the patient and actually listen and take care of them." (*Professionalism)*
Co-located	"When physicians value the work of psychologists, and not all do, the results are often to the benefit of the client." (*Power & respect)*	"Someone who reads my notes and attempts to interact." (*Professionalism)*
Integrated	"Being able to care holistically for patient's needs, including their psychiatric medications and a more powerful plan to care for their chronic illnesses, which often have a mind-body connection." *(Collaboration)*	"Access, openness, collaboration" (*Collaboration)*

Note: Provider themes in inter-professional relationship values include: professional behavior and conduct, power and respect, collaboration, and other.

Providers' perceived organizational/administrative support. Providers were asked to rate how supported they currently feel by their upper administration and management. The following represents their narrative responses to the follow up question "Please explain how you do or do not feel supported by your upper administration and management." Responses in this category were categorized as satisfied, dissatisfied, or not applicable (N/A). Participants made a total of 83 statements about

organizational/administrative support (see Table 17). Overall, analysis of responses revealed that participants were about evenly satisfied (42%) and dissatisfied (43%) with the level of administrative/organizational support they receive. The remainder of providers (15%) reported that the question did not apply (N/A) as they are in private practice or management positions. These providers were primarily psychologists and physicians in traditional settings. Separated by provider type and work setting, providers' narratives told a somewhat different story. The majority of psychologists in co-located and integrated settings were dissatisfied with their level of administrative support (60%); while the majority of PCPs not in private practice or management (51%) were satisfied with upper administration.

Table 17

Provider Level of Organizational/Administrative Support Participant Response Examples

	Provider	
Setting	**Psychologists**	**Physicians**
Traditional	"Generally supportive of our work. However, not responsive to issues of short staffing or under-market pay." (*satisfied/dissatisfied)*	"Everyone listens to input I have and takes my suggestions seriously." (*satisfied)*
Co-located	"We have to advocate for our own needs (access to patients' charts, office space, access to facility areas, etc.)." (*dissatisfied)*	"Always open to suggestions on better workflow and protocols for improving patient care." (*satisfied)*
Integrated	"Administration seems divided on whether integration is the best model for our organization, and so I often feel pressure to make a case for continued use of it." (*dissatisfied)*	"Administration is committed to wholistic care." (*satisfied)*

Note: Provider themes are satisfied or dissatisfied with their organizational support.

Providers' perspectives on healthcare disparities and barriers. Providers were asked about their experiences working with women and women from specific marginalized groups. Results will be discussed for each group of women. Providers were asked about their successes working with each of these groups as well as "What are your challenges in working with them? What specific barriers get in the way (e.g. patient, provider, or systems level factors)?" Themes were categorized into patient factors, provider factors, relational and dyadic factors, systems factors, or other factors. Responses were also coded as sensitive to health disparities or not, depending on their acknowledgement of systemic barriers for diverse populations.

Healthcare disparities among women overall. Providers were asked to comment on their work with female patients overall, including their perception of the successes and challenges in their work.

Successes. A total of 67 statements were made by participants regarding successes with their female patients in general (Table 18). Relationship/dyad factors was the most common theme (37%) among providers speaking to their successes, with other common themes including patient factors (25%) and provider factors (21%). There were differences in provider experiences of their successes with female patients across provider type. Psychologists were much more likely to focus on relationship/dyad factors (57%) compared with physicians (22%). Physician responses also varied considerably by their level of integration. Traditional PCPs were the only group to have a substantial number of their responses fall into the N/A category (45%). These responses focused on how the gender of their patients made no difference in their care. PCPs in co-located settings had the most varied experiences of success with their female patients, defining successful experiences through patient (21%), provider (36%), and relationship factors (36%). Lastly, PCPs in integrated settings looked to their patients to define their successful experiences more than any other group (42%).

Table 18

Providers' Successes Working with Female Patients Participant Response Examples

	Provider	
Setting	**Psychologists**	**Physicians**
Traditional	"Being able to establish a positive working relationship." (*Relationship/dyad)*	"Same success whether male or female, makes no difference." (*N/A)*
Co-located	"I find that empowering women in the therapy space to identify the areas in which they want to change (or not) is so powerful. Often therapy is hierarchical with female clients expecting to be told what to do." *(Relationship/dyad)*	"Being female is helpful! I have a lot of female patients of all age ranges. I do a lot of reproductive and women's health care, and am trusted to provide them with that information from both a medical and personal perspective. I feel like they are comfortable discussing their women's health issues with me comfortably. I also do prenatal care and obstetrics and meet many women and families through this." (*Mixed)*
Integrated	"Generally I feel very good about my work with female clients - many report feeling heard and validated and describe this as a contrast from how they feel in the rest of their lives." *(Relationship/dyad)*	"I consider it success if they identify their health goals and I help move towards them." (*Patient)*

Note: Provider themes include patient factors, provider factors, relational and dyadic factors, systems factors, or other factors.

Challenges. A total of 88 statements were made regarding providers' experiences of their challenges and barriers working with female patients (Table 19). Providers' narratives surrounding challenges and barriers with their female patients were more

focused on systems (34%) and patient factors (41%) for all groups, compared to the focus on provider factors in successes. By group, physicians in co-located settings were the most likely to mention systems factors (55%) as challenges and barriers with their female patients. Systems barriers discussed by providers included clinic/organizational issues (e.g. scheduling, staff turnover, access to care), issues affecting women (e.g. discrimination, childcare), and larger systems issue like insurance.

Table 19

Providers' Challenges/Barriers Working with Female Patients Participant Response Examples

	Provider	
Setting	**Psychologists**	**Physicians**
Traditional	"Ongoing trauma makes resolving old trauma challenging." (*Patient)*	"Patients can be very difficult to keep to their scheduled time--arriving late and wanting much more time than their appointment calls for." (*Patient)*
Co-located	"Systemic sexism" "Access to safe spaces within facilities and privacy, hierarchical relationships [between] MDs and psychologists" (*System)*	"Transportation issues are common in my area. Being in a residency practice is difficult for coordination/continuity of care sometimes. I often have to refer to procedure clinic instead of placing IUDs or other procedures during my clinic hours." (*System)*
Integrated	"Female patients are often highly affected by their relationships, but have a hard time accepting that they can't change the people in their lives." (*Patient)*	"Inability to follow up in a timely fashion because of schedule constraints. Lack of understanding of what we can realistically accomplish for their medical concern, Lack of belief that psychosocial factors can play a strong role in their medical concerns." (*Patient)*

Note: Provider themes include patient factors, provider factors, relational and dyadic factors, systems factors, or other factors.

Providers were also asked about their experiences (both successful and challenging) in working with women from the following groups: women of color, elderly

women, sexual and/or gender minority women, women with disabilities, low socioeconomic status (SES) women. Themes that emerged in provider narratives for each group will be discussed (patient, provider, relationship/dyad, systems, and other factors). Coders also rated the perceived level of sensitivity (sensitive, insensitive, or ambiguous) for each response.

Women of color. A total of 105 statements were made regarding providers' successes and challenges providing care to women of color (Table 20). Similar patterns were found in themes for women of color compared to providers' responses for their female patients in general. Overall, the most common theme regarding successful work with women of color was relational/dyad factors (41%). This was even more common for psychologist across the board (58%). However, PCPs' responses were more likely to fall into "not applicable" (40%), which largely responses were stating they had limited experience with population or that they were no different from other patients. Both types of providers were more likely to focus on patient (31%) and systems factors (24%) when discussing challenges working with women of color. Overall, providers were evenly spread out in their sensitivity to the specific health disparities of women of color, across sensitive (36%), insensitive (29%), and ambiguous (35%). Physicians' responses regarding working with women of color were rated more insensitive (46%) than psychologists' (14%).

