A Phenomenological Investigation of Physician Job Satisfaction in Rural Integrated Primary Care

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DISSERTATION

Submitted in partial fulfillment for the degree of
Doctor of Psychology in the Department of Clinical Psychology
at Antioch University New England, 2012

Keene, New Hampshire

Department of Clinical Psychology

DISSERTATION COMMITTEE PAGE

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A PHENOMENOLOGICAL INVESTIGATION OF PHYSICIAN JOB SATISFACTION IN RURAL INTEGRATED PRIMARY CARE

presented on July 18, 2012

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Acknowledgments

To my girls—Kate, Olive, and Imogene—for you, the moon.

To my parents, whose quiet confidence has always inspired me.

To my mentors—Jim, Tom, Amanda, Bill, Cassie, and Beth—your efforts, time, patience, humor, and generosity have not been lost on me.

To my friends and my family, especially to my brothers, you've taught me to abide.

To 5:00 am—the hour when coffee, clarity, solitude, and opportunity join.

This work is dedicated to my Grandpas Ray Kolnik and Eugene Paul Austin, whose college ambitions were only realized in their children and grandchildren. Thank you.

Disclosure: Two of the dissertation committee members are employed as doctoral level providers at one of the clinics that participated in this research.

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Abstract

The job satisfaction of rural primary care physicians is of import given the crucial role these physicians play in rural health care systems and their consistent decline in numbers nationwide. The professional isolation of practicing in rural areas, particularly in accessing specialty care, creates greater burdens for rural physicians than their more urban counterparts, which likely contributes to their low level of job satisfaction. The shortage of mental health providers in rural areas in particular is thought to create a burden for rural primary care physicians, who generally neither have the time, training, nor expertise to adequately deal with complex mental health difficulties. Thus, integrated primary care—the provision of mental health services in the clinical flow of primary care medicine through the employment of behavioral health consultants—might reasonably improve rural physician satisfaction. Due perhaps to the novelty of this practice in rural primary care clinics, little research has examined this idea. This study uses a qualitative methodology—interpretive phenomenological analysis—to explore how rural physicians in integrated primary care settings experienced this innovative practice. Connections of this practice to physician job satisfaction are discussed, as are the implications toward facilitating this service in rural primary care practices. Limitations of this study are considered and directions for future research suggested. This research concludes with a personal reflection on my experience as a trainee in a rural integrated primary care clinic.

Keywords: Primary Care Behavioral Health; Rural Integrated Primary Care; Integrated Primary Care; Primary Care Physician Job Satisfaction; Rural Physician Job Satisfaction

Chapter 1

Rural Areas Struggle to Retain Physicians Due to Lower Job Satisfaction

Rural areas face marked difficulty in attracting and retaining physicians, a fact likely due in part to features of practicing in these areas that promote physician stress and burnout (Jenkins, 1998). While the shortage of primary care physicians (PCPs) has been growing nationwide (Garibaldi, Popkave, & Bylsma, 2005; McKinlay & Marceau, 2008), it is felt most acutely in rural areas, where there are 25 to 50% fewer physicians per 100,000 people than in urban areas (Doescher, Skillman, & Rosenblatt, 2009) and a larger percent of these physicians are primary care physicians (Hart, Salsberg, Phillips, & Lishner, 2002). Various factors may account for the disparity in the number of PCPs in rural areas, such as limited exposure to rural practice in medical school and the increased responsibilities of rural primary care physicians (Cutchin, 1997; Hart & Taylor, 2001; Mainous, Ramsbottom-Lucier, & Rich, 1994). High rates of job stress and burnout experienced by physicians in rural areas likely also contributes to this disparity. For instance, one study found that 25-36% of rural PCPs reported high levels of depersonalization and emotional exhaustion in their work (Jenkins, 1998). Not surprisingly, heightened levels of job-related stress have been associated with lower levels of physician satisfaction (Williams et al., 2002).

The job-related stress of PCPs in rural areas seems directly related to the professional isolation of practicing in these areas. Poverty and low population density in rural areas are associated with burnout and job stress (Hart, Lishner, & Johnson, 2003; Hart et al., 2002). Poverty and low population density make it difficult to financially support multiple physicians (an obvious disincentive for larger health care organizations), thus creating a more acute sense of professional isolation. This professional isolation, and the associated limits in time off and

wages, has been identified as the primary barrier inhibiting medical students from seeking careers in rural areas (Doescher et al., 2009). Professional isolation also creates a unique burden of responsibility for physicians in rural areas–the lack of easy access to specialty medicine and tertiary care hospitals can force a more conservative approach to medical decision-making (Farley, 1998). This isolation also limits coverage during vacations or for after-hour care (Hart et al., 2003). Because of these factors and more, rural areas face an immense challenge in attracting and retaining PCPs.

Shortage of Mental Health Professionals Impacts Rural PCP Job Satisfaction

Rural areas also suffer from a shortage of mental health providers (DeLeon, Wakefield, & Hagglund, 2003), which creates an extra burden on PCPs. While the ubiquity of mental health concerns in primary care appointments is well known (Coyne, Thompson, Klinkman, & Nease, 2002; Kroenke & Mangelsdorff, 1989; Regier et al., 1993), the problem is exacerbated in rural areas due to inadequate access to specialty mental health services (Valleley et al., 2007). Although the frequency or distribution of mental health problems is not substantially different in rural areas (Hoyt, Conger, & Valde, 1997), residents of rural areas are more likely than their urban counterparts to maintain stigmatized views of mental health care (Fox, Blank, Rovnyak, & Barnett, 2001; Rost, Pyne, Dickinson, & LoSasso, 2005). Those seeking mental health care also face obstacles regarding confidentiality and privacy given the tight-knit nature of rural communities (Farley, 1998). For instance, parking one's car at a rural community mental health clinic may broadcast one's mental health problems to neighbors. As a result of such stigma, those who need mental health care may be less likely to seek it; should they pursue professional assistance, they will likely seek it from their PCP. Thus, rural primary care clinics bear the brunt of the lack of access and utilization of specialty mental health care in rural areas.

Integrated Primary Care May Enhance Rural Physician Job Satisfaction

What is Integrated Primary Care? Integrated Primary Care (IPC) is an innovative practice that provides mental health services within primary care, typically via the use of behavioral health consultants (BHCs; Blount, 1998; Gathchel & Oordt, 2003). BHCs are licensed mental health professionals, often psychologists or social workers, trained to deliver behavioral and mental health interventions within the primary care context. This integration unifies the mental and physical treatments from the perspective of the patient, while providing PCPs with an on-site resource in dealing with complicated mental health issues that would otherwise be their responsibility. Multiple studies have shown that IPC delivers on its promises across various patient outcomes (Blount, 2003), including improved clinical outcomes (Robinson, Del Vinto, & Wischman, 1998; Von Korff et al., 1998), improved patient compliance (Katon et al., 1995; Morisky et al., 1983), improved patient satisfaction with care (Katon et al., 1999; Matalon, Nahmani, Rabin, Maoz, & Hart, 2002), and maintained health improvements (Roy-Byrne, Katon, Cowley, & Russo, 2001; Schulberg, Block, & Madonia, 1996). For an extensive review of the outcomes and cost offsets of various types of integrated care, see Blount et al., 2007. This innovative approach to patient care promises much to primary care stakeholders.

How might IPC enhance rural physician job satisfaction? Although IPC is growing in acceptance and popularity across the country, little research has examined the hypothesized link between IPC and physician job satisfaction, a potential high-leverage area for investigation given the growing physician shortage. Of the extant research, one study found that 80% of physicians found a collaborative approach to managing depression in primary care increased their satisfaction with care delivered (Katon et al., 1995). A pilot study examining integrated care specifically targeting high-utilizers of medical services found that IPC was associated with a

dramatic improvement in physicians' perception of the provider-patient relationship (Matalon et al., 2002). A study of an IPC practice in Ontario found that most physicians were particularly satisfied with increased communication and professional support associated with IPC (Farrar, Kates, Crustolo, & Nikolaou, 2001). This small body of existing research confirms what most would expect: IPC seems to positively impact physician satisfaction.

The physician satisfaction literature provides some insight into how IPC may improve primary care physician satisfaction. Williams et al. (2002) found that certain practice features have direct and indirect (i.e., mediated by stress) relationships with primary care physician job satisfaction. Practice features positively related to satisfaction include control over clinical issues, control over resources/decisions in the workplace, and a workplace emphasis on quality of care. IPC likely enhances providers' sense of the clinical resources available to treat their patients, at least in terms of mental health. Given the breadth and depth of literature demonstrating IPC's effectiveness in terms of clinical outcomes and patient compliance, one would expect that IPC would enhance physicians' perceptions of the quality of care delivered.

Two practice features, time pressure and organizational support for work/family balance, indirectly influenced provider satisfaction via their relationships with physician stress (Williams et al., 2002). Physicians who were less satisfied with time pressures, reported increased stress levels, which was negatively related to job satisfaction. In IPC clinics, the ability for physicians to hand off the time-intensive demands of patients with mental health problems should alleviate time pressure while enhancing work/family balance. IPC's potential for reducing these practice-related stressors may well contribute to enhanced physician satisfaction.

Across physician settings, but particularly in rural primary care clinics, the quality of relationships with other health care providers emerges as an important component of physician

job satisfaction (Doescher et al., 2009; Duffy & Richard, 2006; Karsh, Beasley, & Brown, 2010; McMurray et al., 1997; Williams et al., 2002). In various ways (e.g., consultation, collaboration) IPC should ameliorate some of the professional isolation experienced by rural physicians while also diffusing the emotional burden that comes with managing the complex needs of patients with mental health issues. IPC in rural areas might also simplify some of the complex multiple relationships physicians report navigating in small, close-knit areas (Farley, 1998). It is for these reasons and more that the Presidents New Freedom Commission on Mental Health pointed to IPC as a crucial part of improving the quality of health care in rural underserved areas (Unutzer, Schoenbaum, Druss, & Katon, 2006).

