A Multimethod Study of Mental Health Care Patients' Attitudes Toward Clinician-Level Performance Information

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Objective: Research demonstrates variability in mental health clinicians' overall and domain-specific outcomes for their patients. Despite calls to increase patient access to provider performance information, little is known about patients' attitudes toward and valuing of this information. This study explored patient attitudes, preferences, and values regarding the use of clinician outcome track records in provider selection and treatment decision making.

Methods: Community mental health patients (N=403) completed a multicomponent survey, and a subset of patients (N=15) completed a follow-up semistructured interview. Interview data were analyzed with consensual qualitative methods.

Results: Overall, participants endorsed valuing access to clinician outcome track record information and endorsed the belief that using such information would enhance the referral process and promote better mental health outcomes.

Conclusions: Harnessing measurement-based information on clinicians' effectiveness to make more personalized treatment decisions could promote better treatment engagement, retention, and outcomes.

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Research shows statistically significant and clinically meaningful differences among mental health care (MHC) clinicians in their patients' outcomes (1). As assessed by standardized, patient-reported outcome (PRO) measures, some clinicians are consistently more than twice as effective as others, even after controlling for case-mix variables that influence outcomes (2). Clinician-level effectiveness also appears to be stable; clinicians who achieve better than average outcomes generally continue to achieve better than average outcomes with subsequent patient cohorts (3).

It is important for MHC stakeholders to consider how to make outcome information actionable to improve care quality. Implications of outcome variability already affect MHC and reimbursement decisions. The Centers for Medicare and Medicaid Services have instituted data-informed, value-based payment programs, recently extending requirements to psychologists. In addition to requiring collection and report of quality data, the payment program has established reimbursement levels on the basis of a clinic's or individual provider's performance relative to predetermined benchmarks (4).

The Institute of Medicine (IOM) (5) recommends that patients be granted access to clinician performance data to guide treatment decisions. However, patient perspectives on clinician performance track records remain conspicuously absent in MHC discussions. For example, do patients view this information as trustworthy and useful? Care decisions and preferences are multidimensional and complex (6). Ostensibly, helping patients become informed and empowered in their decision making is a laudable goal; however, it is conceivable that patients may struggle to interpret and use clinical-level performance information. Moreover, patient preferences for how to use clinician outcomes data (e.g., direct to consumer, through third-party referral sources) have received little attention.

HIGHLIGHTS

- Patients' perspectives on having access to clinician performance information are lacking from the research literature.
- Survey and interview results indicated that patients would value access to clinician outcome track records to inform care decisions.
- Patients believe that referrals informed by clinician track records would improve outcomes.

This exploratory, multimethod study examined MHC patients' attitudes toward, valuation of, and potential concerns about clinician selection and use of track record information about clinician outcomes in treatment decision making. For this study, a team of MHC stakeholders developed a quantitative patient survey and a semistructured interview protocol. Such efforts can inform the development and implementation of measurement-based care strategies to improve MHC decision making and outcomes.

METHODS

All procedures were approved by a university institutional review board. Survey recruitment was based on rolling, voluntary self-selection between November 9, 2015, and November 1, 2016. Survey completers could then volunteer to participate in an interview to gather more in-depth and personally relevant information and recommendations. All participants were eligible for gift card compensation.

Survey participants were patients receiving treatment at one of 12 community mental health centers in the northeast United States (N=403). Inclusion criteria were any individual who was seeking or receiving MHC services and was responsible for MHC decision making for him- or herself, a family member, or an important other who was unable (e.g., because of cognitive impairments) to participate on his or her own behalf.

The study survey was developed in collaboration with a stakeholder advisory board. (A description of the stakeholder advisory board and the survey items are available as an online supplement to this report.) The survey assessed participants' demographic information, MHC service history and provider experience, and attitudes and preferences regarding provider performance information, both in general (yes/no items) and in comparison with alternative treatment factors (Kuder Richardson-20 internal consistency = 0.74).