Table 20

Providers' Experiences Working with Women of Color Participant Response Examples

	Provider	
Setting	**Psychologists**	**Physicians**
Traditional	"The hospital where I work is not conveniently located with respect to public transit. It has a reputation for being a treatment setting for rich people, even though our specific program takes insurance and often serves low-income patients. Our patients tend to be white, and most of our staff is white, so patients of color can feel uncomfortable." (*Challenge, Systems, Sensitive)*	"No different than White [women]" (*N/A, Insensitive)*
Co-located	"Helping them find their identity, especially in our very white community." (*Success, Relationship/Dyad, Sensitive)*	"Myths, preconceived ideas, their grandmother's theories at times." (*Challenge, Patient, Insensitive)*
Integrated	"As a white, educated woman I know that there are many experiences that I do not understand for my female clients of color. Getting them to feel comfortable enough with me to discuss openly how their race/ethnicity might be impacting them when it is relevant to their mental health care feels successful." (*Success, dyad, sensitive)*	"I don't think I have any female patients of color." (*N/A, Ambiguous)*

Note: Provider themes include patient factors, provider factors, relational and dyadic factors, systems factors, or other factors describing either their successes or challenges with this patient group. Providers' responses were also coded as sensitive or insensitive to health disparities or ambiguous.

Elderly women. A total of 105 statements were made surrounding providers' successes, challenges, and barriers of working with elderly women (Table 21). Providers' experiences with elderly women were very similar across groups of providers. Relationship/dyad was the most common theme for successes with elderly women (37%), while providers focused on patient factors (42%) again when speaking to the challenges and barriers. Across levels of integration and discipline providers' sensitivity to the specific health disparities of elderly women was ambiguous (65%).

Table 21

Providers' Experiences Working with Elderly Women Participant Response Examples

	Provider	
Setting	**Psychologists**	**Physicians**
Traditional	"Decreased depression, improved family relationships. Decrease in grief symptoms." (*Success, Provider, Ambiguous)*	"We have great relationships with elderly female patients. All of the providers and staff get to know them and can tell when something is not normal even before the patient voices it." (*Success, Relational/Dyad, Ambiguous)*
Co-located	"Chronicity and severity of illness is often a barrier." (*Challenge, Patient, Ambiguous)*	"Since I am an internist most of my patients are geriatric, and in the VA population the oldest female veterans have some phenomenal stories! It is fun to get them hooked up with other female veterans, and we have a wide range of social, medical and recreational supports and programs here." (*Success, Relational/Dyad, Ambiguous)*
Integrated	"Easy to build rapport, often have a great amount of insight that easy to build upon. Personally, I find these patients rewarding to work with because they tend to have amazing life stories and lessons." (*Success, Relational/Dyad, Ambiguous)*	"Unrealistic patient expectations of what can be accomplished for them, i.e. not accepting that their age itself poses a physiologic barrier to achieving a health/medical goal they have." (*Challenge, Patient, Ambiguous)*

Note: Provider themes include patient factors, provider factors, relational and dyadic factors, systems factors, or other factors describing either their successes or challenges with this patient group. Providers' responses were also coded as sensitive or insensitive to health disparities or ambiguous.

Sexual and gender minority women. One hundred and five (105) statements were made for providers' perspectives on the successes, challenges, and barriers of working

with sexual and gender minority women (Table 22). Similar patterns in themes emerged as for other groups of women. Overall regarding provider successes with LGBT patients N/A was the most common theme (31%), followed by provider factors (29%), and relationship/dyad factors (25%). Challenges working with LGBT women were attributed to patient factors (26%) or systems factors (24%). These patterns were relatively true across provider groups. As with previous group of women, psychologists were somewhat more likely to focus on relational successes (35%), while PCPs focused more on provider factors in successes (33%). Providers' level of sensitivity toward the specific health disparities for LGBT women was ambiguous (42%). Traditional physicians stood out from other groups of providers as the most insensitive towards LGBT patients (59%).

Table 22

Providers' Experiences Working with LGBT Women Participant Response Examples

	Provider	
Setting	**Psychologists**	**Physicians**
Traditional	"Validating their identity and educating their loved ones on their experience. Also providing them with a safe space to process their experience and empowering themselves despite rejection from others." (*Success, Relational/Dyad, Sensitive)*	"I have to admit I wasn't entirely sure if the transgender female teenager I was working with was truly transgender or attention seeking. I primarily only addressed her ADD." (*Challenge, Patient, Insensitive)*
Co-located	"Same as with other minority statuses." (*Success, N/A, Insensitive)*	"I don't know if I have any because they have not self identified." (*N/A, Ambiguous)*
Integrated	"High degree of social stigma, certainly individuals with these considerations in this geographic region, not sure that they feel secure in seeking assistance for concerns related to gender, sexual orientation, not sure that our healthcare system does a good job of outreach to individuals in these communities." (*Challenge, Systems, Sensitive)*	"I have familiarized myself with their specific health needs/risks and offer appropriate care." (*Success, Provider, Ambiguous)*

Note: Provider themes include patient factors, provider factors, relational and dyadic factors, systems factors, or other factors describing either their successes or challenges with this patient group. Providers' responses were also coded as sensitive or insensitive to health disparities or ambiguous.

Women with disabilities. Providers made 107 statements on their successes, challenges, and barriers of working with women with disabilities (Table 23). The most common theme related to successes with women with disabilities was provider-related factors (40%) across all groups of providers. Overall, the most common theme related to

challenges and barriers working with women with disabilities were systems factors (39%). This pattern was true across most groups of providers; however, integrated physicians named patient factors (29%) and systems factors (29%) equally. Traditional psychologists were the most divergent group with the most common challenge for them relating to provider factors (31%). Overall, providers' level of sensitivity to disparities for women with disabilities was ambiguous (51%). Psychologists in traditional settings were the most sensitive (63%) compared to other providers.

Table 23

Providers' Experiences with Women with Disabilities Participant Response Examples

Setting	Provider	
	Psychologists	**Physicians**
Traditional	"Establishing positive relationship, advocating for them in the medical system when needed." (*Success, Relational/Dyad, Sensitive)*	"Whatever barriers their disabilities cause--ex, someone wheelchair bound is going to have difficulty simply getting to my office. Someone in a major depression is not going to have the energy/ambition to get dressed and make an appt, etc." (*Challenge, Systems, Ambiguous)*
Co-located	"Physical concerns may trump mental health ones in the mind of the client at the facility; they may be looking for relief from physical pain, etc., first and foremost." (*Challenge, Patient, Ambiguous)*	"Unless severe disability (and on Medicare) resources are limited. Particularly invisible disabilities can be very difficult to help." (*Challenge, Systems, Ambiguous)*
Integrated	"Significant work with chronic pain patients throughout the life span, generally good collaboration between myself and their PCPs with regard to tapering off opioid medications, cognitive-behavioral approaches to pain management, enhanced function and improved daily activity." (*Success, Provider, Ambiguous)*	"Patient [barriers], esp. if they use nursing/nurses aids at home who help them but those people not coming to the appts." (*Challenge, Patient, Ambiguous)*

Note: Provider themes include patient factors, provider factors, relational and dyadic factors, systems factors, or other factors describing either their successes or challenges with this patient group. Providers' responses were also coded as sensitive or insensitive to health disparities or ambiguous.

Low SES women. Providers made 113 statements regarding their successes, challenges, and barriers of working with women with low socioeconomic status (SES; Table 24). The most common theme overall in regards to successful experiences was provider-related factors (36%), which aligned with providers' narratives of working with women with disabilities. This pattern was true across groups of providers, except for traditional psychologists who focused more on successes in the relationship/dyad (30%) or fell under N/A (40%) Psychologists in co-located settings were also divided between provider-related successes (29%) and N/A (29%). Across all providers, the most common theme regarding challenges and barriers for low SES women was patient factors (47%). Providers' level of sensitivity towards disparities for low SES women was again primarily ambiguous (42%), but sensitive responses were close behind (38%). This pattern was relatively true across provider groups; however, traditional and integrated psychologists tended to be the most sensitive (57% and 53% respectively).