Nonetheless, the literature linking integrated care to physician satisfaction is in its infancy. The extant research is limited in terms of (a) sample size (Adam, Brandenburg, Bremer, & Nordstrom, 2010; Farrar et al., 2001; Nettleton et al., 2000; Robinson et al., 1998), (b) a narrow focus on highly specialized forms of integrated care (Corney, 1986; Marsh & Barr, 1975; Robinson et al., 1998), and (c) scientific rigor (Matalon et al., 2002; Robinson et al., 1998). In addition, the relationship between IPC and physician satisfaction may well be quite complex. For instance, one study (Taylor, Terry, Gunn, Towle, Eubank, & Klatzker, 1999) reported a positive relationship between integration and provider satisfaction, but the physicians in this study also expressed doubts about this form of care thriving in a real world setting, citing a discomfort in sharing decision-making responsibilities. Finally, few researchers have examined the relationship between physician job satisfaction and IPC specifically in rural areas (Bauer, Batson, Hayden, & Counts, 2005; Bird, Lambert, Hartley, Beeson, & Coburn, 1998; Meadows, Valleley, Haack, Thorson, & Evans, 2010; Sears, Danda, & Evans, 1999; Valleley et al., 2007). Clearly, work remains to be done in understanding the interaction of IPC and rural PCP job satisfaction.

Integrated Care Evaluation (ICE) project finds that IPC and satisfaction are linked. The Integrated Care Evaluation (ICE) project, a naturalistic research study, examined IPC as sustained by 4 primary care clinics in rural/underserved areas of New Hampshire. As part of this study, data from all employees and staff were collected to assess, among other things, employee job satisfaction and perceptions of the level of IPC. These data were used as an interpretive aid in understanding the primary research questions related to patient care, and to provide a preliminary glimpse into rural IPC and satisfaction.

All employees at the four clinics, including staff (e.g., nurses, medical assistants, receptionists) and medical providers (i.e., physician assistants, nurse practitioners, medical doctors), were asked to participate in the study. The instruments used were the Measure of Job Satisfaction (MJS; Traynor & Wade, 1993), a seven-scale measure found to outperform similar measures in its reliability and content validity (van Saane, Sluiter, Verbeek, & Frings-Dresen, 2003), and the Level of Integration Measure (LIM; Blanchard, Fauth, & Tremblay, 2009), a Six-scale instrument designed to assess features of integrated care. Both measures also provide an overall score. A total of 118 employees completed these measures (82 staff members and 36 medical providers). Both the MJS (alpha ranging from .68 to .89 for the subscales and .97 for the total score) and LIM boasted strong internal consistency (alpha ranging from .71 to .92 for the subscales, and .95 for the total score).

Analyses revealed that scores on the LIM and MJS were correlated, with effect sizes in the small to medium range. Especially strong were correlations between *Overall level of integration* and *Overall job satisfaction* (r =.53) and between *Overall level of integration* and *Personal Satisfaction* (r =.67). In other words, providers that perceived their clinics as generally more integrated reported generally higher levels of overall and personal satisfaction. The pattern

of correlations between these measures suggests that clinics that place greater emphasis on integrating mental health service, particularly in the training they provide and the systematic way in which they address mental health concerns of their patients, tend also to be clinics with providers that report being more personally satisfied and more satisfied with their workload. Overall, the ICE results suggest that a relationship between IPC and rural physician job satisfaction may well exist.

However, this research is subject to several limitations. For instance, the small sample size is problematic. Especially limiting was the small number of physician participants (n=14) represented in the dataset. Furthermore, these findings are restricted by the *a priori* limits imposed in the selection of the two primary instruments. Finally, the ICE data fail to capture the lived experience of integrated primary care and job satisfaction in the lives of these rural physicians. We cannot distinguish from this data what about this model impacts their job satisfaction and how. These rural physicians possess a privileged perspective on their own work experiences, including those experiences related to their job satisfaction and IPC.

Exploring the Relationship: Using Qualitative Investigation to Supplement These Findings

Supplementing the quantitative ICE data with qualitative interviews designed to harvest these experiences could maximize what can be learned from this relatively small sample (Johnson & Onwuegbuzie, 2004). Individual interviews with rural physicians in IPC practices would provide a more detailed explanation of the lived experience of those physicians possessing a unique perspective on this relationship. Thus, qualitative inquiry could provide further insight into the interface between IPC and rural physician job satisfaction.

Statement of Purpose: How do PCPs in Rural IPC Clinics Experience This Model?

IPC has much to offer the rural health care system in terms of improving patient care and enhancing physician job satisfaction. Unfortunately, the interaction of IPC and rural PCP job satisfaction has received insufficient research attention to date. Given the growing shortage of physicians serving rural areas and the crucial role these physicians play in their rural health care systems, the time is right for more research on this important topic. Building on the promising findings in the ICE pilot study, this research employs interpretive phenomenological analysis (IPA) to better understand this interaction from the perspective of rural physicians practicing in IPC clinics. This method of investigation provides richness and depth to a data set that points to a strong relationship between physician satisfaction and IPC, but is constrained by a small number of physician participants responding to *a priori* quantitative measures.

The primary research question driving this research is: What is the lived experience of rural physicians in IPC practices? Embedded in this question is the recognition that this lived experience likely contains an array of factors impacting job satisfaction. The task of this research is to provide as clear a picture as possible about how IPC relates to job satisfaction in the lives of a handful of rural primary care physicians.

Chapter 2: Literature Review

This chapter discusses factors related to physician job satisfaction, and in particular the job satisfaction of rural PCPs. The chapter also presents IPC as an innovation capable of enhancing PCP job satisfaction. Finally, this chapter introduces the available literature on rural IPC's apparent relationship with physician job satisfaction, and considers the implications of this literature for this research.

Job Satisfaction and Dissatisfaction are Distinct Phenomena

Before discussing this literature, it is worth noting a subtle yet significant point in the language employed in job satisfaction research. Job satisfaction research more generally has discovered that the factors that drive satisfaction and dissatisfaction are distinct, and that it is thereby important to measure them with separate scales. For example, while age is typically related to physician satisfaction, it is not related to dissatisfaction. Unfortunately, the physician satisfaction literature has inconsistently recognized the importance of this distinction and has not always assessed satisfaction and dissatisfaction with separate scales (Stamps & Cruz, 1994). This creates problems in reviewing and synthesizing research on physician job satisfaction. For instance, how does "least satisfied," a low item on a scale assessing degrees of satisfaction, relate to a scale that ranges from "very dissatisfied" to "very satisfied" (Stamps & Cruz, 1994)? In reviewing the literature, insofar as possible, I will describe factors as being associated with either satisfaction or dissatisfaction. It is important to bear in mind that the majority of the existing literature focuses on factors related to physician satisfaction, and only a very small body of research has examined factors related to physician dissatisfaction (Landon et al., 2002; Murray et al., 2001) and physician burnout (Chopra, Sotile, & Sotile, 2004; Deckard, Meterko, & Field, 1994; Rafferty, Lemkau, Purdy, & Rudisill, 1986).

Physician Job Satisfaction is a Multi-faceted Construct

Despite the large number of physicians practicing in this country, a relatively small body of research has considered what factors drive physician job satisfaction (Duffy & Richard, 2006). In reviewing the literature, one finds that factors thought to drive physician satisfaction have not changed substantially since the late 1970s when researchers began studying this concept (Breslau, Novack, & Wolf, 1978; Stamps, Piedmont, Slavitt, & Haase, 1978). These factors include physician autonomy, professional relationships, administrative or organizational expectations, adequate resources to perform one's job, income and prestige, quality of patient care, and the extent to which one's practice permits or provides for adequate personal time (McMurray et al., 1997; Stamps et al., 1978; Williams et al., 1999). Research in recent years demonstrates that the significance of these components of job satisfaction varies according to practice setting and specialty (Duffy & Richard, 2006; Freeborn, 2001; Linzer et al., 2000; Murray et al., 2001), though physician autonomy, work/life balance, and administrative or organizational expectations (particularly as they relate to paperwork and productivity) are argued to be more universal in impacting physician job satisfaction (Lee, Lovell, & Brotheridge, 2010; Linzer et al., 2000; Weinstein & Wolfe, 2007; Williams et al., 2002).

The most extensive research on physician job satisfaction, conducted by the Society of General Internal Medicine's (SGIM) Career Satisfaction Study Group (McMurray et al., 1997; Williams et al., 1999), demonstrates the multifaceted nature of physician job satisfaction. Through extensive qualitative research this group developed a measure consisting of ten distinct factors of physician satisfaction and three global scales of job, career, and specialty satisfaction, which was then administered to over 2500 physicians in various settings and specialties nationwide. They found that five factors consistently related to global physician job satisfaction

across specialty and setting: patient care issues (r=.55), pay (r=.47), relationship with staff (r=.43), relationship with colleagues (r=.42), and autonomy (r=.41). Subsequent research has enhanced these findings to indicate that adequacy of time with patients (Linzer et al., 2000) and with day to day practice issues as they impact clinical autonomy and professional collaboration (Landon, Reschovsky, & Blumenthal., 2003) are related to physician satisfaction, while lower pay (Landon et al., 2002; Stoddard, Hargraves, Reed, & Vratil, 2001) and amount of time spent on administrative tasks (Bovier & Perneger, 2003) is distinctly related to dissatisfaction.

In the past decade, other contemporary factors–direct-to-consumer advertising of pharmaceuticals (Robinson et al., 2004), internet-derived healthcare information (Wald, Dube, & Anthony, 2007), more frequent malpractice suits (Zuger, 2004), the diminished patient relationships (Brewster, 2008), and the time pressures associated with managed care (Murray et al., 2001)–have also been posited to drive physician job satisfaction. Future research should consider how these and other unique features of contemporary medical practice impact physician job satisfaction.

PCP Satisfaction Is Especially Responsive to Income, Creativity, Autonomy, and Relationships

Beyond satisfaction with professional relationships, patient care, work/life balance, income, and autonomy, which appear to drive satisfaction for all physicians, several factors have emerged as distinctly important for PCP job satisfaction (Duffy & Richard, 2006). These include a sense of accomplishment, ability to be creative in their work, job security, and most importantly, the long-term nature of patient relationships (Fairhurst & May, 2006; Garibaldi et al., 2005; Van Ham, Verhoeven, Groenier, Groothoff, & De Haan, 2006).

Duffy and Richard (2006) examined the relationship between various work-related factors and physician job satisfaction. Working with physicians across six specialty areas, including PCPs, the authors first asked physicians to identify from a list of 16 critical factors related to job satisfaction which factors most influenced their job satisfaction. Next, they asked physicians to rate their satisfaction with each of these 16 critical factors and provide a rating of global satisfaction. Interestingly, the factors identified by PCPs as significant in the first round differed from the factors that in the second round correlated with their global rating of job satisfaction. Of the factors PCPs initially identified as determinants of job satisfaction (i.e., caring for patients, sense of accomplishment, continuity of care, autonomy, and personal time), only sense of accomplishment and autonomy correlated with PCP global job satisfaction. Several other factors also emerged as correlated with PCP global satisfaction (i.e., satisfaction with income, creativity, job security, and interactions with other health care providers). Distinct from sense of accomplishment and job security, which were consistently correlated with global job satisfaction across all physician specialty areas, PCP job satisfaction was uniquely correlated with satisfaction with income, autonomy, creativity, and interaction with other health care providers.