Through convenience sampling, 37 participants volunteered to complete follow-up interviews via conference call. Recorded interviews were transcribed. Using standards for consensual qualitative research (CQR) (7), we randomly selected 15 interviews for analysis. The final set of questions (see online supplement) covered the following domains: experiences finding an MHC provider, information that would have been helpful in making a more informed provider selection, experiences with PRO measures, interest in and reasons for (or against) accessing clinician outcome information, factors that are important when finding a provider, willingness to use and comfort level using a list of "matched" providers based on PRO information, and perceived costs or pitfalls of using provider track record information. Interview transcripts and raw audio recordings were analyzed with CQR (7) methods (see online supplement).

RESULTS

The survey sample was mostly female (N=268, 67%) and White (N=206, 51%); the mean±SD age was 41.20±12.58 years. (A table with additional sample characteristics can be found in the online supplement.) The most common problem areas were anxiety, depression, and trauma. The most common current treatment was individual psychotherapy, followed by medication, group psychotherapy, and community-based support. The most common referral source was self, followed by another MHC provider and primary care physician. (A table with additional treatment and referral details is available in the online supplement.)

Survey results, as a percentage of "yes" endorsements for each yes/no item, are reported in Table 1. A majority of participants endorsed experiencing difficulty finding an MHC provider in their lifetime; a minority endorsed receiving a recommendation to see a specific MHC provider. When a specific referral had been provided, little explanation was given regarding its basis. Overall, participants endorsed struggling to navigate the clinician selection process and feeling as though they had received little systematic guidance. Additionally, approximately 21% of participants endorsed the belief that all MHC providers are capable of helping.

Remaining survey questions posed the hypothetical scenario of patients being able to access clinician track record information in the context of PRO monitoring. A majority of participants endorsed interest in accessing clinician performance track record information and the belief that such information would lead to more effective referrals and care outcomes. Additionally, over 90% endorsed the belief that matching informed by providers' track records would increase the likelihood of being helped.

Interview coding domains and tables showing complete results are available in the online supplement, and themes are summarized here. Regarding experience with MHC, several participants remarked about struggling with clinician turnover, which retriggered the difficult process of finding a provider. Several patients reported experiencing limited clinician choice and becoming savvy in advocating for themselves as patients only after years in the MHC system. Regarding experience with PROs, most participants reported completing self-report evaluations of some kind; however, few were able to articulate the purpose of completing such evaluations. Concerning the use of provider performance information, participants expressed interest in accessing a list of well-matched providers. Several noted that they would be willing to remain on a waitlist for a longer period to see an empirically better-matched provider.

Regarding potential pitfalls of using clinician performance track records, participants expressed concern about placing too much weight on them in decision making, because patient perspectives of patient outcomes (which drive the track records) are subjective. Concerning preferences, a majority of participants identified interpersonal and relational factors as being similarly important (in relation to outcome track records) when finding a good-fitting clinician. Access to track record information was perceived as valuable, yet relational fit remained important. Participants

TABLE 1. Mental health care patients (N=403) endorsing survey items related to clinician choice and access to clinician outcome track records[a]

Question	N	%
15. Were there any times in your life when you wanted a mental health provider and could not find one?	234	58
16. Has it been hard to find a mental health provider who you were confident could help you?	281	70
17. Has a health care provider or agency ever recommended a specific mental health care provider to you?	140	35
17a. If you responded "Yes" to question 17, did the person or agency that gave you the recommendation explain what the recommendation was based on?	319	79
18. Has any professional ever discussed with you the pros and cons of choosing one mental health provider vs. another?	93	23
19. Have you ever used a consumer satisfaction rating website, such as Angie's List or Healthgrades, to find a mental health care provider?	55	14
19a. If you responded "Yes" to question 19, did you find the website helpful in finding a provider?	132	33
20. Do you believe that all mental health care providers are capable of helping you?	83	21
21. Imagine that you could see a list of mental health providers' track records in helping people with issues like your own (that is, a list of the percentage of people who they have helped versus the percentage of people who they have not helped). Would you trust these data and how they were collected?	314	78
22. Imagine that you could see a list of mental health providers' track records in helping people with issues like your own. Would you use this list to help you select your provider?	367	91
23. Imagine that a health care professional like your primary care doctor is giving you a referral for a mental health provider. Would you feel more confident about your options if you knew that this person had reviewed providers' track records in helping people like you?	377	94
24. Imagine that your insurance company is giving you a referral for a mental health provider. Would you feel more confident about your options if you knew that your company had reviewed providers' track records in helping people like you?	302	75
25. Would you pay more out of pocket to see a mental health care provider who is listed as highly effective in treating the problems that you have?	223	55
26. Should mental health care consumers have access to information on the track records of providers in the local area?	378	94
27. Would it be important for you to be assigned or referred to a mental health care provider based on their track record in helping people with issues like your own?	375	93
28. Would it be more important than usual for you to be assigned or referred to a mental health care provider based on their track record in helping people with issues like your own if you previously have not benefited from mental health treatment for that problem?	365	91
29. Do you think access to information on the track records of mental health care providers would increase the likelihood of someone being helped by treatment?	377	94
30. Do you think that matching a consumer with a provider who has a track record of helping people with similar issues would increase the likelihood of that consumer being helped by treatment?	379	94