Table 24

Providers' Experiences Working with Low SES Women Participant Response Examples

	Provider	
Setting	**Psychologists**	**Physicians**
Traditional	"Low SES can be so limiting -- no $, lack of treater options, sometimes dependent on unhealthy relationships for material support for themselves or their children." (*Challenges, Patient, Sensitive)*	"Most grew up in similar family household, so they do not have role models with good health habits." (*Challenge, Patient, Ambiguous)*
Co-located	"Transportation." (*Challenge, Patient/Systems, Ambiguous)*	"Often have perception that as a healthcare provider we make a lot of money - oh you don't understand or commenting on jewelry and not getting off to a good start." (*Challenge, Patient, Ambiguous)*
Integrated	"Clients fearing a bill, clients not having many referral options and or referrals taking a long time to process, delaying care." (*Challenge, Patient/Systems, Sensitive)*	"I am working on changing languages, drawing simplified pictures on exam table paper to try to make it something for the patient to understand." (*Success, Provider, Ambiguous)*

Note: Provider themes include patient factors, provider factors, relational and dyadic factors, systems factors, or other factors describing either their successes or challenges with this patient group. Providers' responses were also coded as sensitive or insensitive to health disparities or ambiguous.

Providers' perspectives on the current political climate. Related to healthcare disparities and barriers for diverse women, providers were also asked, "In your opinion, how do you think the current political climate impacts your work providing care to women?" Themes again fell into six categories: patient, provider, relationship/dyad,

systems, or other factors, and not applicable (N/A) and were rated for their sensitivity to health disparities for diverse women. A total of 60 statements were made regarding providers' experiences providing care to diverse women within the current political climate (Table 25). The impact on patients (40%) was the most common theme overall. This was true across most provider groups except for traditional and integrated physicians. Seventy (70%) of traditional physicians did not feel there was an effect from politics and fell under the "N/A" theme. Integrated physicians were evenly split among three themes: systems factors (29%), N/A (29%), and patient (21%). Most providers recognized the impact of the current political climate on patients and showed sensitivity to potential disparities for diverse women within this climate; fifty-two percent of all responses were rated as sensitive and twenty-five percent as ambiguous. However, there were differences across providers. Almost all of the physicians in traditional settings felt that the current political climate did not impact their work with women and were rated as insensitive (70%). Physicians overall were less sensitive (41%) compared to psychologists (64%).

Table 25

Providers' Perspectives on the Impact of the Current Political Climate Participant Response Examples

	Provider	
Setting	**Psychologists**	**Physicians**
Integrated	"Hugely! Many of my clients were very upset after the election and continue to be upset about it. It helps them to have a therapist who can reflect their concerns and hold them in safety." (*Patient, Sensitive)*	"Zero impact" (*N/A, Insensitive)*
Co-located	"For my clients of color, the political climate has an immense impact. I feel I am currently working within a context where my clients feel that racism is never going to end. There is a hopelessness that must be validated. The challenge is being able to instill hope in their own humanity and the humanity and dignity of others." *(Patient, Sensitive)*	"Some ignorance regarding their rights. For example "Obamacare is dead" so didn't sign up for insurance or 'I refuse Medicare wellness exam' because they don't like the idea of Obamacare." (*Patient, Ambiguous)*
Integrated	"Many patients I work with are scared of them or their loved ones being deported or detained, many are afraid of losing their health insurance or public benefits." (*Patient, Sensitive)*	"Increased overall stress level impacts their mental well-being." (*Patient, Sensitive)*

Note: Provider themes include patient factors, provider factors, relational and dyadic factors, systems factors, or other factors. Providers' responses were also coded as sensitive or insensitive to health disparities or ambiguous.

Providers' suggestions for addressing health disparities and barriers. Lastly, providers were asked for suggestions for how to improve healthcare for women from diverse and marginalized backgrounds. A total of 295 statements regarding provider suggestions were coded into the same categories used in previous areas (patient, provider, relational/dyad, systems, or other factors). Examples of suggestions from providers in each category are included in Table 26. The majority of providers of all types and settings focused on systems recommendations (58%). Systems recommendations included suggestions regarding cost/access, health care systems changes (especially single payer and universal health care), societal/social change, and health care administration. Provider focused recommendations were the next most common theme among provider suggestions (20%). Provider's felt that provider competence (particularly cultural competence), education/training, and diversity in demographics were important considerations in improving healthcare for diverse women. The rest of provider suggestions were spread out between patient-focused (3%), dyad-focused (2%), other recommendations (7%), and not applicable (9%). These patterns were largely persistent across provider groups.

Table 26

Providers' Recommendations to Improve Healthcare for Diverse Women Themes and Participant Response Examples

Theme	**Example**
System Recommendations (58%)	
Cost & Access	"Improve access to care."
Administration Demographics	"More women and POC in leadership positions of larger healthcare orgs."
Administrative Competence	"The organization needs to understand the

	needs of their community and tailor health options to that population."
Social Services	"Increased resources for social support."
Health Care System	"Universal health care."
Societal Change	"A living minimum wage."
Women's Health Policy	"Stop intervening in women's health care choices! Stop meddling in a woman's right to make her own decision regarding her body."
Voting and Advocacy	"Vote for politicians that you believe will benefit the people the most!"
Provider Recommendations (20%)	
Provider Competence	"Competence in dealing with racism and sexism as well as gender bias in health care."
Provider Education	"Good trainings should be available."
Provider Demographics	"Diversifying the pool of providers so women of multiple minority identities see other women of multiple minority identities."
Provider Compensation	"If providers are compensated better, they likely will be more open to accepting insurance plans. That in turn would improve access for low-income populations."
Patient Recommendations (3%)	"Ask for providers trained in women's health care needs. Feel free to talk about supports and stresses."
Dyad/Relational Recommendations (2%)	"Empower them! Teach them about their health and how to become engaged with their health and provider. More community health education opportunities."

Overall, in all provider narratives related to patient health disparities and barriers, the most common theme was patient factors, found in around a quarter of all responses.

Psychologists on the whole were more likely than physicians to focus on relational and dyad factors. Few psychologist responses were rated as insensitive, though they were about evenly split between sensitive and ambiguous. Their responses did not differ greatly across levels of integration. Physician's responses were more evenly spread across patient, provider, and systems factors in their views on patient health disparities and barriers. Physicians in all settings were more likely than psychologists to have responses rated as insensitive to health disparities and barriers, meaning that they expressed views that showed a denial of potential issues, concerns, and social determinants of health for diverse women. However, physicians in co-located and integrated settings had similar rates of ambiguous sensitivity as psychologists. Though physicians in traditional settings had similar rates of sensitivity to health disparities as other physicians, they stood out as the most insensitive group overall. They were the most likely provider group to fall into the not applicable theme, as they reported that different social identities (gender, race, etc.) did not impact care.

CHAPTER FIVE

Discussion

This study aimed to bridge the gaps in literature on integrated healthcare, inter-professional collaboration, and health disparities for diverse women. This study explored providers' (psychologists and primary care physicians) perspectives on women's healthcare using a relational and systems model. This study aimed to explore differences in providers' perspectives across varying levels of integration as well as explore interrelationships and predictors of provider experiences. Additionally, this study aimed to identify themes within provider narrative data on their perspectives on women's health care disparities, barriers, and healthcare experience.

The results of this study will be discussed using an ecological systems model that includes the following system levels: Individual level (patient factors and well-being), Microsystem (provider factors, patient-provider relationships), Mesosystem (inter-professional relationships), Exosystem (organizational/administrative support), and Macrosystem (health disparities and barriers and current political climate). This discussion will integrate quantitative and qualitative findings to provide an overall picture of provider healthcare experiences. The findings will also be explained using supportive literature from relevant fields. Furthermore, limitations, implications, and future directions of this study will be presented.

Overall, quantitative and qualitative results were aligned and showed a consistent picture of provider experiences within the healthcare system. For several domains, narrative data illuminated additional information in providers' experiences not apparent from their quantitative responses. One of these areas was provider job satisfaction, where

quantitative data showed high rates of provider job satisfaction across provider type and setting, while provider narratives suggested that co-located providers had the lowest job satisfaction compared to other participants. Additionally, providers' quantitative ratings of organizational support were also uniformly high; however, across participants their narratives showed more frustration with upper administration than illuminated by their quantitative ratings. Quantitative and qualitative data were well aligned for provider experiences of inter-professional collaboration and provider holistic beliefs. Only qualitative data was available for provider perspectives on patient-provider relationships and patient healthcare disparities and barriers. The intersection of quantitative and qualitative data will be discussed in depth for each domain.