Building on the work of the Career Satisfaction Study Group, Williams et al. (2002) sought to determine the extent to which physician, practice, and patient features related to PCP job satisfaction. Their analysis found that while few physician or patient characteristics predicted job satisfaction, seven practice features were significantly associated with job satisfaction. These practice features included greater satisfaction with control over workplace and clinical issues, greater emphasis on quality of care, and more support for work/family balance. Practice features associated with increased levels of dissatisfaction included less control over clinical issues, a

greater emphasis on productivity, and more perceived time pressure. This study points to the importance of practice features that provide the PCP with flexibility to provide clinical services in an autonomous manner. These findings are congruent with the work of Van Ham et al. (2006), which argues that factors associated with the professional activities of doctoring tend to enhance satisfaction, whereas factors associated with fiscal/administrative aspects of the job (e.g., productivity expectations, paperwork demands) increase dissatisfaction.

A distinct perspective on PCP job satisfaction centers on the idea that PCPs are especially drawn to the relational nature of their work. Karsh's (2010) exploration of this idea found that relationships with coworkers was the strongest predictor of overall PCP job satisfaction, while satisfaction with the quality of their relationships with both patients and coworkers was most strongly related with their satisfaction with practice, even surpassing the impact of their satisfaction with time pressures, income, and autonomy. These findings are consistent with other research pointing to the central role that patient relationships have in the overall satisfaction PCPs derive from their work (Deshpande & DeMello, 2010; Fairhurst & May, 2006). Studies examining the reasons that medical students choose primary care over specialty medicine reiterate this point in that students choose primary care because they desire long-term relationships with clients, diversity in clinical work, and a more desirable work/life balance (Brewster, 2008; Garibaldi et al., 2005).

Several themes emerge from the literature on PCP job satisfaction. While PCP job satisfaction is driven by many of the variables related to physician job satisfaction in general (i.e., autonomy, professional relationships, quality of patient care, and income), it appears especially sensitive to the quality of the patient relationship as well as the ability to operate with professional autonomy and minimal administrative and practice burdens (e.g., paperwork,

productivity expectations) while having a balanced personal life. Furthermore, a complex relationship exists between practice features and physician satisfaction: while PCPs appreciate having greater control over administrative issues, they are more dissatisfied when expected to execute a large number of administrative tasks. Perhaps having influence over administrative decisions provides a sense of empowerment, while performing the administrative tasks pushes their competencies and time resources (Van Ham et al., 2006).

Our understanding of the relationship between these factors and PCP job satisfaction is somewhat limited as studies to date have been primarily quantitative and thus bound by the quality and constraints of the measures employed. For example, the work of Duffy and Richard (2006) is limited because the 16 factors of job satisfaction on which their work is built may fail to adequately represent all salient factors; in addition, each factor was represented by a single item, raising questions about the quality of the measure. Furthermore, their investigation, as is the case with most research on physician satisfaction, did not explore the mediating and moderating relationships that likely exist among these factors. Future investigation in this area should employ qualitative investigation to examine the lived experiences of PCPs in order to better understand the relationships among these variables and to identify what other factors may be uniquely relevant to modern medical practice. Targeted interviews with physicians in a specific setting would begin to capture the complex relationship among these factors driving physician satisfaction. Understanding the relationships among these factors is important given today's rapidly evolving health care system and the well-documented impacts of physician dissatisfaction, including risky prescription patterns, patient outcomes, and the cost of replacing burned out physicians (Buchbinder, Wilson, Melick, & Powe, 1999; DiMatteo et al., 1993; Melville, 1980).

Quality of Professional Relationships Especially Important for Rural PCP Satisfaction

A smaller body of research suggests that the aforementioned job factors are also salient for rural PCPs, with workload, community relations, and professional isolation being especially important in the their context (Pathman, Williams, & Konrad, 1996). Hart et al. (2003) argued that the importance of these factors could be attributed to the professional isolation, low population density, and poverty of rural areas. The lower population density and higher rates of poverty are seen as critical structural differences creating a geographic maldistribution of providers (Hart et al., 2003), with fewer providers in rural than in more affluent and suburban/urban areas where it is easier to financially sustain a practice. This professional isolation in rural areas and its attendant elevated patient care responsibility is also thought to dissuade many from wanting to practice in these areas (Cutchin et al., 1994; Doescher et al., 2009) and produce high levels of job stress and burnout in those who do (Deckard et al., 1994; Jenkins, 1998).

A recent study that sought to identify the salient features related to job satisfaction of Canadian general practitioners in rural versus urban practice settings found that (a) rural physicians, despite working longer hours, were more satisfied than their non-rural counterparts and (b) the quality of relationships with other health professionals emerged as the most important predictor of job satisfaction among rural practitioners (Lepnurm et al., 2007). In contrast to other research (e.g., Hancock et al., 2009), satisfaction with community engagement was not found to be a significant driver of rural physician satisfaction, though satisfaction with financial reward and a sense of recognition for their hard work was. The importance of quality collaboration with other health professions is consistent with previous research (see Ramsbottom-Lucier et al.,1995), but this study extended this knowledge by demonstrating that satisfaction was

particularly related to the perception of the efficiency in accessing advanced care and the ease of communication with specialized health services, even if services existed at a great distance. This study points to the importance of a sense of access to and collaboration with other health care professionals in the job satisfaction of rural PCPs. It also underscores the point that rural PCP job satisfaction may be driven by unique factors not well-captured by *a priori* measures of job satisfaction: who would expect that rural physicians with heavier workloads would report higher levels of satisfaction, as long as their connections with health care colleagues are robust?

Some of the earliest investigations of rural physician satisfaction can be found in research examining rural physician retention and attrition. One such study asked rural physicians to identify areas of practice they found most satisfying and most dissatisfying (Pathman, Williams, & Konrad, 1996). The results suggested that physicians were most satisfied with their relationships with patients, clinical autonomy, life in small communities, and the sense of providing care to medically needy patients. Rural physicians reported the greatest dissatisfaction with their access to urban amenities (e.g., cultural events, shopping) and with the limited amount of time spent away from practice. This research is consistent with other studies that point to workload and amount of leisure time as related to rural physician satisfaction and retention (Doescher et al., 2000; Mainous, Ramsbottom-Lucier, & Rich, 1994). Much remains to be explored in understanding how the heavier workload of rural physicians drives their satisfaction, particularly how other factors mediate this relationship (i.e., the quality of available professional relationships, professional autonomy, meaningful nature of work). Qualitative investigation may well expand our understanding of rural physician satisfaction, thereby fueling more sophisticated quantitative research in the future.

Integrated Primary Care May Enhance PCP Job Satisfaction

Integrated primary care (IPC) refers to the situating of mental and behavioral health services within primary care in order to readily provide mental health consultation to physicians and specialty mental health services to primary care patients (Blount, 1998). While the actual therapies provided in IPC vary, what is unique to IPC is the physical integration of mental health services within primary care. This closing of the gap between primary care and specialty mental health care is thought to remove significant treatment barriers for clients while improving communication among health providers. This health care delivery model provides needed mental health services to people who would otherwise be reluctant to seek mental health care, while enhancing primary care services through addressing, among other mental health issues, behavioral issues related to illness prevention and treatment compliance (Department of Health and Human Services, 2001). Apart from direct client care, IPC also fosters frequent, easy consultation between medical and mental health providers, consultation that not only enhances the quality of care (Grumbach & Bodenheimer, 2004), but may also improve PCP job satisfaction.

IPC has emerged over the last three decades in response to the realization that the majority of patients with mental health problems seek treatment from their primary care physician rather than a mental health specialist (see Gunn & Blount, 2009, for a complete review of this literature). In other words, primary care has become a core component of the *de facto* mental health care system (Regier et al., 1993).

Multiple studies have demonstrated that IPC is related to improved patient outcomes (Hegel et al., 2005; Krahn et al., 2006; Lang, Norman, & Casmar, 2006), maintained health improvements (Morisky et al., 1983; Roy-Byrne et al., 2001; Schulberg et al., 1996), and

improved patient satisfaction with care (Katon et al., 1999; Matalon et al., 2002; Taylor et al., 1999). Studies have also suggested that IPC produces significant cost offsets. For instance, a meta-analysis of the cost-offsets of IPC found that, on average, recipients of integrated care reduced their health care costs by 17%, while those in control groups increased their medical costs by 12% (Chiles, Lambert, & Hatch, 1999). However, little research has investigated the hypothesized link between IPC and PCP job satisfaction. With the estimated cost of replacing a PCP placed between $235,000 and $265,000 (Buchbinder et al., 1999), understanding how IPC may improve PCP satisfaction is critical.

One study of physicians in 36 Canadian IPC clinics reported high levels of physician satisfaction with this model of care. In particular, physicians reported that they felt IPC increased their skills in addressing their patients' mental health needs and enhanced patient care (Farrar et al., 2001). Similar findings have also been reported in primary care settings with IPC models ranging from simple (Anderson & Hasler, 1979; Corney, 1986) to complex and multidimensional (Katon et al., 1995; Matalon et al., 2002), although PCP job satisfaction tends to be only a secondary consideration in these studies.

Numerous pathways may exist between IPC and physician job satisfaction: improved clinical outcomes would help PCPs feel more satisfied with the quality of care, maintained health outcomes may reduce the time burden imposed on physicians by complex patients, and improved patient satisfaction with care may enhance PCPs satisfaction with the quality of the physician-client relationship. Furthermore, the professional collaboration and support that is central to IPC may enhance PCPs satisfaction with the quality and availability of professional relationships. Unfortunately, these hypothesized links have received little to no research attention to date.

How Might IPC in Rural Clinics Impact Physician Job Satisfaction?

In rural clinics, IPC's impact on job satisfaction is likely to be especially powerful, given the relative professional isolation of rural PCPs. While the available literature provides reason to suspect that rural IPC is well received by both patients and providers, due to IPC's novelty and low base rate in rural clinics, little research has examined this relationship. Existing studies suggest a connection between physician satisfaction and IPC, specifically through its impact on physician time demands, revenue generation, and treatment compliance. One early adopting rural clinic reported that rather then spending time addressing mental health crises or psychosomatic complaints, their PCPs time was spent more effectively addressing physical health complaints (Bauer et al., 2005; Farley, 1998).