[a] The entire survey is available as an online supplement to this report.

reported that outcome track records would be valued and used to some degree, if made available. Ideally, other preference-related information would also be taken into consideration (e.g., being assigned to a clinician with a track record of positive outcomes who also matches a gender preference).

DISCUSSION

Clinicians are an important source of outcome variability in MHC. Agencies and policy makers have advocated for quality monitoring and the use of quality data in MHC stakeholder decision making. Little is known about patients' attitudes regarding the use of clinician outcome track records in decision making (8). These results demonstrate that patients are given little information or direction regarding clinician selection. When patients engage in MHC, unsystematic and nonpersonalized referrals may result in a poor patient-provider match and poor outcomes (9). Clinician track record information would be a valued resource in the decision-making process. Few participants endorsed the belief that all MHC providers are capable of helping. This finding may indicate that most participants do not view care providers as interchangeable or that patients lack faith in MHC in general.

Consistent with IOM recommendations, results indicate that access to and use of clinician outcome track record information would be a patient-centered MHC practice. This practice does not necessarily require directly providing track record information to patients; rather, such information could be provided to referral sources, such as primary care, to guide decisions. Many people with psychiatric problems have them treated solely in primary care (10). Yet, primary care providers often feel underequipped to meet patients' MHC needs (11), reinforcing the importance of effective referral from primary care to MHC. Regardless of indirect or direct access, a majority of patients endorsed the belief that such information would enhance the referral process and treatment outcomes.

Results from the interviews provide more nuance. Specifically, track record information based on PRO data should not be the sole factor in referral and assignment decisions. Rather, track record information should be integrated into a broader assessment of and responsiveness to care preferences when possible. Notably, patients were somewhat protective of clinicians with regard to the implications of track record information. Both the survey and interview distinguished between patient satisfaction ratings (e.g., number of stars out of five on a website) and outcome data based on psychometrically valid self-report measures of symptoms and functioning. Participants viewed satisfaction ratings and testimonials as somewhat useful yet also expressed skepticism regarding their validity. Some expressed concern about overreliance on outcome information for personnel selection and reimbursement policies; potential negative effects (e.g., inequitable reimbursement practices due to failure to account for contextual factors) of overreliance on PROs to inform health service decisions cannot be ignored (12). However, overall, PRO-derived performance information was perceived as more valid than satisfaction ratings. Rather than rely on clinicians' self-identified competence domains and patient testimonials, patients may value the inclusion of outcome-based track record information in provider directory platforms.

The results of this study must be considered in light of several limitations. These results come from a single study of community patients from one region of the United States. Although survey items were developed on the basis of stakeholder input with an emphasis on content validity and internal consistency was adequate, structural and predictive validity were not established. In addition, both aspects of the study were based on self-selecting, volunteer samples. Estimates of sampling error could not be calculated; thus, results may be subject to multiple sources of error.

We also recognize that care decisions and provider selection are not solely within the control of the individual. Numerous factors may limit choice, and barriers often hinder access to any service. Additionally, the framing of this study and both the survey and interview questions implied somewhat hypothetical scenarios in which patients have more freedom to make choices about their care than they might have in real-world situations, although the results clearly indicate that patients would value being more empowered in their treatment decisions. Relatedly, our sample comprised participants with relatively fewer financial resources. Although we acknowledge the implications of this characteristic for generalizability, it could be argued that this subpopulation is in particular need of decision support tools to avoid perpetuating health disparities and further marginalization.