Providers' Perspectives on Women's Healthcare

Providers' perspectives on patient well-being. At the individual level from a systems perspective, there are patient factors and outcomes. As the current healthcare system shifts its focus towards patient-centered care, it is important for providers to evaluate patient outcomes with a focus on overall well-being as opposed to the alleviation of specific symptoms (Epstein et al., 2010). Narrative data revealed providers' perspectives on how they evaluate their work with their patients' outcomes as well as their overall well-being. Provider (both psychologists and PCPS) responses were primarily holistic overall, in that they used a variety of physical and psychological markers to evaluate patients' well-being. Providers' differed somewhat by provider type in their responses as psychologists also focused on mental health/psychological factors, while PCPs focused on other factors including patient self-report and rapport. This is promising as it aligns well with a patient-centered care model in valuing patient

experiences and preferences, which is important in overcoming health disparities (Epstein et al., 2010). For diverse women in particular, relational factors and a desire for empowerment are important and should be considered in evaluating their healthcare outcomes (Juuso et al., 2013; Rathert et al., 2015; Svensson et al., 2012). Overall, holistic perspectives on patient well-being may also reflect an overall movement within the health care system towards providing holistic care. For example, the Veteran's Health Administration has enacted a Whole Health initiative focusing on overall health and wellness and patient centered care (U.S. Department of Veteran's Affairs, 2017). This finding provides hope that the healthcare field is moving toward a more holistic and patient-centered model overall, regardless of level of integration or discipline.

Provider characteristics. In the next level of the system (microsystem), we have provider characteristics (provider beliefs and job satisfaction) as well as their perspectives on the patient-provider relationship.

Provider beliefs. Our hypothesis that providers working in higher levels of integration would have more holistic beliefs (adhering to a biopsychosocial model) was not supported. However, overall levels of identification with a holistic or biopsychosocial model were high across all participants, which aligned with our qualitative findings related to provider views of patient well-being. This is a positive finding for patients, especially from diverse backgrounds, as provider beliefs have been found to impact provider recommendations and decision making with patients, especially those impacted by social determinants of health (Domenech et al., 2011). Provider holistic beliefs did increase with level of integration, but the difference between levels of integration was not significant. This aligned with our qualitative findings on provider perspectives on patient

well-being that were also holistic across levels of integration. This finding may point to an overall movement toward more holistic beliefs for providers regardless of level of integration. This aligns with early research on biopsychosocial beliefs that suggested that newer providers were more likely to endorse more holistic beliefs (Gavin et al., 1998). Participant bias may be an alternative explanation, where providers with more holistic beliefs may be more likely to choose to participate in this study.

There was a significant difference between psychologists and physicians in holistic beliefs, with psychologists endorsing more holistic beliefs. However, this may be due to bias within the measure. This finding departed from previous research indicating equally holistic beliefs for mental health and medical providers (Gavin et al., 1998). Additionally, in evaluating significant predictors of provider beliefs, provider type (psychologist/physician) emerged as the only significant predictor of provider holistic beliefs. This finding did not support our hypothesis that integrating care may influence provider beliefs. This finding suggests that provider training and discipline trumps work setting, aligning with research suggesting that specific biopsychosocial training is needed to impact provider beliefs (Domenech et al., 2011). Even within integrated settings, providers may continue to conceptualize patients focused on their area of expertise (biomedical or psychological factors), without assimilating other factors (Funderburk et al., 2012). Given the potential for provider beliefs to impact patient care (Domenech et al., 2011), it may be beneficial to provide specific trainings to providers in a holistic biopsychosocial perspective even within integrated care.

Aligning with previous research, provider satisfaction with inter-professional collaboration was correlated with more holistic provider beliefs (Gavin et al., 1998). This

was an interesting differentiation between level of integration and providers' satisfaction with inter-professional collaboration, as only inter-professional collaboration correlated with provider beliefs. This finding may indicate that inter-professional collaboration is more important in the development of a holistic perspective than work setting.

Additionally, there was a positive correlation between provider holistic beliefs and their job satisfaction. This is a new finding and direction of this relationship is unclear; whether providers with more holistic beliefs are more satisfied with their jobs or if providers who are more satisfied with their jobs are more open to a holistic perspective. Moreover, since both provider beliefs and job satisfaction also have a positive relationship with inter-professional satisfaction, it may be that these factors influence each other. However, previous research has linked provider characteristics such as emotional intelligence with job satisfaction and burnout (Weng et al., 2011). Since job satisfaction and burnout are also related to provider views of their patients (Weng et al., 2011), provider holistic beliefs may positively impact provider job satisfaction through more positive patient related beliefs and conceptualizations.

Provider job satisfaction. Overall, providers included in this study reported high job satisfaction. There were not significant differences in jobs satisfaction across provider type or level of integration. This aligns with previous research for both PCPs and psychologists suggesting that work environment and support are the most important predictors of provider job satisfaction (Ballenger-Browning et al., 2011; DeStefano et al., 2005; Landon et al., 2003). As expected, perceived level of administrative/organizational support correlated positively with provider job satisfaction indicating that providers with more support experience more job satisfaction, consistent with prior research (Scanlan &

Still, 2013). Additionally, in a model of provider job satisfaction, level of administrative support emerged as the only significant predictor. Again, this aligns with research highlighting the importance of institutional support and feedback, rewards, and supervision from upper administration (Eklund & Rahm Hallberg, 2000; Scanlan & Still, 2013). In this study, previously identified factors such as satisfaction with inter-professional relationships (Eklund & Rahm Hallberg, 2000) and our hypothesized factor of level of integration did not predict job satisfaction.

Narrative data on provider job satisfaction aligned with quantitative findings that providers were generally satisfied with their work; however, more differences emerged between provider groups in their narrative responses. Psychologists' responses appeared more satisfied overall, with co-located PCPs standing out as the most negative of any group when discussing job satisfaction. Psychologists in co-located settings were also less satisfied than other psychologists. We expected that level of integration would act in a linear fashion in that job satisfaction and other outcomes would be the lowest in traditional settings, increase in co-located settings, and be the highest in integrated settings. Contrary to our expectations, job satisfaction levels were similar in traditional and integrated settings, while satisfaction from co-located providers lagged behind. Though previous research has not examined the impact of healthcare integration on job satisfaction, co-located settings may come with unique work frustrations for both psychologists and PCPs. Research has suggested that co-locating providers alone is not enough to provide a suitable environment to support providers in collaborative care (Beehler & Wray, 2012; Maslin-Prothero & Bennion, 2010). This research combined with the known importance of organizational support in provider job satisfaction

(Ballenger-Browning et al., 2011) likely explains the lower job satisfaction within co-located provider narratives. Narrative results also indicated that personal fulfillment and the patient-provider relationship were the most important factors in providers' job satisfaction. Providers who mentioned job frustrations were most likely to point to these administrative and organizational factors. This finding can also help explain co-located providers' lower job satisfaction, in that they may have separate administrators for mental health and primary care that can add complications to their work. It may be frustrating for providers to expect a higher level of collaboration without the structure and clarity that integrated models may bring (Beehler & Wray, 2012) and without clear expectations for inter-professional work (Maslin-Prothero & Bennion, 2010). Thus, co-located providers lower job satisfaction is likely related to a mismatch in expectations as they clearly value inter-professional work, but a co-located setting may not offer the support or infrastructure needed.