Another study of a rural IPC clinic (Meadows et al., 2010) examined reimbursement rates and time spent with clients by physicians. Behavioral health concerns were found to substantially increase the time spent by physicians with patients while reducing their reimbursement rates. Onsite referrals for behavioral health care reduced the amount of time physicians spent billing for behavioral health problems (i.e., at a much lower reimbursement rate) and increased the physician's ability to see more clients. The implications for physician job satisfaction appear obvious: freeing up time to serve more clients and bill at a higher rate likely impacts physician experiences of time pressures while increasing revenues. Handing off emotionally complex clients to on-site mental health professionals may also reduce the burden associated with caring for such patients while improving physicians' satisfaction with the quality of care delivered.

Similar findings were reported (Valleley et al., 2007) in a study of referral compliance by children recommended to behavioral health care in a rural IPC practice. In this study, the rates of follow through with behavioral health referrals approached 89%, nearly double what is typically

found in non-integrated clinics. As evidenced by the previously mentioned study, increasing behavioral health referral compliance may enhance rural physician satisfaction by reducing time pressures associated with addressing behavioral health concerns, increasing physician time spent on more lucrative services, and decreasing the emotional toll associated with the overutilization of primary care services by rural patients with mental health problems (Hoyt et al., 1997; Rost, Smith, & Taylor, 1993).

A recent study—the Integrated Care Evaluation (ICE) project—found that the extent of integration was strongly related to the job satisfaction of physicians and staff in rural/underserved areas of New England (Fauth, Tremblay, & Blanchard, 2010). The level of integration was measured with the Level of Integration Measure (LIM; Blanchard, Fauth, & Tremblay, 2009), and provider/staff job satisfaction was assessed with the Measure of Job Satisfaction (MJS; Traynor & Wade, 1993). LIM and MJS data were collected from 118 providers and staff members, of whom 25 were physicians or associate providers (i.e., nurse practitioners or physician assistants). Analyses revealed strong correlations between LIM and MJS scores. The aspects of integration bearing the strongest relationship on job satisfaction included training in IPC, integrated practices (e.g., sharing access to electronic medical records, sharing brief consultations on patients), and onsite leadership in IPC. These findings are surprising in that they suggest non-clinical, organizational factors like onsite leadership and training in IPC may be as strongly related to physician satisfaction as more clinically-oriented factors like shared patient contacts. These trends remained even when the data set was reduced to reflect only physicians (n=12).

Given the limitations of the ICE project and other studies (e.g., small sample sizes), it remains unclear how rural physicians experience IPC, and how it relates to their job satisfaction.

In order to advance our knowledge in this domain, we need not only larger-scale quantitative studies, but also more exploratory qualitative investigations into the lived experience of IPC by rural PCPs. Such investigation will help unravel the complex relationships among the many factors that relate to physician job satisfaction. Increased knowledge in this domain could have important implications for broader-scale diffusion of the IPC innovation, for improved patient care, and for attracting and retaining rural PCPs.

Chapter 3: Methods

Why Supplement Quantitative Findings with a Qualitative Investigation?

The inherent limitations of either quantitative or qualitative methods employed in isolation have given rise over the last two decades to Mixed Methods Research (MMR), a methodology that uses both quantitative and qualitative research methods to offset the weaknesses of the other (Teddlie & Tashakkori, 2009). Quantitative research methods can be thought of as confirmatory because they test specific hypothesis by applying statistical principles and practices to a dataset. As such, quantitative research is inherently limited by the theory or knowledge base from which the tested hypotheses are derived, an aspect of quantitative research that leads some to consider it as a deductive method of inquiry. The quantitative approach limits possibilities for understanding through the *a priori* constraints imposed upon the type and nature of the data collected (Driscoll, Appiah-Yeboah, Salib, & Rupert, 2007). Although quantitative research can explore relationships among variables, "the more detailed understanding of what the statistical tests of effects sizes actually mean is lacking" (Clark & Creswell, 2010, p. 9). Most quantitative methods also require large sample sizes.

Qualitative research can be thought of as exploratory in that it seeks to understand particular phenomenon in detail, then inductively generates broader ideas and principles (Teddlie & Tashakkori, 2009). While qualitative methods produce rich data and promising theories, due to limited and ideographic sampling, these findings are not as easily generalized as those findings emanating from quantitative research. Thus, qualitative research lacks the ability (and quite often even the interest) to test the extent to which theories can be generalized or withstand critical investigation (Clark & Creswell, 2010).

Creswell and Clark (2010) point out that adding exploratory qualitative research to quantitative research limited by a small dataset brings the potential for a richer exploration of the phenomenon of interest by boosting the inferential strength of both approaches in adding depth and understanding of suspected or observed relationships. Thus, nuances and subtleties that might otherwise be overlooked when relying only on quantitative methods can emerge and be accounted for in the interpretation of the data.

This combined approach is fitting in studying the interaction of IPC with rural physician job satisfaction because of the paucity of rural practices employing integrated care and the limited number of physicians in the ICE dataset. Given the state of knowledge on how rural IPC impacts physician job satisfaction and the small number of rural IPC clinics, employing qualitative research promises to be an efficient way of expanding and clarifying our understanding of one of the high leverage areas of this innovative practice.

IPA: Making Meaning through Collaborative Inquiry

IPA has been described as a qualitative method uniquely suited to the healthcare context (Biggerstaff & Thompson, 2008) because it provides a rigorous means of exploring psychosocial phenomenon and the meaning individuals apply to those experiences. IPA retains the scientific rigor and discipline of traditional investigation, while employing processes of inquiry that generate themes built upon rich descriptions of the examined phenomenon (Smith, Flowers, & Larkin, 2009). Researchers analyze these descriptions in order to elucidate the meaning participants might otherwise be unable to articulate or even identify from their perspective in relationship to the phenomenon (Smith & Osborn, 2008).

IPA sprang out of a philosophical position that emphasizes the active, interpretive role played by individuals in making meaning of various experiences (Biggerstaff & Thompson,

2008). This theory seeks to understand how people make sense of their world in order to better appreciate the meaning these individuals attribute to certain experiences. Obtaining a richly detailed description of an individual's lived experience facilitates an interpretive process in which meaning can be distilled (Smith & Osborn, 2008). IPA also recognizes the interpretive processes at play as the researcher engages the experiences of the individual in a meaning-making process. To offset this inherent limitation, IPA researchers engage in a reflective process through which biases and sources of blind spots are carefully considered (Smith et al., 2009).

IPA is built upon what Smith and Osborn (2008) refer to as a double hermeneutic in that two distinct interpretive processes are engaged over the course of the research. The initial interpretive process occurs when the participant, in describing an experience, makes sense of that experience through the process of selecting words and through the implicit process of attributing certain meanings to those words. The second interpretative process follows as the researcher, in examining the language of the participant, seeks to understand the meanings attributed to aspects of the experience considered. IPA recognizes the limitations of language; therefore, it also attends to what might be left unsaid–or unheard–in the process of capturing experience in language (Smith & Osborn, 2008).

As a research method, IPA focuses on gathering as detailed a description as possible of a given phenomenon from participants. It is not interested in testing hypotheses or generalizing the findings. Instead, IPA emphasizes the exploratory process of collaborative inquiry into how an individual with a privileged perspective of an experience makes sense of that phenomenon (Smith et al., 2009). Because of this interest in gaining the perspective of privileged individuals, sampling is often more purposive in selecting homogeneous groups of fewer participants capable of providing a rich description of the phenomenon examined. In this case, the privileged

perspective is that of rural physicians practicing in integrated primary care clinics; the phenomenon examined is how their job satisfaction varies in light of IPC.

Defining the Phenomenon: Rural IPC and Physician Job Satisfaction

In this study "rural" refers to counties lacking a central urban area of at least 50,000 people and with a population density of less than 500 people per square mile (Coburn et al., 2007). The concept of *Integrated Primary Care* (IPC) refers to primary care practices in which mental health professionals function as on-site mental health providers on, at a minimum, a part-time basis (Blount, 1998). *Physician Job Satisfaction* is the extent to which physicians feel satisfied in their professional role. It is thought to be a multidimensional construct, comprised of at least eight key factors: relationships with patients, colleagues, and families; personal factors including work/family balance and professional efficacy; day-to-day practice features related to stress and paperwork; administrative issues; government issues; autonomy; income and prestige; and the quality of care delivered (Linzer et al., 2000; McMurray et al., 1997; Williams et al., 2002). Physician job satisfaction is complex in that it is strongly influenced by idiographic factors such as practice setting (HMO vs. private practice), physician gender, and even socio-economic background of the physician (McMurray et al., 1997).

Clinics

The three IPC clinics from which physicians were recruited provide IPC for rural and underserved patients. Integrated care at these clinics is financially sustained, relies on co-location of behavioral health specialists, and includes several other integrated care best practices. Because their IPC models were created in response to the needs and desires of clinic stakeholders, buy-in and commitment to integrated care at each clinic is high. At the same time, these clinics differ

substantially in size and number of behavioral health providers, as well as in their model of integration.

Clinic #1. Clinic #1 is a family medicine practice within a large medical system that employs 85 physicians and 37 associate providers representing over 25 medical specialties, with primary care especially well represented. The department of family medicine employs 13 physicians and 17 associate providers (nurse practitioners and physician assistants). Clinic #1 is also connected to a 169-bed regional hospital for the people of the broader surrounding region, the population of which approaches 90,000 from diverse socioeconomic backgrounds. This clinic provides approximately 350,000 outpatient encounters per year.

Clinic #1 initiated IPC in 1998 and employs one behavioral health consultant (BHC), a doctoral level psychologist, in primary care. Another doctoral level psychologist is located in the onsite women's health practice and is available for mental and behavioral health referrals. Clinic #1 also employs two full time psychiatrists, one who treats primarily adult patients and the other who treats primarily children and geriatric patients. IPC at clinic #1 applies a primary care behavioral consultation model that emphasizes brief treatment, coordination with specialty behavioral health services, and consulting with PCPs to effectively manage mild to moderate emotional and mental distress. The onsite BHC shares the electronic medical record and schedules appointments through routine clinic processes. At clinic #1, patients are referred to the BHC on the basis of PCP clinical judgment.