CONCLUSIONS

Historically, MHC stakeholders have been unaware of clinicians' outcome track records, which represents a gap in knowledge transfer. Suboptimal improvement rates in MHC may partly be due to the provider and a lack of personalized referrals or assignments. Because such treatment decisions are often not personalized or are based on convenience or the provider's self-defined expertise (which research shows is often overestimated or inaccurate) (13), patients are equally as likely to see a provider who is stably ineffective at treating their condition as they are to see a more effective provider. Conversely, there is potential in harnessing performance information to match patients to clinicians on the basis of scientific outcomes data. Overall, patients appear to be interested in such an approach. It will be important to replicate these findings and to continue to explore potential implementation strategies.

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Stakeholder Advisory Board

The project advisory board was comprised of two psychotherapy researchers, two decision-making scientists, and three mental health care patients with lived experience. The board included one Black woman, and six White men, with ages ranging from 24 to 60 years. This board also assisted in the development of the qualitative interview protocol. The survey was also pilot-tested and refined based on MHC consumer feedback and quantitative readability metrics. Twelve consumers volunteered to assist with this. This group included three Black women, four white women, four white men, and one Hispanic man; age range 20 to 32 years.

Survey

If completing this survey on another's behalf, please answer the following questions in relation to that person. For example, state that person's age rather than your own.

1. Age in years: _____________

2. Gender:
    _____ female
    _____ male
    _____ transgender
    _____ Other gender
3. Race/ethnicity:
    _____ Hispanic/Latino(a)
    _____ East Asian
    _____ South Asian
    _____ African American/Black
    _____ Native American
    _____ European American/White
    _____ Hawaiian/Pacific Islander
    _____ Biracial/multiracial
    _____ Other race/ethnicity
4. Marital status:
    _____ separated or divorced
    _____ married/in a domestic partnership
    _____ single
    _____ widowed
5. Household annual income:
    _____ Less than $25,000
    _____ $25,001 - $50,000
    _____ $50,001 - $75,000
    _____ $75,001 - $100,000
    _____ $101,001+

6. Religion – if no affiliation, please write "none": ____

7. Highest education level:

   _____ Did not complete high school or GED

   _____ Completed high school or GED

   _____ Some college

   _____ Completed an Associate's degree

   _____ Completed a four year college degree

   _____ Some graduate or medical school

   _____ Completed a master's degree

   _____ Completed a doctoral or MD degree

Treatment History:

Reminder: If completing on another’s behalf, please answer the following questions in relation to that person.

8. Mental health service(s) currently receiving or seeking. Please check all that apply:

   _____ Individual psychotherapy

   _____ Group psychotherapy

   _____ Medication

   _____ Marital therapy

   _____ Family therapy

   _____ Case management

   _____ In home therapy

   _____ Family support

   _____ School based services

   _____ Community support

   _____Other, please describe:____

9. Who referred you or played a key role in your referral to your current treatment setting? Check all that apply:

   _____ Primary/family care doctor

   _____ Other mental health care provider

_____ Insurance company

_____ Friend or family member

_____ Self

_____ Other, please describe:_____________________________________

10. Which of the following problems best capture your reason for seeking services at this time? Check all that apply:

_____ Depression

_____ Anxiety

_____ Trauma

_____ Eating disorder

_____ Marital or family problems

_____ Behavioral problems

_____ Development disability

_____ Learning disability

_____ Attentional problems

_____ Brain injury

_____ Psychotic symptoms

_____ Bipolar disorder

_____ Substance use

_____ Other, please describe:____

11. Do you receive Medicare or Medicaid (for Massachusetts residents, includes MassHealth)?

_____ Yes

_____ No

12. Have you received mental health services in the past?

_____ Yes

_____ No

13. How many different mental health therapists or counselors have you seen in your lifetime?_________

14. How many different providers have prescribed you medication for your mental health in your lifetime?________

15. Were there any times in your life when you wanted a mental health provider and could not find one?

_____ Yes

_____ No

16. Has it been hard to find a mental health provider who you were confident could help you?

_____ Yes

_____ No

17. Has a health care provider or agency ever recommended a <u>specific mental health care provider</u> to you?

_____ Yes

_____ No (if No, please skip to question 18)

17a. If you responded "Yes" to question 17, did the person or agency that gave you the recommendation explain what the recommendation was based on?