Patient-provider relationships. Patient-provider relationships were assessed through provider narrative data. The patient-provider relationship is a key component of healthcare outcomes and patient satisfaction, especially for women. Provider narratives aligned well with previously patient-identified essential components of good patient-provider relationships including communication (Gill & Cowdery, 2014) and trust (Bova, C. et al., 2012; Mason et al., 2004). The majority of provider narratives showed consumer-driven, collaborative approaches in their patient-provider relationships, which is essential for providing quality care to women (Campbell et al., 2007; Trudel et al., 2013), and women from minority groups in particular (Levine & Ambady, 2013). Psychologists' narratives about their patient-provider relationships were rated more

consumer-driven than their PCP counterparts' narratives. This is somewhat expected as research has previously identified that PCPs may have more difficulties in their relationships with diverse (Street Jr et al., 2007) and challenging populations (Matthias et al., 2010; Paez, Allen, Beach, Carson, & Cooper, 2009), while a hallmark of psychologists is their skill in building and maintaining therapeutic relationships. Interestingly, narrative results also revealed higher rates of consumer-driven responses for both PCPs and psychologists in co-located settings. Since this study is the first to compare different types of providers in different levels of integration in this area it is unclear why co-located providers may be more consumer-driven. This finding is also somewhat surprising given the frustrations that emerged for co-located providers in other areas, including job satisfaction. It may be that co-located providers focus *more* on their patients and the patient-provider relationship *because* the structural and administrative factors of co-located care are more ambiguous, uncertain, and often times, exasperating for providers.

Inter-professional relationships. The mesosystem incorporates the relationship between different systems, in this study the focus is on the relationship between providers. Given the importance of coordinating patient care, it is essential to understand what helps this coordination in the relationships between different types of providers. We hypothesized that providers in integrated settings would report more satisfaction with inter-professional relationships and this hypothesis was supported. Both psychologists and physicians in integrated settings had significantly higher levels of satisfaction with inter-professional relationships than providers in other settings. This was expected based on the literature suggesting the importance of regular contact and proximity in

strengthening inter-professional relationships and communication (Bray & Rogers, 1995; Bruner et al., 2011). Interestingly, though there was not a significant difference between co-located and coordinated provider groups on inter-professional relationships, though narrative data pointed to more dissatisfaction within co-located providers. Though it was expected that co-located providers would be more satisfied than traditional providers, it appears that the relationship is less straightforward and co-located settings come with their own inter-professional challenges. It may not be enough to simply have providers in the same space; true inter-professional collaboration requires additional efforts and training (Kirschbaum et al., 2015). Similarly to provider job satisfaction, co-located providers may experience a mismatch of expectations that results in lower satisfaction with inter-professional collaboration as they hope to collaborate with other providers, but the necessary infrastructure, including shared meetings or other organizational changes, are not in place (Beehler & Wray, 2012; Maslin-Prothero & Bennion, 2010). These providers may truly want to collaborate, but do not have the necessary inter-professional training to do so. This finding reflects research that inter-professional work requires a type of cultural competence as different professional disciplines have very different professional languages and norms (Pecukonis, Doyle, & Bliss, 2008).

Organizational/administrative support. Providers work within the context of their organization (exosystem) and so this was an important factor to consider. On average, providers in this study rated their level of support from their organization and administration highly. At the same time, providers' narratives showed a more complex story of frustrations even for satisfied providers. We expected integrated providers to report greater organizational support than other providers, given past research (Robinson

& Strosahl, 2009). This hypothesis was not supported; there were no differences between provider type and setting in provider level of administrative/organizational support. However, this finding aligns with other research that suggests that the level of organizational and institutional support for integrated care may vary and is a key component of successful implementation (Pilgrim et al., 2010; Pollard et al., 2014). It is also important to consider potential differing definitions of "administrative support" in provider responses, as this was not specifically defined. Future studies could consider exploring providers' administrative support in different areas including direct supervisors, clinic directors, and higher levels of organizational administration as well as administrative areas like electronic medical records.

Narrative results revealed that many PCPs and psychologists in traditional settings worked in private practice or settings as their own boss. Narratives for psychologists in integrated and co-located settings showed a lot more dissatisfaction than their quantitative ratings regarding organizational support. These psychologists felt that they often had to prove their worth in the clinic to administrators. No previous studies have looked at organizational and administrative support by provider type or level of integration; thus, it is important for these results to be replicated. Given the discrepancy between quantitative and qualitative reports it will also be important to include multiple methods of measurement of organizational support. These results are important to consider in light of the impact of organizational support on provider job satisfaction and burnout (Eklund & Rahm Hallberg, 2000; Scanlan & Still, 2013). These results also reveal the imbalance in integrating mental health and primary care disciplines that leans strongly toward adding psychologists to the work in primary care as opposed to a more

balanced approach. Attention should be paid to supporting the work of psychologists as equally as their medical colleagues within primary care. This goal could be accomplished through institutional policies (Pollard et al., 2014) to help psychologists feel more supported in order to provide the best care to patients. Policy at the national and state level could aid institutional policy to better support providers through providing financial incentives for integrated and inter-professional work and allow providers to be paid for their time collaborating (Huang et al., 2016).

Providers' perspectives on the current political climate. In line with a systems perspective, the macrosystem encompasses the influence of larger sociocultural beliefs and practices, including politics and health disparities. Healthcare and women's health, in particular, are constantly debated in the world of politics. These policies have a direct impact on providers' work, yet few previous studies have examined providers' beliefs in this area. In this study we found that most providers recognized the impact of the current political climate, but focused on patient individual factors such as stress and health literacy. Few providers recognized the potential impact on themselves or systems levels above individual patients. In particular, physicians in traditional settings stood out as blind to any particular impact of politics today on their work or their patients. This is concerning for their female patients, especially women with other marginalized identities. However, PCPs in co-located and integrated settings were much more aware of the potential impact of the current political climate on their patients mental and physical health and well-being.

Providers' perspectives on healthcare disparities and barriers. Despite a large body of research documenting the existence of health disparities for diverse patients, few

studies (Cunningham, 2009; Delgado et al., 2013; Hasnain et al., 2011; Komaric et al., 2012) have examined providers' perspectives on healthcare disparities and barriers. None of these studies have compared different types of providers or providers in different work settings. Thus, this study provides a unique opportunity to understand potential factors impacting providers' knowledge and beliefs in this important area. Additionally, previous research has had mixed results in documenting how knowledgeable and sensitive providers are in diversity areas. Analysis of provider narratives indicated that providers varied in their sensitivity to healthcare disparities, depending on the specific group, by provider type (PCPs and psychologists) and/or level of integration. Similar to some of the past research, gaps were found in providers' knowledge and appreciation of diversity and sociocultural factors (Delgado et al., 2013), but many providers showed an overall sensitivity to health disparities, which provides hope in correcting provider related health disparities. Patterns also emerged in provider narratives on working with women from different marginalized groups that will be discussed.

Past research identified disparities and barriers for diverse women at individual patient (Powell et al., 2016), provider (Loeb et al., 2016), relational (Bova, C. et al., 2012), and structural/systems levels (Agency for Healthcare Research and Quality, 2015). Few provider responses recognized all of these interconnected factors however, which aligns with the mixed research indicating physicians' limited understanding of diversity factors and health disparities (Dovidio & Fiske, 2012), as well as underestimations of their patients psychosocial needs (Bikson, McGuire, Blue-Howells, & Seldin-Sommer, 2009). In their successful experiences, providers focused on relational/dyad factors or provider factors, essentially, what they are doing right. In discussing the challenges and

barriers working with diverse women, providers shifted their focus to systems or patient factors that got in the way. Interestingly, both psychologists and PCPs were well aligned in their focus for challenges and barriers, but differed in their discussions of what went well. Psychologists, unsurprisingly, focused more on the relationship, or therapeutic alliance, and PCPs focused on provider factors including their own skills and knowledge. Both types of providers focused on systems factors in their perspectives on health disparities and barriers and their suggestions for how to improve care. These narratives showed providers deflecting responsibility for their potential in correcting health disparities despite research showing that the patient-provider relationship and provider factors have a large impact on patient care, especially for diverse women, in patient satisfaction and outcomes (Bova, C. et al., 2012; Govender & Penn-Kekana, 2008; Paez et al., 2009). Moreover, research reveals that provider implicit bias, including stereotyping, is likely a contributing factor in health disparities for women, especially women from diverse backgrounds (Chapman et al., 2013; Sabin & Greenwald, 2012; Zestcott et al., 2016). Provider narratives in this study did not show an awareness of their own potential bias as a challenge or barrier in providing care to diverse women, though increased awareness of implicit bias has been shown to reduce bias in care (Chapman et al., 2013). However, social desirability bias could be impacted these results as providers even with awareness of their own potential bias may be unlikely to admit this in a survey. Accordingly, more healthcare provider trainings are needed in order to increase provider knowledge of their prejudices and implicit biases. Research also supports the need for institutional involvement and change, especially in medical schools, given that past

studies found that implicit bias is pervasive and actually *increases* later in medical training (Zestcott et al., 2016).