Clinic #2. Clinic #2 is an independent, non-profit federally qualified health center (FQHC) look-alike operating in rural New England state. Clinic #2 provides a full range of primary care services to patients of all ages. Its 69 employees include 16 clinicians and 46 support staff. As a FQHC look-alike, clinic #2 does not receive federal grant monies. It stands on

its own financially and provides approximately 85% of the primary care in the area (i.e., 55,000 outpatient encounters per year). In order to improve access to primary care for the community, clinic #2 recently moved into a new building where office space exists for up to five clinical psychologists. Clinic #2 currently employs nine physicians, four associate providers, and three full time clinical psychologists who serve as BHCs.

Clinic #2's psychologists are fully integrated and function as a team to provide behavioral health care to patients. Clinic #2's integrated model uses universal screening with the PHQ-2 to flag emotional and mental distress, and prompt referral to co-located behavioral health. IPC at clinic #2 uses a focused, short-term therapy model, ready access and open communication between physical and mental health providers, and an integrated electronic medical record to serve patients with mental and behavioral health needs.

Clinic #3. Clinic #3 is a family medicine practice located in a rural., economically disadvantaged, and medically underserved area of New England. A regional hospital owns and operates this clinic. This clinic employs a total of five PCPs and two associate providers. Clinic #3 also has OB/GYN and Physical/Occupational Therapy services on site. This clinic provides about 17,000 outpatient visits per year, ranging from yearly physical exams to urgent care.

Clinic #3 implemented co-located integrated care in February 2009 after a successful planning process. Through an arrangement with the local community mental health center, clinic #3 has co-located one licensed mental health counselor (.8 FTE) and one psychiatrist (.2 FTE). Clinic #3 relies on the clinical judgment of its PCPs to refer patients for behavioral health intervention. The BHC focuses on brief forms of treatment for patients with mild to moderate emotional and mental distress, while referring more severely afflicted patients to specialty behavioral health services. The psychiatrist consults with PCPs about medication issues and

provides psychiatric services to a limited number of patients. The BHC and PCPs share the same electronic medical record, attend staff meetings together, and regularly consult with one another.

Participants

Primary care physicians from these clinics were recruited to participate in this study. Both medical doctors (MDs) and doctors of osteopathic medicine (DOs) were invited via e-mail and selected according to convenience. The goal was to recruit a minimum of six participants. IPA does not mandate specific sample sizes, but rather emphasizes the researcher's commitment to the detailed interpretive process that often produces large amounts of data from relatively few participants (Smith & Osborn, 2008). Seven participants were recruited, from which ample data was gathered to address the questions posed by this research.

Participants were recruited via an electronic communication that provided a detailed explanation of the research objective, a list of the intended interview questions, as well as an informed consent document. Participants were offered a $50 gift card to Amazon.com or the opportunity to have a $50 donation made to a charity of their choice as compensation for the time involved with interviewing and reviewing the interview summary. All interested participants were asked to contact me directly to coordinate the interviews. Confidentiality for sites was provided by replacing any obvious site-specific references (e.g., names of the employing clinic, names of surrounding towns) with generic titles in the transcripts of the interviews. Employing pseudonyms in the interview transcripts and omitting any uniquely identifying information from the analysis and presentation of findings ensured participant confidentiality. All data, including interview transcripts and interview notes, were stored in a locked file cabinet or in an encrypted file separate from consent forms or other participant-identifying information. Audio recordings from each interview were destroyed once the coded

transcripts were prepared and checked for accuracy. Although no risk was predicted from participating in this study, each participant was reminded that they were permitted to withdraw at any point if they felt that their participation would in any way negatively impact their professional or personal well-being.

Procedure

After participants were successfully recruited, several steps were employed to lay the groundwork for the interviews (see Appendix A for an outline of these steps). The first step involved an electronic communication confirming the participant's intent to participate, providing them with the informed consent document and a copy of the interview questions. Interviews times were established once informed consent documents were received. During the initial portion of the interview the nature of the study was reviewed, confidentiality was discussed, and any potential risks associated with participation were also considered, although none were foreseen. Signed informed consent documents were collected and stored in a thrice-locked location separate from the interview transcript.

Interviews were performed via telephone in a private location selected at the discretion of the interviewee outside of normal working hours. Participants were provided in advance with the core questions guiding the interview (See Appendix B) in order to provide time to reflect upon and develop their answers. Because of the value IPA places on structured exploration (Smith et al., 2009), I used a semi-structured interview format to guide each interview. The following questions and prompts guided each interview, and follow-up questions were used to enrich each interview. The foundational questions and prompts were as follows:

1. In thinking about an ordinary week at your clinic, describe the most common ways in which you interact, directly or indirectly, with your clinic's onsite mental health professional(s).

- Common responses might include hallway consultations, medical record reviews, warm hand-offs, diagnostic clarity assessments, medication consultations, and short-term therapy. Do any of these resound with you? Are there others?

- How would you describe the frequency of these contacts?

2. If all of your clinic's mental health positions were terminated next month, what would you miss most?

- How would you first notice their absence in terms of your job satisfaction?

- What new burdens would you expect to emerge?

3. If your clinic were to announce a major increase in the number of psychologists on staff, what would you most look forward to? What benefit or burdens would that represent in terms of your job satisfaction?

- How would this influence your job satisfaction?

- Which would you most look forward to? What would you least look forward to?

4. Please describe a specific instance when having a mental health professional on staff improved your sense of job satisfaction.

- How do you suspect this encounter would have been different without readily available mental health professionals?

- What contributions by the mental health professional did you experience as most relieving?

5. Conversely, please describe a specific instance when having a mental health professional on staff detracted from your sense of job satisfaction.

- What do you wish had gone differently in that situation?
- What aspects of this situation bore most directly on your job satisfaction?

6. Which patients are you most likely to seek help with from your clinic's mental health staff?

- What factors drive this decision?
- How does your ability to refer these patients impact your job satisfaction?

7. Describe what you experience as the primary limitations of your clinic's mental health resources.

- What impact do these limitations have on your workload, job stress, or overall job satisfaction?
- In what ways might your clinic's mental health staff change to address these limitations?

8. How do the non-clinical elements of integrated care (i.e., relational support, crisis counseling, staff education, etc.) influence your job satisfaction?

- How do you suspect your practice would have been different in the absence of these non-clinical elements?
- What "extras" (or non-patient care expertise) does your clinic's mental health professional bring to your clinic's culture that you find important?

9. What aspects of being a rural physician are relevant to how you experience integrated care?

- What parts of being in a rural practice make integrated care especially useful?
- Is there anything about being a rural physician that you can do better because of integrated care?

10. What other aspects of integrated care are particularly important to your overall job satisfaction?

- How has integrated care impacted the culture in your practice?
- At the end of the day, how do you think integrated care impacts your job satisfaction?

At the end of each interview and periodically throughout, I attempted to verbally summarize how I understood participants' responses, and I solicited further input and clarification. The next step in this process involved transcribing and coding each interview for dominant themes. These themes were categorized or nested into superordinate themes. Once each interview was transcribed, the interviewee's responses were summarized and returned to the participant for validation. Participants were contacted with a follow-up e-mail that documented the interview questions and a summary of their responses. This document offered space for participants to provide any input or feedback they wished to offer. Following return of this form, participants were compensated for their participation.

Credibility, Reliability, and Investigator Bias

While traditional quantitative research methods use concepts like reliability and validity to describe the strength and quality of the data, researchers in the qualitative tradition use the concepts of credibility, transferability, dependability, and confirmability to identify necessary qualities of useful data (Robson, 2002). These terms are not meant to replace the concept of validity, but rather to expand the construct to consider other aspects of the trustworthiness of data. Several steps can be taken to ensure maximal credibility of IPA data, including recording the interview and transcribing for accuracy, creating written documentation of the logic and data behind interpretations reached, creating an audit trail of research activities and choice-points, and

member-checking, which is the term for providing summaries of interpretations to participants to assess for accuracy of interpretations (Robson, 2002). Each of these steps were taken, and an auditor, a psychologist familiar with IPA and the primary care behavioral health model, was engaged to review the coding decisions and ensure fidelity to the interview data.

This type of research must also take steps to balance the influence that researcher biases and values have on the interview and interpretation process (Gergen, Gergen, & Steier, 1991). Phenomenological investigation places special value on the researcher's ability to be reflexive, or aware of the extent to which personal values, beliefs, and experiences influence the research program (Robson, 2002). As opposed to seeking objectivity, reflexivity urges the researcher to continually monitor the extent of personal engagement with the researched material. To promote reflexivity, Ahern (1999) suggests that prior to interviewing participants, the researcher should engage in a reflective writing process that considers one's personal biases, assumptions, and beliefs about the phenomenon to be researched. A researcher should also seek to articulate one's value system and acknowledge areas where one is clearly subjective. Finally, one should also be aware of potential feelings that will influence neutrality. Throughout the research process the researcher should be constantly vigilant for instances when contradictory or confusing data is avoided or ignored, as these situations suggest that research biases and values are influencing the interpretative process.

The following list summarizes my beliefs, assumptions, biases, and values regarding how integrated primary care in rural clinics should influence physician satisfaction:

1. I believe IPC alleviates a substantial burden from rural physicians by equipping them with an in-house resource to manage the mental health needs of their patients.

2. I assume that rural primary care physicians are less satisfied in general than their urban counterparts because they experience more patient demands challenging their competency, have fewer referral resources, and face a greater challenge balancing personal and professional boundaries.

3. I believe that mental health professionals are more effective than primary care physicians in dealing with the mental health needs of patients, and psychopharmacology alone typically only manages symptoms without resolving underlying problems.

4. I think that the future of rural primary care will involve more mental health professionals on staff as this provides a substantial cost offset in client care, promotes treatment compliance and effectiveness, helps prevent more serious problems from developing, and improves the sense of efficacy of medical providers.

Prior to these interviews, the above list was reflected upon in writing and any further examples of potentially influencing values or beliefs were recorded. I also reflected on the following questions (Hohnecker, 2008) in a research journal:

1. What outside factors might influence how I engage the participant?

2. Am I hoping or trying to hear one specific story?

3. How will I know that I am being an ethical and responsible researcher?

4. When will I experience myself as interfering with the participant's description of the phenomenon?

5. Am I holding on to any assumptions or biases about these particular participants?

6. Will I be able to accept and interpret stories I experience as different or starkly divergent from what I expect?

Several extra steps were taken to ensure that ideographic factors/biases related to the interview (e.g., initial discomfort in the interview, misunderstood questions, incomplete responses) were considered and engaged as necessary. These steps included taking notes during the interview in three domains: personal reactions to content, reflections prompting further investigation (particularly investigation deviating from the interview questions), and any impact that the process seems to have had on the participant's engagement. These notes permit clarifying questions later in the interview and prompt reflection while interpreting the data. Time set aside post-interview for the interviewee to clarify responses and ask questions also ensured that any idiosyncratic interview-related factors that could impair the interpretive process were addressed. Finally, the member-check also ensures credibility of the interpretation in that the participant was therein able to comment in a forum that may have been more conducive to open communication (Robson, 2002).