_____ Yes

_____ No

18. Has any professional ever discussed with you the pros and cons of choosing one mental health provider vs. another?

_____ Yes

_____ No

19. Have you ever used a consumer satisfaction rating website, such as Angie's List or Healthgrades, to find a mental health care provider?

_____ Yes

_____ No (if No, please skip to question 20)

19a. If you responded "Yes" to question 19, did you find the website helpful in finding a provider?

_____ Yes

_____ No

20. Do you believe that all mental health care providers are capable of helping you?

_____ Yes

_____ No

21. Imagine that you could see a list of mental health providers' track records in helping people with issues like your own (that is, a list of the percentage of people who they have helped versus the percentage of people who they have not helped). Would you trust these data and how they were collected?

_____ Yes

_____ No

22. Imagine that you could see a list of mental health providers' track records in helping people with issues like your own. Would you use this list to help you select your provider?

_____ Yes

_____ No

23. Imagine that a health care professional like your primary care doctor is giving you a referral for a mental health provider. Would you feel more confident about your options if you knew that this person had reviewed providers' track records in helping people like you?

_____ Yes

_____ No

24. Imagine that your insurance company is giving you a referral for a mental health provider. Would you feel more confident about your options if you knew that your company had reviewed providers' track records in helping people like you?

_____ Yes

_____ No

25. Would you pay more out of pocket to see a mental health care provider who is listed as highly effective in treating the problems that you have?

_____ Yes

_____ No

26. Should mental health care consumers have access to information on the track records of providers in the local area?

_____ Yes

_____ No

27. Would it be important for you to be assigned or referred to a mental health care provider based on their track record in helping people with issues like your own?

_____ Yes

_____ No

28. Would it be more important than usual for you to be assigned or referred to a mental health care provider based on their track record in helping people with issues like your own **IF** you previously have not benefited from mental health treatment for that problem?

_____ Yes

_____ No

29. Do you think access to information on the track records of mental health care providers would increase the likelihood of someone being helped by treatment?

_____ Yes

_____ No

30. Do you think that <u>matching</u> a consumer with a provider who has a track record of helping people with similar issues would increase the likelihood of that consumer being helped by treatment?

_____ Yes

_____ No

For the last three questions, please circle the response that best fits you (scale of 1- 6).

	<u>Not at all good</u>				<u>Extremely good</u>	
How good are you at working with fractions?	1	2	3	4	5	6
How good are you at figuring out how much a shirt will cost if it is 25% off?	1	2	3	4	5	6
	<u>Never</u>					<u>Very often</u>
How often do you find numerical information to be useful?	1	2	3	4	5	6

Interview Method

Upon transcription and further review, five of the 37 interviews/recordings were deemed inappropriate for subsequent analysis, either due to problems with the recording or being of highly atypical in length (thus, judged to be non-adherent). As noted, based on existing standards for consensual qualitative research (CQR), we randomly selected 15 interview cases for analysis.

The interviewers were one female and one male advanced doctoral student who were extensively trained in the interview protocol. Both identified as White. Subsequent to extensive training, judges independently coded transcripts. This was followed by discussions to achieve consensus, with the consensus codes then being reviewed by an external data auditor. Judges integrated auditor feedback and continued to pursue final consensus through an iterative process. The judges consisted of two female and two male advanced doctoral students. All identified as White. The auditor was male, White, with significant CQR experience. The judges and auditors had positive views of MBC. However, the analysis team did not have strong expectations regarding how participants would respond to the specific interview questions. Compared with other qualitative methods, the goal of CQR is not to achieve theoretical saturation, in part, because such thresholds are not clearly defined. CQR is specifically designed to foster an in-depth examination of individuals' experiences, and the recommended sample size is 8-15 (7).

Codes were broken down into three main components: domains (overarching themes prevalent within the data); core ideas (the basic foundation of participants' own words; each core idea reflects a complete thought within each domain); and categories/subcategories (grouping established to determine degree of prevalence across transcripts). Consistent with the CQR approach, representativeness of categories/subcategories were classified as: general (emerged for 13 or 14 participants); typical (emerged for 8-12 participants); variant (emerged for 2-7 participants); and rare (emerged for 1 participant).