Additionally, this study was among the first to examine providers' views on health disparities for different groups of women. Rates of sensitivity to disparities did not differ greatly between narratives relating to different groups of women, but the area of focus (patient, provider, etc.) did change. Moreover, the narratives of psychologists and PCPs were more closely aligned for certain groups of women (women with disabilities, low SES women, and elderly women) than for others (women overall, women of color, and LGBT women). When discussing women with disabilities and those from low SES backgrounds, psychologists were more in line with PCPs focusing on their own (provider) successes. In provider narratives on the challenges and barriers for these two groups, differences emerged. Providers emphasized systems barriers for women with disabilities more than for any other group, which aligns with the literature suggesting that individuals with disabilities face significant barriers in healthcare access and other systems issues (Iezzoni, 2011). Conversely, patient/individual barriers were the focus of provider narratives on female patients from low SES backgrounds. In other words, providers were less likely to take systemic barriers into account when identifying the challenges of low SES women and more likely to blame the individual. This finding may reflect stigma and stereotypes blaming individuals for their socioeconomic status and resulting health disparities (Allen et al., 2014), as providers were unlikely to do the same for their patients with disabilities. This is an important finding, considering that socioeconomic status is one of the largest social determinants of health and health disparities, over and above the effects related to race and other factors (Agency for

Healthcare Research and Quality, 2015). This finding may help explain why, despite government intervention and policy, health disparities remain for low SES individuals (primarily women), while improving for people of color and other groups (Agency for Healthcare Research and Quality, 2015). Thus, patient-blaming beliefs about people from low SES backgrounds should be specifically targeted in future provider trainings (Chapman et al., 2013). Furthermore, these differences illuminate the need to examine provider beliefs, knowledge, and practices across different groups, not just in "diversity" or "cultural competence" as a whole. Thus, specific trainings may target the specific needs of different types of providers. At the same time, these findings highlight the difficulty in becoming "competent" to work across all groups. Alternative models with change at the organizational level such as the cultural safety model could be explored (Kirmayer, 2012). Patient-centered care may also help to bridge this gap by focusing on individual patient needs and values (Tucker et al., 2007)

Lastly, past research has identified the shortcomings of PCPs in their work with diverse women in providing equal treatment and care (Anderson, R. T. et al., 2001). We hoped that integrating psychologists in primary care could address these problems, through provider training and exposure to a biopsychosocial model. Based on preliminary research (Poleshuck & Woods, 2014), we hypothesized that we would see differences in providers' narratives, particularly those from PCPs, on patient health disparities by level of integration. This hypothesis was partially supported, as narratives from co-located and integrated PCPs were often similar to those of psychologists. PCPs in traditional settings stood out as the most insensitive to health disparities of any provider group, which provides support for previous research suggesting the potential benefit of integrating care

for reducing health disparities (Bridges et al., 2014; Huang et al., 2016; Poleshuck & Woods, 2014). It was not surprising that previous studies showed dissatisfaction in PCPs for diverse women (Anderson, R. T. et al., 2001), as traditional PCPs not only lacked knowledge of disparities, but expressed views that were at times derogatory and prejudiced toward their female patients, especially women of color and LGBT women aligning with previous research on provider implicit and explicit bias (Chapman et al., 2013). Based on provider narratives it appeared that some of this insensitivity came from lack of understanding of diverse populations as well as taking a "color-blind" approach that these providers may have thought was helpful in not treating or recognizing differences between groups of patients, despite the existence of health disparities. It is also possible that providers' experience and training impacted this finding as PCPs in traditional settings were the generally the most experienced group of providers. Diversity and cultural competence are relatively new competency areas in education and training for both psychologists (Rodriguez-Menendez, Dempsey, Albizu, Power, & Campbell Wilkerson, 2017) and physicians (Mujawar et al., 2014). Providers with more experience, likely went through training earlier, and may not have as much exposure to diversity and multiculturalism topics. Additionally, integrated settings at present, because of funding considerations, are often federally or state funded and serving diverse and underserved populations. Physicians in traditional settings work with less diverse patients and they may not have as much knowledge or sensitivity to these areas simply because of lack of exposure and potential need.

At the same time, integrated physicians responses were also not always more sensitive. For some groups, including women of color, integrated physician's responses

were also rated as more insensitive to diversity and disparities, which was unexpected. This suggests that this problem is much more complicated to solve than simply integrating providers. It is possible that diffusion of responsibility occurs with integration where PCPs feel they don't have to worry about social factors as the domain of their psychologist colleagues, which has been suggested in other research (Funderburk et al., 2018). No studies have specifically compared cultural competence in physicians and psychologists; however, one study found that psychologists had higher ratings of ethical intent compared with physicians (Ferencz Kaddari, Koslowsky, & Weingarten, 2018). This suggests that differences in provider training likely play a role in differences in provider sensitivity to potential issues. It is also possible that differences in training are compounded by generational differences as PCPs had significantly more experience than psychologists in this study. Again, differences in exposure to diversity related training and education could play a role in differences seen between providers in sensitivity due to differing levels of experience.

Limitations

There are several limitations of this study that impact the generalizability of the results. The online and self-selected nature of this study may influence the results and future studies could use random sampling of providers. The time constraints on health care providers, as well as limited compensation, may also have influenced which providers chose to participate in this study. Providers' busy schedules could also impact their effort in responding. The mixed methods nature of this study is another factor to consider. This method had many benefits in providing a balance of accessibility, in depth information, and group differences. However, due to the nature of this study we are not

able to establish causality. Biases of the research team should also be considered. Furthermore, a grounded theory, more in-depth qualitative study would provide rich narratives from providers in this new area; however, it comes with its limitations, primarily time and accessibility for busy providers. The mixed methods nature of this study also meant for a smaller sample size for quantitative analyses. A larger, random sample of providers could help with making these results more generalizable to providers at large.

This study focused on different levels of healthcare integration; however other factors could have contributed to differences in providers' perspectives including age and experience. This was a relatively young sample of health care providers, which could influence perspectives. Additionally, the PCPs included in this sample were significantly more experienced than the psychologists included. Providers (both psychologists and PCPs) in higher levels of integration tended to have less experience, which speaks to the newness of this work setting. Though the difference in level of experience between practice settings was not significant, experience could potentially influence provider perspectives, especially through potential differences in the level of focus on diversity and cultural competence areas in training and education. Other unknown provider differences, including differences in the amount of diversity and inter-professional training of providers could have also impacted these findings. Moreover, it may be important to consider differences in the amount of time each provider usually spends with their patients as PCPs often spend 15 minutes with patients, while psychologists have much longer. Psychologists in traditional and co-located settings will have similar hour-long sessions, while psychologists in integrated settings may have closer to 20-30

minutes with patients. However, the specific average time spent with patients is unknown for our providers and could have impacted results. This study was aimed at recruiting healthcare providers in New England; however, due to the online nature of the study and that participants did not provide their location, this is difficult to confirm. Thus, regional differences may have unknowingly influenced responses.

Other limitations, including clarity in the language of the survey should be considered. Specifically, the survey asked several questions about "women with disabilities," which may be interpreted as physical and/or mental disabilities. Furthermore, in asking about providers' level of administrative support, this could have been interpreted in multiple ways, including direct supervisors or higher levels of organizational administration. Lastly, this study only looked at providers' perspectives, a systemic approach could also include perspectives and objective data from patients, direct observations of provider behavior, healthcare administrators, and other stakeholders.