Data Analysis

Each interview was analyzed to identify emergent themes related to rural physician job satisfaction and IPC. This process began with multiple readings of each interview during which comments were made in the right margin detailing thoughts triggered upon reading and noting instances when the physician referred to any aspect of IPC. This process of familiarization creates an important comfort and understanding of the text, which is helpful in engaging the interviewee's reported experience (Smith & Osborn, 2008). Each transcript was then reviewed for themes that emerged, both in the original text of the interview and in the notes in the right margin. These themes and notes were then compiled in a master spreadsheet according to their chronological appearance in each interview. This master spreadsheet was then scrutinized for clusters of similar themes that emerged across interviews. These theme clusters were further

grouped according to unifying central themes, which constitute the findings of this research. Smith and Osborn (2008) state that as this clustering occurs, it is vital that the researcher continually return to the transcripts to ensure fidelity to the original ideas and to ensure that subtleties within clusters are not subsumed by generalizations. To prevent such blurring of ideas, a directory of themes and superordinate theme clusters was established so that examples from the manuscripts could quickly be identified. This directory is captured in the table at the beginning of the next chapter.

While the targeted selection of participants facilitates the emergence of similar superordinate themes across interviews, IPA expects a degree of divergence to occur as well. Such divergences can be used to sharpen the understanding of what might cause variance in the experience of the phenomenon (Smith et al., 2009). Once a group of superordinate themes were established from the interviews, the findings were transformed from a table to a narrative in which themes were explained in relationship to each other and to the experience of rural physician job satisfaction in IPC practices. This narrative forms the results section of the research. Discussion of these results and their implications for training and practice are interwoven in this narrative. A brief discussion of the limitations of this study follows as well as suggestions for future research concludes this paper.

Chapter 4: Results

Analysis

The first round of analysis involved labeling *every* instance in the transcripts when physicians referred to their experience with their BHC. For example, when a physician said that his BHC helped by working with his most complex patients, this was tagged as, "Appreciates assistance in managing complicated patients." An auditor—a clinical psychologist trained in IPC and familiar with qualitative research methods—reviewed the transcripts and the coded items, suggesting further clarifications and modifications. Each theme was transferred to a database and organized according to its chronological appearance in the interviews. The net was intentionally wide at this level of analysis to capture every potentially relevant statement. These statements were then culled according to their clear relevance to provider satisfaction or dissatisfaction.

The next level of analysis involved grouping the themes into conceptually related clusters, with the commonality captured insofar as possible by the cluster name. For example, several themes describing the BHC's provision of targeted assessments were grouped into a thematic cluster titled, "Targeted assessment and ongoing monitoring." This analysis generated 11 clusters describing how these physicians experienced integrated primary care. The final analytical step involved searching across thematic clusters to identify broad, overarching themes describing how IPC impacts physician satisfaction. The superordinate themes are as follows: patient evaluation and monitoring, easy access to consultation supports PCPs, staff development and support, BHC interventions unburden PCPs, and Improved patient access and utilization of appropriate care. Table 1 displays the five superordinate themes in relation to their thematic clusters, with example quotations from the transcripts.

Table 1: *Master Table of 5 Superordinate Themes, Theme Clusters, Participant Support, and Exemplar Quotes*

Superordinate Theme	Theme Cluster	N	Examples
1. Patient evaluation and monitoring (N=7)	Targeted assessment and ongoing monitoring	6	"The other piece is the ADHD evals, a lot of times patients would rather just have you start them on a med, so being able to have a psychologist right there who can do an evaluation can be helpful in terms of determining to what degree mood disorders might be playing a role, you know that is another really big piece."–Targeted assessment and ongoing monitoring; Participant #4
	Thorough psychosocial interviews	3	"I mean I consider myself fairly savvy in ferreting out social issues that patients have, but there are things that our psychologists here have discovered about people that I didn't know and that really helps me understand them better."–Thorough psychosocial interviews; Participant #3
2. Easy access to consultation supports PCPs (N=7)	Desires more psychiatric consultation	6	"Well, in broad strokes I'd like to see us have a psychiatrist on staff. I think it would be immensely helpful. At least a psychiatric nurse practitioner, preferably really experienced, at least one would be helpful. …PCPs, internists are taking on more and more of the mental health burden, but our training is in some areas just not, not thorough enough."–Desires more psychiatric consultation; Participant #2
	Convenient curbside consults	5	"Well I probably speak to the psychologist seven times a day…I can just walk up the hallway and immediately walk into one of the psychologist offices which is great so … I can stop into one of their offices and just say, by the way I wanted to ask you about such and such."–Convenient curbside consults; Participant #1
3. Staff development and support (N=7)	In-house training	6	"They… give inservices to the nursing staff, so that is going to help, wherever the nursing staff improves their skills and their knowledge is going to help us too."–In-house training; Participant #5
	Personal and professional support	5	"We've had challenging patients that have really involved more than just behavioral health and medical clinicians, but…they [the BHCs] will do debriefings and then develop protocols for all staff about how to handle specific situations."–Personal and professional support; Participant #3

Table 1 (continued)

Superordinate Theme	Theme Cluster	N	Examples
4. BH interventions unburden PCPs (N=7)	Shared responsibility for challenging patients	6	"I mean there have been times when I was trying to decide if someone was actively suicidal, I mean I can remember a time, and this is way more infrequent, but I can remember situations when I have had the BHC person see that patient at that time and then get his input on the situation."–Shared responsibility for challenging patients; Participant #7
	Saving PCP time	3	"It helps immensely, because what I will do often, especially with a new patient, what I will do is set an appointment to see the psychologist then I will talk to the psychologist, so it is essentially a big time saving element for me. We can take care of what the patient needs and give them all the help we can in a more fruitful way."–Saving PCP Time; Participant #2
5. Improved patient access and utilization of appropriate care (N=7)	Care coordination	7	"To send a task to our psychologist or our psychiatrist … through our EMR, I get either an answer that can help me better serve our patient's needs or get them to a place where they can get the service they need, either with our MH professionals or some outside service."–Care coordination; Participant #7
	Onsite BH intervention	6	"They also help us with…change management: for quitting smoking, obesity, people who have medical disease not well controlled, to try to sort out if there are behavioral or other issues that might help this person…being more invested in taking better care of themselves."–Onsite BH interventions; Participant #3
	Increased patient comfort with BH	4	"I think that the biggest thing in having someone on staff, beyond the stuff I already mentioned, is that patients are a little more willing to at least take that first step of seeing someone, knowing that they are coming back to a place that they are already, that is part of their regular health care."–Increased patient comfort with BH; Participant #4

Patient Evaluation and Monitoring

Six of the seven participants appreciated how BHCs augmented treatment planning by eliciting more and better psychosocial information through testing, assessment, and interviewing. Ongoing patient evaluation and monitoring provided diagnostic clarity and confidence, particularly when comorbid diagnoses were suspected.

Targeted assessment and ongoing monitoring. Six participants discussed the role targeted assessments have played in informing treatment plans, with PCPs at each clinic emphasizing assessments for different conditions such as ADHD, dementia, and substance abuse. Two physicians felt more comfortable prescribing controlled medications for ADHD due to targeted assessments conducted by the BHCs. Participant #3 described the professional burden of working with geriatric clients in a rural area where formal dementia evaluations can involve a two-hour drive and a six-month wait for testing. The BHC's assessment and monitoring was perceived as crucial to developing better-informed interventions for these patients. In fact, three participants desired *more* access to specialized assessments and monitoring of behavioral health/substance use conditions.

Thorough psychosocial interviews. Three participants described the value of thorough psychosocial interviews conducted by their BHCs. According to these physicians, the extended time available to the BHCs, as well as their enhanced skill at conducting psychosocial interviews, promoted more thorough understanding of patients. For example, participant #1 described leaving an exam room knowing the patient's family system was distressed, only to learn after the more extensive BHC encounter that substance abuse was a major contributing factor.

Easy Access to Consultation Supports PCPs

Six of the seven participants appreciated how convenient access to expert consultation from their BHCs supported them in working with challenging patients. This convenient consultation provided greater professional support that allowed patients more comprehensive treatment. At the same time, most of the physicians spoke of desiring more psychiatric support.

Desire more psychiatric consultation. Six physicians desired more consultation about psychiatric medications or managing patients with acute psychiatric problems. Participants described how poor access to psychiatric care in their areas placed considerable burden on them to manage patients with increasingly complex psychiatric needs. For instance, participant #7 decried the practice in his area of discharging patients from the mental health unit on new psychiatric medications to his care; while he has appreciated talking to his non-psychiatric BHC about these patients, he specifically desired more assistance from a psychiatric provider.

Convenient curbside consults. Five participants appreciated brief, frequent consultations for diagnostic assistance, patient conceptualizations, or treatment planning. These physicians talked about the importance of physical proximity to the BHC's office, in combination with the BHC's open door policy, in permitting the "curbside" consultations that are critical given the unpredictable nature of primary care. Participant #4 stated that dropping into her BHC's office to talk about patients also developed her overall level of expertise and efficacy in effectively identifying and responding to behavioral health issues. Four participants described how electronic availability via the electronic medical record (EMR) or e-mail provided frequent, convenient BHC consultation.

Staff Development and Support

Every participant described the important role that their BHCs played in supporting and developing all primary care staff at professional and personal levels. This team development and support was described as critical in fostering a sense of efficacy in handling the wide array of behavioral health conditions present in the primary care context.

In-house training. Six participants spoke of the importance of ongoing training in managing mental health issues in primary care. Participant #7 stated that their occasional BHC inservices are helpful in updating his diagnostic and treatment skills for things like managing bipolar disorder in primary care. Another physician stated that his BHC equipped the triage nurses with training for working with difficult patients, which in turn has made his job easier because his staff felt more comfortable doing their jobs. While most PCPs mentioned that the trainings BHCs offered have been helpful, two participants wished there would be more trainings on topics like working with specialized patient populations (e.g., post-incarceration).