Consumer Interview Items

1. What mental health services are you (or the identified client) currently receiving? Have received in the past?

2. What types of mental health care providers have you (or the identified client) worked with?

3. Can you describe, in as vivid detail as possible, what your experience has been when trying to identify a mental health care provider with whom to work (or with whom the identified can work)?
    - How have you found providers in the past?
    - Has it been easy or difficult to find someone?
    - Did you know anything about your provider(s) before the first appointment?
    - Did you feel as though you had a say in selection?

4. What do you think would have been helpful/what would you have wanted to help you make a more informed choice regarding your treatment provider?

5. In the context of receiving services, have you ever been asked to complete a questionnaire asking you about your (or the identified client's) difficulties (e.g., symptoms, functioning, quality of life) and/or satisfaction with your provider or services?

    a. If so, how do you think that information is used?
    b. How should it be used?

6. Do you, or would you, want access to provider performance information (i.e., provider success rates in treating their previous clients)? Why or why not?

    a. If you do want access, how would you prefer to receive it? E.g., Online? Through another provider who is referring you? As a handout?

7. What factors are important to you when selecting a treatment provider (or when considering a provider for the identified client)?

    a. Are these factors more, less, or equally important? Can you rank them in terms of importance?

8. Given its capability of identifying "higher" and "lower" performing providers based on their track record, the field also could potentially match clients to providers who seem particularly well suited for them. Would you be willing to wait to see a "preferred" or matched provider if he or she was currently unavailable?

    a. Would you pay more?

   b. Are there other things in your previously stated list of important factors in making provider decisions that you would rank lower than seeing a "preferred" or matched provider were it possible to do so?

9. If you were given a list of "well-matched" providers, would you feel comfortable making a provider selection based on that list?
   a. Alternatively, would you feel more comfortable if other professionals use such a list to make a specific recommendation or recommendations? That is, would you want your primary care doctor or outpatient care setting to make a specific referral recommendation based on this information rather than have direct access to it yourself?
   b. Would you prefer a list of "preferred" providers in your area, or the identification of a specific provider?

10. What are the potential costs or pitfalls to using provider track record information for provider selection?

11. Should higher performing providers be reimbursed at a higher rate?

12. Please discuss, in as much detail as you can, the steps that you think should be taken to improve the mental health care provider selection process. What would be most helpful to you? We are very interested in your voice on this important matter.

Table

Demographic characteristics and endorsed presenting problem domains (N = 403)

Demographic			Presenting Problem	n	%
Age *M* ±*SD*	41.30±12.58		Depression	295	73.4
	n	%	Anxiety	315	78.4
Gender			Trauma	172	42.8
Female	268	66.5	Eating	42	10.4
Male	130	32.3	Marital/Family	72	17.9
Transgender	5	1.2	Behavioral Problems	89	22.1
			Developmental	24	6.0
Ethnicity			Learning	69	17.2
Hispanic	60	14.9	Attention	108	26.9
Asian	10	2.7	Brain Injury	17	4.2
African-American	57	14.1	Psychotic	38	9.5
Native American	6	1.5	Bipolar	131	32.6
White	206	51.1	Substance Use	89	22.1
Multiracial	24	6.0	Other	27	6.7
“Other”	40	9.9			
Marital Status					
Separated/Divorced	77	21.4			
Married/Domestic Partnership	66	18.4			
Single	203	56.5			
Widow	13	3.6			
Education					
Did Not Complete HS/GED	50	13.9			
Completed High School/GED	98	27.3			
Some College	114	31.8			
Associates Degree	46	12.8			
Four-Year Degree	26	7.2			
Professional Degree	25	6.9			
Household Income					
Less than $25K	300	83.6			
$25K - $50K	38	10.6			
$50K - $75K	6	1.7			
$75K - $100K	5	1.4			
More than $100K	10	2.8			
CMS	346	86.1			
Previous Treatment	348	98.9			

Note. HS = high school; GED = general education development; CMS = Center for Medicare/Medicaid [participants]. Some totals either do not sum to 403 due to missing data or exceed 403 because participants could check multiple domains (e.g., presenting problem).