Implications

Given the exploratory nature of this study, it adds immensely to the research in the both areas of health disparities and integrated healthcare. This study also connects these to topics in a novel way. The results of this study added support for the power of integrated primary care to improve healthcare for diverse women. This can be used to support the continued implementation of this model in primary care settings. Nevertheless, the results of this study also showed that integration might not be enough to change provider beliefs and behaviors in working with women from diverse and marginalized backgrounds. This study confirmed the complicated nature of healthcare beliefs and practice and illuminated potential other factors to explore including inter-

professional collaboration and administrative/organizational support. Unfortunately, many providers may still have implicit biases toward marginalized groups that they are not aware of; however, this is an area to target for intervention and training of providers that organizations should consider making sure that all providers have implicit bias and other diversity related trainings. It may be worth considering how to best motivate busy providers to attend diversity trainings to improve their work with vulnerable populations. Additionally, care should be taken in implementing integrated healthcare models that emphasize, support, and synthesize the perspectives of inter-professional providers. Without this shift, integrated care will not be enough to change provider beliefs and practice that can impact their relationships and treatment with diverse women, which is needed to work toward correcting health disparities. This was shown to be especially true in PCPs patient-blaming views of their low SES female patients, the group facing the most unchanging health disparities. Thus, this study has implications for future provider training in diversity, implicit bias, cultural competence, and health disparities.

This study also has implications for improving inter-professional collaboration between psychologists and PCPs. This study provides support for integrating psychologists into primary care as it improves satisfaction with care coordination and interdisciplinary collaboration for both types of providers. However, the results of this study also indicate that co-locating disciplines results in more dissatisfaction and frustration with coordinating care for patients. Though integrated care is sometimes talked about in a stepwise fashion, it is clear that co-located care does not necessarily add any benefit, and potentially leaves providers worse off than in traditional, separated care. Thus, it is worth considering fully integrating care as opposed to simply co-locating

providers of different disciplines or focusing on more inter-professional specific training within co-located settings to improve the relationships between providers. Psychologists, in particular, ideally, should be given an equal voice, value, and support within primary care settings. Many integrated care models have PCPs at the top of the hierarchy with psychologists and other mental health providers there to support the PCP's work. However, psychologists expressed frustration with this model and additional support would likely improve their job satisfaction, which is known to also impact patient outcomes. Furthermore, education, training, and continuing education can be tailored depending on the healthcare setting and level of integration. Lastly, it is also important to consider specialized and community mental health centers as an important support system even within integrated care. An essential role of psychologists in integrated primary care is to act as a first-line of defense and connect patients with specialized mental health care or other resources if needed. Overall, this study provides support for an integrated primary care model and factors to consider in getting the most out of healthcare integration.

Conclusion and Future Directions

Research on the implementation of integrated healthcare remains a burgeoning field. Additionally, healthcare disparities for women and vulnerable populations persist, with little improvements despite interventions so far. Many theoretical models propose the benefit of integrated healthcare for improving healthcare disparities and women's health. This study was the first to provide in depth, qualitative data on the experiences of *both* mental health and primary care providers at varying levels of healthcare integration, using an ecological systems approach. The results illuminated key differences in

experiences between psychologists and PCPs at varying levels of integration of care. This study showed that integrated care successfully improved collaboration between providers, which in turn should improve holistic care for diverse women. However, frustrations for co-located providers should be further explored in order to improve work within these settings. Additional training in inter-professional collaboration should be considered for co-located providers. The results of this study also showed potential for integrated care to improve knowledge and sensitivity to health disparities and care for some marginalized groups, but providers' narratives varied when discussing different groups of women. In particular, providers overall showed the most patient-blaming views when discussing the challenges of low SES women, the group potentially most affected by longstanding health disparities.

Finally, these findings provide some insight into training models and pedagogy of providers as well as their choice of work setting that target certain clientele. The process of inter-professional collaboration and the nature of service strategies, particularly for female clients with other marginalized identities, and organizational support are closely linked. Thus, in-depth inquiry into those domains in our healthcare settings will facilitate better understanding across services provided by medical and mental health providers for patients of diverse backgrounds and their needs, particularly in integrated health care settings. Moreover, this will enhance designing training programs and organizational support for culturally responsive healthcare to reduce disparities among communities at large.

Future studies should also consider other provider characteristics that could impact provider perspectives including personality and levels of training in diversity and

inter-professional areas. The future of women's healthcare rests in their providers' hands, but they only play a part in the systemic change needed to correct health disparities for women from different marginalized groups. More work should be done in investigating how to empower providers to be the change they wish to see in the healthcare system as well as support this work through organizational and systems changes. Many providers may feel powerless over large healthcare system issues, but offered many suggestions that should be considered. Future research should continue to integrate the barriers and challenges for diverse women at each level in this complicated system. Solutions to overcoming health disparities are likely just as complicated and should be a coordinated effort at patient, provider, organizational, and societal levels. This study looked at provider perspectives, but future studies should integrate patient, organizational, and societal perspectives and solutions in order to improve the healthcare system as a whole so that it provides the best care for *all* patients.

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Appendix A

Q1 What type of provider are you?
- ❍ Physician (MD or DO) in primary care → (branch to the following survey)
- ❍ Mental health provider (psychologist) → (branch to psychologist version)
- ❍ Other → (branch to end of survey message)

Physician survey version:

Instructions: Please complete the following information about yourself. Remember all information provided will be kept confidential. We will not require you to provide your name or any personal contact information in this section. For the remainder of this survey, please respond using your current work setting. If you work in multiple settings, please respond using the setting where you spend the most time.

Demographics

Q2 How many years of experience do you have in this occupation? _____

Q3 Age (optional):
- ❍ 18 - 24
- ❍ 25 - 34
- ❍ 35 - 44
- ❍ 45 - 54
- ❍ 55 - 64
- ❍ 65 - 74
- ❍ 75 - 84
- ❍ 85 or older

Q4 Self-Identified Gender Category:
- ❍ Male
- ❍ Female
- ❍ Other (please specify) _____

Q5 Race/ethnicity (please check all that apply):
- ❑ White
- ❑ Black or African American
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Native Hawaiian or Pacific Islander
- ❑ Latino/Hispanic
- ❑ Other _____

Q6 What primary language do you speak?
- ❍ English
- ❍ Others (please specify): _____

Q7 What other languages do you speak (if any)? _____

Q8 Please select your primary work setting (s):
- ❑ Hospital
- ❑ Group practice
- ❑ Private practice
- ❑ community health center
- ❑ direct primary care
- ❑ Other _____

Q9 Level of employment:
- ❍ Full time
- ❍ Part time
- ❍ Other (please specify): _____

Appendix B

Patient Population

Q10 Please think about your self-identified female adult (18+) patients for the questions in this survey. Please describe the patient population that you work with in your own words.

Q11 What percentage of your patients are female?

Q12 Please answer the following questions regarding your self-identified adult (18+) female patient population. Please provide the approximate percentage breakdown for the patients you see in each category.

Q13 Age

	What is the approximate percentage breakdown for the patients you see?
Children	
Adolescents	
Adults	
Older Adults (70+)	

Q14 Race/Ethnicity

	What is the approximate percentage breakdown for the patients you see?
White	
Black or African American	
American Indian or Alaska Native	
Asian	
Native Hawaiian or Pacific Islander	
Latino/Hispanic	
Other	

Q15 Socioeconomic Status/Income

	What is the approximate percentage breakdown for the patients you see?
Low Income	
Middle Income	
High Income	

Q16 Sexual Orientation

	What is the approximate percentage breakdown for the patients you see?
Heterosexual	
Homosexual	
Bisexual	
Other	
Unknown	

Q17 Disability status

	What is the approximate percentage breakdown for the patients you see?
Able bodied	
People with physical disabilities	
People with psychological disabilities	
Other	

Q18 Language

	What is the approximate percentage breakdown for the patients you see?
English speaking only	
Non-English speaking	
Multilingual (English and other languages)	

Q19 Do you use language interpreters in your work with patients?

- ❍ Yes
- ❍ No

Display This Question:
If Do you use language interpreters in your work with patients? Yes Is Selected

Q20 For what language (s)?

Q21 What languages do you predominately speak with your patients?