Personal and professional support. Five participants described the personal and professional support BHCs offered to staff and providers, which has helped manage the strain of practice. One physician described a trying situation in which her staff cared for a homeless mother of three children who was losing her battle with cancer. Her BHCs helped the team deal with the complex emotions following her death by encouraging them "to take a few steps back from the situation and practice the power of observation that we don't usually let ourselves have." Participant #4 said her BHC has been "a resource to provide some validation … someone who kind of knows what you are doing and going through, but different from a friend who listens but doesn't really know what it is like." She stated that his support over her years since residency has enhanced her confidence to function in her role and in her setting.

BH Interventions Unburden PCPs

A common theme across interviews was the extent to which mental health problems created extensive burdens for PCPs, which could be addressed in part through behavioral health interventions. Each participant described benefits that BHCs offered in directly engaging challenging patients and in assuming responsibility for time consuming aspects of their work.

Shared responsibility for challenging patients. Six of the seven participants commented on the importance of having BHCs readily available to engage difficult patients. For example, participant #1 described a scenario in which a patient, known to be depressed, presented to a scheduled appointment manifesting recent cutting behaviors. The physician, recognizing the acuity and complexity of the situation, called on her BHC for assistance. The BHC interviewed the patient, determined her level of risk, and activated a safety plan that resulted in the patient being hospitalized. This assistance deescalated a dangerous situation, assisted the patient in accessing care, and provided the PCP with crucial professional support.

Saving PCP time. Three physicians detailed the impact IPC has on their work productivity and efficiency. Participant #3 reported that prior to working with her BHC she was often left with no other option than to get off-schedule when crises emerged in her clinic or when patients needed more time for supportive counseling. Another participant noted that scheduling a patient with a known mental health issue to see the physician and the BHC on the same day ensured that all of his patient's health needs were addressed without consuming the entire medical visit.

Improved Patient Access and Utilization of Appropriate Care

Connecting patients to the appropriate level of care is central to primary care medicine, but in rural areas, multiple factors confound a physician's ability to refer patients to mental

health treatment. Each participant described ways BHCs have helped patients access specialty mental health care, including by providing physicians with information about community resources or by meeting with the patient to evaluate and refer accordingly. BHCs also provided treatment when patients did not need extensive mental health care or were limited by various barriers.

Care coordination. Six participants described at least one instance when their BHC helped patients or physicians engage resources in the community. Participant #5 said his BHC has promoted patient engagement with broader mental health care resources, and that if his BHC's position were terminated, the burden of accessing mental health care in the community would shift entirely onto his patients. Similarly, participant #1 stated that while her clinic does not have access to resources like social work, her BHC has communicated with schools regarding patient needs, provided clarity about resources remaining in her community, and helped her families navigate confusing channels of access in the community. In her area, where mental health resources frequently change based on state-level funding, having a BHC with an awareness of available resources has enhanced referrals to specialized care.

Onsite behavioral health interventions. Beyond connecting patients to services in the community, improving access to optimal care also means providing interventions within primary care when various obstacles prevent patients from seeking care in the community. Six participants referred to ways in which their BHC provided specialty mental health services within primary care. Participant #1 stated that while she can identify a patient's emotional issues, she does not have the expertise to address these problems. She said, "I feel like, 'oh, this is brilliant,' you know I really played the doctor, but then I have no idea what to do with them after that." In instances when patients and their families may not need extensive treatment, her BHC

has been able to step in and provide brief, targeted interventions. These physicians also appreciated being able to make in-house referrals for targeted behavioral health care, particularly around chronic disease management and in promoting health management behaviors.

Increased patient comfort with BH. Stigma associated with seeking and receiving mental health care is thought to be a primary barrier to accessing care for many rural patients (Farley, 1998; Fox et al., 2001; Rost et al., 2005). Four physicians said that having BHCs onsite assisted patients in engaging appropriate care because the patient was able to meet briefly with the BHC, which may have destigmatized the experience of receiving mental health treatment. One physician noted that following a brief meeting with her BHC, the patient finally became open to engaging in care with a mental health provider in the community, which improved the quality of the physician's relationship with the patient. Participant #1 said this model helps engage patients in mental health services because they can inconspicuously share a waiting room with other primary care patients.

A Dissenting Opinion

A strength of qualitative research is its ability to adequately represent discrepant or minority viewpoints that would otherwise remain hidden in traditional quantitative research. One such discrepant voice emerged in this study as a participant described extensive dissatisfaction with her clinic's model of integrated primary care. Her site's implementation of IPC looked more like co-located care in that her BHC provided onsite mental health services, but offered little in the way of consultation or timely assistance with complex patients. IPC at this clinic was also hampered by a tedious BHC referral process for each patient. Finally, there was a mismatch between the specialized expertise desired by the physician, and the areas of expertise of her

BHC. Overall this physician felt that while the model sounded good in the planning stages, its implementation created more dissatisfaction than satisfaction.

Chapter 5: Discussion, Limitations, and Implications

This research examined the lived experiences of physicians in rural integrated primary care clinics in order to identify elements of this model of care relevant to rural physician job satisfaction. This section will first consider the findings that emerged from this research in light of what the literature identifies as drivers of rural physician job satisfaction. Next, limitations to this study and areas of useful future research will be considered. Implications for improving rural PCP satisfaction will then be discussed. Finally, I will offer a personal reflection on these findings in light of my experience as a BHC trainee in a rural primary care clinic.

Rural Integrated Primary Care and Physician Job Satisfaction

The five themes emerging from this study suggest that IPC interacts with physician job satisfaction through direct patient care (e.g., patient assessment and monitoring, targeted behavioral health interventions) and behind-the-scenes work (e.g., curbside consultations, trainings for the clinical staff, care coordination). In this section each of these themes will be further considered in light of the literature on rural physician job satisfaction.

Patient evaluation and monitoring. Participants appreciated their BHC's direct involvement with patients because their specialized skills provided improved patient conceptualization and treatment planning, while also enhancing patient monitoring. Access to specialty expertise, even outside of primary care, has been associated with rural physician satisfaction (Lepnurm et al., 2007). Furthermore, greater capacity for assessment and monitoring may reduce the sense of burden and isolation rural PCPs face when managing complicated patients, particularly patients requiring more intensive monitoring due to medical conditions (e.g., dementia) or the medication associated with treatment (e.g., narcotics). Placing this expertise in primary care seems to increase their sense of support and their satisfaction with the

care their practice is able to provide. It may also be that BHC support in evaluating and monitoring challenging patients allows physicians more time to spend with other patients who are more likely to respond to their interventions.

Easy access to consultation supports PCPs. Apart from direct patient contact, participants also appreciated access to curbside or electronic consultations, which aided the PCP's diagnosis, treatment planning, and sense of efficacy with challenging cases. Convenient access to these consultations, either electronically or in person, probably further reduced a sense of professional isolation when making major decisions about a patient. These consultations likely expand the PCP's repertoire for treatment options, which may inspire greater flexibility and creativity, two qualities of work primary care physicians are believed to especially value (Duffy & Richard, 2006). Access to consultation, albeit casual and informal, represents smooth collaboration across health care disciplines (Lepnurm et al., 2007), which has also been associated with rural physician job satisfaction. The physician who spoke most critically of this model identified the lack of informal consultation as a crucial missing ingredient, as it left her still dealing independently with her most complex patients. It seems that convenient access to informal consultation positively impacts the culture of rural practice settings because it provides a greater sense of teamwork that buoys PCP sense of support and self efficacy when independently engaging complex patients.

Staff development and support. Participants valued the BHC-facilitated in-house trainings, as well as the personal and professional support BHCs provided for themselves and their staff. BHC training and support helped physician and staff feel more prepared to manage the various patient populations seen in primary care, as well as feel more supported in the aftermath of difficult encounters. The relational support, as well as the development and

implementation of protocols for managing certain clinical needs (e.g., dementia evaluations), helped team-members function in a work environment that, in the absence of specific protocols for the most common and/or burdensome clinical conditions and needs, can quickly become frenetic and overwhelming. This finding is consistent with research suggesting that the contact with quality of the relationship with colleagues is an important component of PCP job satisfaction (Van Ham et al., 2006). Establishing protocols to manage mental health-related patient issues may also make it easier to consistently apply higher standards of care, which likely contributes to PCP satisfaction with the quality of care provided. Improving the team's abilities to consistently care for patients (through protocol development and trainings) likely creates a greater sense of accomplishment and satisfaction with care delivered, both of which are thought to be strongly associated with PCP job satisfaction (Duffy & Richard, 2006; Pathman et al., 1996; Williams et al., 2002). While participants did not comment on this explicitly, the onsite trainings may have also helped bridge a knowledge gap experienced in rural medicine, where medical innovations may be later in arriving and slower in being adopted.

BH interventions unburden PCPs. Participants described the role of their BHCs as crucial because they conveniently assisted (i.e., provided direct patient care) with complex, challenging, and time-consuming patients. Such assistance improves physician job satisfaction because it diminishes a sense of professional isolation often experienced in rural practice. That isolation, and its attendant elevation in patient care responsibilities for the most difficult patients, is thought to dissuade physicians from practicing in rural areas (Doescher et al., 2009). Without BHCs, physicians are limited in their choices for responding to challenging patient situations. One participant said that at regular check-ups she frequently learns that a patient is under considerable life stress, which requires extensive listening. Having a BHC available to take over

these critical but time-consuming aspect of primary care contributes to job satisfaction, as time management is a major challenge for rural primary care physicians (Doescher et al., 2000; Mainous et al., 1994). Beyond contributing to better time management, BHC involvement can be seen as distributing the mantle of responsibility that rural physicians otherwise bare independently. The dissenting opinion highlights this point–in the absence of ready access to her BHC, especially for a very high priority population (patients with poly substance abuse), PCP frustration and dissatisfaction with IPC was clearly evident. It seems that the more integrated the BHCs are in a rural practice the better they are able to share this burden of responsibility and the more likely they are to contribute to physician job satisfaction.

Improved patient access to appropriate level of care. Physicians appreciated BHC assistance in helping patients access the appropriate level of mental health care, either within primary care or by providing linkages to specialty mental health care or other community resources. BHCs maintained better awareness of available community resources than other members of the primary care team, and as such, were in a strong position to help patients access these resources. This support removes an administrative burden from the physician, which is important because excessive administrative responsibilities have been argued to drive physician dissatisfaction (Bovier & Perneger, 2003). Increasing patient engagement with local resources reduces the demand on PCPs to independently manage mental and behavioral health problems, which may help strengthen physician-patient relationships, an important component of primary care physician job satisfaction (Karsh, 2010). Increased access to appropriate care encompasses care BHCs provide that helps bridge patients to treatment, especially patients reluctant to pursue treatment with a community provider. This in-house care likely improves PCP satisfaction as the

physician no longer must approximate such care, but has a trained professional on site to provide it while also assisting patients in accessing care in the community.