Table

Survey participant reported current treatment modalities and referral sources (N = 403)

Treatment Modality	n	%	Referral Source	n	%
Individual Psychotherapy	360	89.3	Primary Care Physician	89	22.1
Group Psychotherapy	61	15.1	Other Mental Health Care Provider	144	35.8
Medication	298	73.9	Insurance Company	11	2.7
Marital/Couples Therapy	15	3.7	Friend or Family Member	62	15.4
Family Therapy	30	7.4	Self	151	37.6
In Home Therapy	21	5.2	Other	30	7.5
School Based Services	29	7.2			
Community-Based Support Services	61	15.1			
Other	12	3.0			

Note. Some totals either do not sum to 403 due to missing data or exceed 403 because participants could check multiple domains (e.g., presenting problem).

Table

Semi-structured interview domains from patients in the sample

Domain 1: Experience with mental health care
Domain 2: Experience searching for a mental health care provider
Domain 3: Experience evaluating mental health care outcomes
Domain 4: Perspectives on provider performance information
Domain 5: Mental health care preferences/considerations
Domain 6: Relative valuing of mental health care preferences/considerations

Table: Domain 1: Experience with mental health care

Category	Subcategory	No. of Core Ideas	No. of Cases	Typicality
Providers worked with		44	14	G
Outpatient services		41	14	G
	Individual counseling/psychotherapy	16	11	T
	Medication management	16	11	T
	Group counseling/psychotherapy	3	3	V
	Other services	2	2	V
	Psychoeducation/classes	1	1	R
Services receive(d)		37	13	G
	Hospitalization	5	4	V
Negative mental health care experiences		27	10	T
	Gaps in care/turnover	10	7	V
	Insurance difficulties	5	4	V
	Other negative experiences	4	4	V
	Characteristics or behavior of providers	6	3	V
	Variable provider performance	2	2	V
Focus on treatment		9	5	V
	Skills worked on	3	3	V
	Problems addressed	4	2	V
Switching providers/ numerous providers		7	5	V
Frequency of receiving services		7	5	V
Positive mental health care experiences		6	3	V
	Accessibility of services	3	2	V
	Warm/empathic	1	1	V
Duration of experience with mental health care		3	3	V

Note: G = General, T = Typical, V = Variant, R = Rare. The total number of core ideas in each category will sometimes be greater than the total number in each category’s respective subcategories, as some core ideas only fit into the broad category level and were not placed into a subcategory. Thus, the number of core ideas in a category reflects the total number of core ideas in its respective subcategories and the number of core ideas that only fit at the broader category level.

Table: Domain 2: Experience searching for a mental health care provider

Category	Subcategory	No. of Core Ideas	No. of Cases	Typicality
Perceived agency in the provider selection process		24	14	G
	Adequate agency	12	8	T
	Lack of agency	12	8	T
Positive experience with the provider selection process		22	14	G
	Availability of provider information	4	3	V
Provider selection process		78	13	G
	Professional referrals	31	10	T
	Personal referrals	13	9	T
	Looked for providers independently	11	6	V
	Expressing preferences	7	4	V
	Trial and error	7	3	V
	Contacted clinics by phone	4	3	V
	Received list of providers from insurance company	4	3	V
Difficulty searching for providers		65	13	G
	Unavailability of provider information	15	12	T
	Logistics	10	6	V
	Insurance	18	5	V
	Negative emotional experiences	8	5	V
	Time consuming and complicated	3	3	V
	Waitlist	5	2	V
	Clinicians’ expertise	3	2	V
	Clinicians’ personal characteristics	3	2	V
Difficulty maintaining providers		13	7	T
	Clinician turnover	8	4	V
	Insurance	2	2	V
Other		1	1	R

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Table: Domain 3: Experience evaluating mental health care outcomes