Appendix C

Provider Work Experience

Level of Integration

Q22 Below are three kinds of settings where providers usually work.

Coordinated	Co-Located	Integrated
You work in separate facilities from mental health care providers. You have separate systems. You communicate about cases rarely to periodically, driven by provider need or specific patient issues. You may never or very rarely meet in person. You may have a limited understanding of their roles, but appreciate these providers as resources.	You share a space and work in the same facility with mental health care providers. You may have separate or shared work systems. You communicate with them regularly about shared patients via phone or email, and in person when needed. You collaborate for more reliable referrals, consultation, or coordinated care plans. You meet in person occasionally or regularly.	Mental health care providers are integrated into the practice where you work. You share the same space and facility. You communicate frequently and/or consistently in person. You collaborate as a team. You have regular team meetings to discuss patient care. You have an in-depth understanding of each other's roles and culture.

Q23 Which description above best describes your current work setting where you spend the most time?

- ❍ Coordinated
- ❍ Co-Located
- ❍ Integrated

Q24 Which description above best describes your ideal work setting?

- ❍ Coordinated
- ❍ Co-Located
- ❍ Integrated

Q25 Please select all other settings you have worked in:

- ❑ Coordinated
- ❑ Co-Located
- ❑ Integrated
- ❑ No other settings

Q26 Which of the following types of providers do you work with (please check all that apply)? (primary care)

- ❑ Primary care physicians
- ❑ Nurse practitioners (NPs)
- ❑ Physicians assistants (PAs)
- ❑ Others (please specify) _____
- ❑ None

Q27 Which of the following types of providers do you work with (please check all that apply)? (mental health care)

- ❑ Psychologists
- ❑ Family therapists
- ❑ Social workers
- ❑ Masters level therapists and clinicians (mental health counselors, etc.)
- ❑ Psychiatrists
- ❑ Others (please specify) _____
- ❑ None

Appendix D

Level of Administrative/Organizational Support

Q28 How supported do you currently feel by your upper administration and management?

- ❍ Not at all supported
- ❍ A little supported
- ❍ Somewhat supported
- ❍ Moderately supported
- ❍ Very supported

Q29 Please explain how you do or do not feel supported by your upper administration and management.

Appendix E

Inter-professional Relationships

Q30 The next set of questions are concerning your experience as a provider. Some of these questions are open-ended in order for you to provide as much detail as possible.

Q31 For the next few questions, please think of your work with mental health care providers. How often do you refer your patients to mental health care providers?

- ❍ Never
- ❍ Rarely
- ❍ Somewhat often
- ❍ Moderately often
- ❍ Very often

Q32 Which of the following types of providers do you usually refer your patients to (please check all that apply)? (mental health care)

- ❑ Psychologists
- ❑ Family therapists
- ❑ Social workers
- ❑ Masters level therapists and clinicians (mental health counselors, etc.)
- ❑ Psychiatrists
- ❑ Others (please specify) _____
- ❑ None

Q33 How often do you refer your patients to other medical providers?

- ❍ Never
- ❍ Rarely
- ❍ Somewhat often
- ❍ Moderately often
- ❍ Very often

Q34 What other types of medical providers do you usually refer your patients to (i.e. cardiology, dermatology, etc.)?

Q35 What percentage of your referrals come from the following sources:

	Percent
mental health care providers	
other physicians	
emergency room	
schools/colleges	
insurance	
internet	
Other	

Q36 How often do you communicate with mental health care providers regarding patient care?

- ❍ Never
- ❍ Rarely
- ❍ Somewhat often
- ❍ Moderately often
- ❍ Very often

Q37 What is the context of your communication (meetings, phone calls, etc.)?

What is your preferred communication method?

Q38 How often are you unable to refer your patient to mental health services or coordinate with your patient's mental health care provider when you felt they were needed?

- ❍ Never
- ❍ Sometimes
- ❍ About half the time
- ❍ Most of the time
- ❍ Always

Q39 Please explain the challenges or what helps facilitate this coordination.

Q40 Please rate your level of satisfaction with the quality of your collaboration with mental health care providers?

- ❍ Extremely dissatisfied
- ❍ Somewhat dissatisfied
- ❍ Neither satisfied nor dissatisfied
- ❍ Somewhat satisfied
- ❍ Extremely satisfied

Q41 Please explain your reasons for your satisfaction/dissatisfaction with your collaboration with mental health care providers.

Q42 What do you value in your relationship with other providers?

Appendix F

Patient-Provider Relationship

Q43 Please answer the following questions keeping in mind your care for adult (18+) self-identified female patients.
What are the successful components of your patient-provider relationships?

Q44 What are some of the challenges of the patient-provider relationship?

How have you overcome challenges in this relationship?

Q45 How do you know when you've gained your patient's trust?

Appendix G

Providers' Perspectives on Patient Healthcare Disparities and Barriers

Q46 Providers have various experiences working with patients across settings. As a provider, please answer the following questions based on your experience in your current work setting.

What are your successes working with your female patients in general?

Q47 What are your challenges in working with them?
What specific barriers get in the way (e.g. patient, provider, or systems level factors?)

Q48 Now we will ask you several questions about working with female patients from different backgrounds.
What are your successes working with your female patients of color?

Q49 What are your challenges in working with them?
What specific barriers get in the way (e.g. patient, provider, or systems level factors?)

Q50 What are your successes in working with your elderly female patients?

Q51 What are your challenges in working with them?
What specific barriers get in the way (e.g. patient, provider, or systems level factors?)

Q52 What are your success working with your sexual or gender minority female patients?

Q53 What are your challenges in working with them?
What specific barriers get in the way (e.g. patient, provider, or systems level factors?)

Q54 What are your successes working with your female patients with disabilities?

Q55 What are your challenges in working with them?
What specific barriers get in the way (e.g. patient, provider, or systems level factors?)

Q56 What are your successes working with low socioeconomic status (SES) female patients?

Q57 What are your challenges in working with them?
What specific barriers get in the way (e.g. patient, provider, or systems level factors?)

Q58 In your opinion, how do you think the current political climate impacts your work providing care to women?

Q59 As a provider, please provide your specific recommendations to improve healthcare for women, particularly from marginalized backgrounds (racial/ethnic minority, low SES, etc.) in the following areas:
Patient level:

Q60 Provider service level:

Q61 Organizational/administrative level:

Q62 System/policy level:

Q63 Other:

Appendix H

Providers' perspectives on patient satisfaction and well-being

Q64 How do you assess your adult (18+) self-identified female patients' well-being? What are the specific indicators (ex: patient rapport, symptom reduction, etc.)?

Appendix I

Provider Job Satisfaction

Q65 Overall how satisfied are you with your current job?

- ❍ Extremely dissatisfied
- ❍ Moderately dissatisfied
- ❍ Slightly dissatisfied
- ❍ Neither satisfied nor dissatisfied
- ❍ Slightly satisfied
- ❍ Moderately satisfied
- ❍ Extremely satisfied

Q66 Please explain the reasons for your level of job satisfaction/dissatisfaction

Appendix J

Provider Beliefs

Physician Belief Scale. Adapted from Ashworth, Williamson, Montano (1984).

Please select your level of agreement with the following self-descriptions.

	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
I do not focus on psychosocial problems until I have ruled out organic disease.	❍	❍	❍	❍	❍
Mind and brain influence physical disease and body perception.	❍	❍	❍	❍	❍
The biological model of disease is the most appropriate model for health care.	❍	❍	❍	❍	❍
I must consider organic and psychosocial problems concurrently.	❍	❍	❍	❍	❍
My role is to work collaboratively to provide care for the patient.	❍	❍	❍	❍	❍
Evaluating and treating psychosocial problems will cause me to be more overburdened than I already am.	❍	❍	❍	❍	❍
One reason I do not consider psychosocial	❍	❍	❍	❍	❍

information is the limited time I have available.					
Investigating psychosocial issues decreases my efficiency.	❍	❍	❍	❍	❍
I focus on organic disease because I cannot treat the psychosocial.	❍	❍	❍	❍	❍
My role is to direct the care of the patient.	❍	❍	❍	❍	❍