The dissenting opinion. The outlier situation in this study made it clear that when the BHC is not readily available and otherwise fully integrated with the medical team, or able to help with culturally salient issues and critical patient populations, IPC can actually detract from PCP job satisfaction. In this study, such a situation actually added to PCP work stress because of the additional steps required to communicate with and refer patients to the BHC. This PCP felt strongly that BHCs in IPC settings should have specialized training to work in this context, and specialized expertise relevant to rural primary care practice (i.e., substance abuse).

Limitations and Directions for Future Research

One limitation inherent to this type of exploratory study is the small sample and attendant concerns about generalizability. While this method is useful for producing hypotheses, further research–including quantitative research–is necessary to confirm these ideas. Another methodological limitation is the potential for researcher bias introduced in the semi-structured interviews and in the analysis. I attempted to manage these biases by using an auditor to review each interview and the themes that emerged. The heterogeneity among these clinics also presented a limitation–while each clinic qualified as rural, the population they served and the available mental health resources in their communities varied broadly. Each clinic implemented IPC differently, and physicians described distinct BHC usage patterns, which means the interviews reflected fairly idiosyncratic experiences of IPC, as was especially evident in the dissenting viewpoint discussed above. Future research would benefit from recruiting participants from clinics with similar IPC models or by focusing on the PCP experiences in a single practice.

This research illuminated multiple ways in which the presence of BHCs in rural primary care can promote the job satisfaction of rural PCPs. Future research should focus on specific facets of this model (e.g., care coordination) to better understand how PCPs experience specific parts of IPC. Specifically, it would be interesting to assess the extent to which BHC consultation and direct intervention influence patient outcomes, and how that related to PCP satisfaction. Research should also extend into mid-level providers (i.e., physician assistants, nurse practitioners) in rural primary care clinics to see how IPC relates to the job satisfaction and performance of these critical rural health care providers (Doescher et al., 2009). Finally, the role of BHC as a community liaison connecting patients with the appropriate level of care merits further exploration, as it has received little research attention to date.

Implications

This study suggests that physician job satisfaction may be responsive to high quality IPC, which is promising given the shortage of rural PCPs and the costs associated with replacing dissatisfied providers (Buchbinder et al., 1999). Clinics interested in improving their practice could consider structural changes that would likely impact physician satisfaction. These changes include affording BHCs time to perform the behind-the-scenes work of assisting patients access external resources and being available for electronic and curbside consultations. Structural changes also include creating time for BHCs to facilitate staff inservices on mental health issues in primary care and to develop protocols for assessing and monitoring certain conditions. Clinics can also ensure electronic access to BHCs via secure e-mail or through an electronic medical record, which increases access to consultation. A final lever of structural change rural primary care clinics can pull is in the physical proximity of provider offices. Placing a BHC near a PCP office will increase professional cross-fertilization and reduce the perception of professional

isolation. This physical proximity fosters an enduring sense of support and builds a relationship with the team that is seen as essential to this service model (Hunter et al., 2009).

Another implication is in the apparent tension around BHC availability: physicians wanted BHCs readily available for consultation while also wanting to make referrals for in-house mental health care. BHCs need to find a balance between being available to PCPs and providing direct patient interventions. Ready availability may mean permitting interruptions while with patients, which has been described as a paradigm shift for many mental health professionals (Gathchel & Oordt, 2003; Hunter et al., 2009; Strosahl, 2005). Instead of an inviolable 50-minute hour, BHCs should deliver briefer interventions (e.g., 25-minute sessions), and maintain an open door policy even when with patients whenever possible.

Finally, the dissenting opinion highlights the importance of high quality implementation of IPC in enhancing PCP satisfaction. While collocating care may seem a logical and manageable first step toward integration, the limited access to BHC in collocated—but not integrated—care may detract from PCP satisfaction. According to this physician's experience, her BHC's limited availability meant that she experienced considerable burdens and frustrations accessing BHC for the relatively few who could be served by direct BHC intervention, and did not experience any of the other benefits of true IPC (support, consultation, etc.). The dissenting opinion suggests that integration—and not just collocation—may be the minimally necessary ingredient for IPC to promote PCP satisfaction.

Personal Reflection

Throughout this project I have reflected on my first warm handoff in primary care, a clinical encounter that galvanized my interest in primary care behavioral health. It was near the end of a long day and I knew the physician giving me the hand-off was over 45 minutes behind

schedule. She said this man "really just needs to talk to someone," and I knew she really needed to get caught up. After a brief explanation of the patient's situation, his reluctance to establish care with a therapist, and a history of his somatic problems, she was on to her next patient.

I remember walking to the exam room thinking about the role of the relationship in therapy, and whether this person would be willing to see me, a stranger, a student, someone who was not the doctor he had scheduled to see that day. Nervously, I thought I would just introduce myself and maybe invite him to schedule a follow-up appointment if he felt interested. I was expecting a resistant, anxious, dismissive man, but when I opened the door, his countenance communicated something different and profound. His face conveyed a willingness and trust that I had seen only in patients I had worked with for long periods of time. Looking back it makes sense–he was distressed by his mother's poor health, he was underemployed, his health was not as good as it had been, and his doctor had encouraged him to talk to me. The iron was hot.

The session was brief–20 minutes later I was reviewing with his provider highpoints from our discussion. I never saw the patient again, but several months later, the physician gave me an update. After our meeting, the patient began working with a therapist in the community. His anxiety was now better managed and, what's more, the PCP no longer dreaded seeing him on her schedule. This encounter captured for me how this model does not only improve patient care but also physician job satisfaction. This patient-physician dyad was stuck in separate conceptualizations of the problem and of the solution. My entrance into this relationship occurred at a moment when he was perfectly primed to engage and I was able to capitalize on the relationship platform the provider had already established with him. This positive encounter may have destigmatized therapy for him, causing him to more willingly engage in mental health care. His work in therapy reduced the strain on his relationship with his physician because she no

longer spent excessive time working on his psychosocial stressors. She was right, what this patient really needed was to talk to somebody at that moment.

While traditional mental health care will continue to exist as a specialty service external to primary care, the growing emphasis on patient centered care and population health may well position IPC as the mainstream model of mental health in the future. It will continue to be relevant to patients uncertain about pursuing psychotherapy or other forms of mental, behavioral, and substance abuse treatment, and the patients who fill PCP visits with stress-related aches and pains. Moreover, it will continue to be relevant to physicians who can rule out many diagnoses, order a variety of labs, and prescribe every medication, but grow weary from urging patients to pursue external treatment for mental health concerns. Finally, IPC offers a tool to attract physicians to rural primary care medicine and improve their quality of life.

My experience as a BHC trainee introduced me to the multifaceted role the BHC plays in rural IPC clinics, particularly the ways the BHC assists physicians in more effectively managing the burdens of practice. With the assistance of BHCs, physicians are able to provide more thorough treatment, and patients are able to engage in levels of care they might otherwise have resisted or never seriously considered as a treatment option. Extending the reach of psychological expertise and interventions into contexts in which the need and readiness to profit from them are both present is what excites me most about IPC. Hopefully, IPC will continue to thrive as a model of care and expand the role psychologists play in our evolving health care system.

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Appendix A: Steps of the Interpretive Process

Steps for the qualitative interview process	
Step 1	Contact potential participants via e-mail. Interested participants respond accordingly.
Step 2	Interested participants provided via e-mail: description of the study, informed consent document, list of interview questions. Participants asked to reply if still interested.
Step 3	Participants who respond to the previous e-mail provided with a list of times to schedule the individual interview. Interviews scheduled as responses are collected.
Step 4	Prior to beginning each interview informed consent reviewed and any potential risks from participation discussed. Informed consent document signed.
Step 5	Interview completed in person or via telephone. Concluding steps reviewed with each participant.
Step 6	Interviews coded for themes. Superordinate themes established. Summary of interview sent to participant to perform a member-check.
Step 7	Member-check received and reimbursement provided.
Step 8	Analysis of superordinate themes performed. Results compiled in narrative form.

Appendix B: Interview Questions

Interview Questions

1. In thinking about an ordinary week at your clinic, describe the most common ways in which you interact, directly or indirectly, with your clinic's onsite mental health professional(s).

- Common responses might include hallway consultations, medical record reviews, warm hand-offs, diagnostic clarity assessments, medication consultations, and short-term therapy. Do any of these resound with you? Are there others?

- How would you describe the frequency of these contacts?

2. If all of your clinic's mental health positions were terminated next month, what would you miss most?

- How would you first notice their absence in terms of your job satisfaction?

- What new burdens would you expect to emerge?

3. If your clinic were to announce a major increase in the number of psychologists on staff, what would you most look forward to? What benefit or burdens would that represent in terms of your job satisfaction?

- How would this influence your job satisfaction?

- Which would you most look forward to? What would you least look forward to?

4. Please describe a specific instance when having a mental health professional on staff improved your sense of job satisfaction.

- How do you suspect this encounter would have been different without readily available mental health professionals?

- What contributions by the mental health professional did you experience as most relieving?

5. Conversely, please describe a specific instance when having a mental health professional on staff detracted from your sense of job satisfaction.

- What do you wish had gone differently in that situation?

- What aspects of this situation bore most directly on your job satisfaction?

6. Which patients are you most likely to seek help with from your clinic's mental health staff?

- What factors drive this decision?

- How does your ability to refer these patients impact your job satisfaction?

7. Describe what you experience as the primary limitations of your clinic's mental health resources.

- What impact do these limitations have on your workload, job stress, or overall job satisfaction?

- In what ways might your clinic's mental health staff change to address these limitations?

8. How do the non-clinical elements of integrated care (i.e., relational support, crisis counseling, staff education, etc.) influence your job satisfaction?

- How do you suspect your practice would have been different in the absence of these non-clinical elements?

- What "extras" (or non-patient care expertise) does your clinic's mental health professional bring to your clinic's culture that you find important?

9. What aspects of being a rural physician are relevant to how you experience integrated care?

- What parts of being in a rural practice make integrated care especially useful?

- Is there anything about being a rural physician that you can do better because of integrated care?

10. What other aspects of integrated care are particularly important to your overall job satisfaction?

- How has integrated care impacted the culture in your practice?
- At the end of the day, how do you think integrated care impacts your job satisfaction?