Category	Subcategory	No. of Core Ideas	No. of Cases	Typicality
Consumers have experience evaluating mental health outcomes		29	12	T
	Satisfaction	10	8	T
	Symptoms and functioning	10	7	V
	Quality of life	7	6	V
	Unspecified outcomes	2	2	V
Perceived use of evaluations		22	11	T
	Improve services	12	9	T
	Unsure	5	5	V
	Administrative purposes	5	3	V
Beliefs about how evaluations should be used		18	9	T
	Improve services	5	5	V
	Assess provider performance	5	4	V
	Tracking patient progress	2	2	V
	Guide patient treatment	2	2	V
	Improve provider selection	2	2	V
	Research	2	2	V
Never completed evaluations		10	8	T
	Satisfaction	6	6	V
	Unspecified outcomes	4	4	V
Other beliefs		13	7	V
	Evaluations are anonymous	4	3	V
	Evaluations are helpful	4	2	V
	Evaluations are required	2	2	V
	Evaluations are not used to full potential	1	1	R
Perceived evaluating agent		7	3	V
	Clinic/hospital	2	2	V
	Insurance	2	2	V
	State	3	1	R
Discussed evaluations with providers		3	3	V

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Table: Domain 4: Perspectives on provider performance information

Category	Subcategory	No. of Core Ideas	No. of Cases	Typicality
Payment		15	14	G
	Willing to pay more if affordable	7	6	V
	Unwilling to pay more	5	5	V
	Willing to pay more	3	3	V
Provider reimbursement		25	13	G
	Should not be reimbursed at higher rate	10	7	V
	Reimbursed at a higher rate	6	6	V
	If no added cost to patient	4	4	V
	Ambivalent	3	3	V
	For better performance	2	2	V
Positive views of PPI		54	12	T
	Comfortable using PPI	13	12	T
	PPI used for finding best provider	17	9	T
	Access to PPI desired	12	8	T
	PPI would be helpful	8	6	V
	PPI used to improve services	4	4	V
Willing to wait to see a preferred or matched provider		15	12	T
	Yes	8	8	T
	Depends on severity of patient's distress	6	5	V
	No	1	1	R
Differential valuing of PPI vs. other factors		14	12	T
	PPI most important	6	6	V
	Other factors more important than PPI	3	3	V
	Equally important	2	2	V
Preferred method of selecting preferred or matched provider		13	12	T
	List of multiple providers	13	12	T
Potential pitfalls of using PPI		31	11	T
	Subjectivity of patient reviews	13	6	V
	Extreme ratings	6	5	V
	Disadvantage for new providers	3	2	V
	Legitimacy of patient reviews	2	2	V
	Intrusive nature of data collection	1	1	R
Preferred mode of access to PPI		14	10	T
	Internet	9	7	V
	Paper (flyer, pamphlet)	5	5	V

Willingness to travel farther to see a preferred or matched provider		4	4	V
What PPI should include		15	3	V
	Patient reviews	5	3	V
	Data (general)	3	3	V
	Provider background information	3	2	V
	Success rates with specific disorders	2	1	R
	Success rates with treatment modality	1	1	R
	Success rates with specific demographic groups	1	1	R
Would not want access to PPI		2	2	V

Note: G = General, T = Typical, V = Variant, R = Rare. The total number of core ideas in each category will sometimes be greater than the total number in each category's respective subcategories, as some core ideas only fit into the broad category level and were not placed into a subcategory. Thus, the number of core ideas in a category reflects the total number of core ideas in its respective subcategories and the number of core ideas that only fit at the broader category level.

Table: Domain 5: Mental health care preferences/considerations

Category	Subcategory	No. of Core Ideas	No. of Cases	Typicality
Valued provider characteristics		96	14	G
	Interpersonal factors	18	10	T
	Expertise or specialization	14	9	T
	Training, education, credentials	12	7	V
	Experience (years worked)	8	7	V
	Therapy style	11	5	V
	Past patient outcomes/success rates	8	5	V
	Skill or competence	7	5	V
	Gender	6	4	V
	Cultural sensitivity	6	3	V
	Clean professional record	2	2	V
	Match on patient characteristics	1	1	R
	Preferred or matched provider	1	1	R
	Other	1	1	R
Ways to improve mental health care		77	14	G
	Greater access to provider information	27	10	T
	Collecting outcome data	6	6	V
	Streamlined logistical aspects/insurance changes	6	6	V
	More information online	7	4	V
	Greater patient say in treatment	6	4	V
	Information from past patients/patient reviews	6	4	V
	Increased accessibility	3	3	V
	More providers needed	3	3	V
	Greater advertisement of resources	5	2	V
	Improve interpersonal fit	3	2	V
	Better mental health awareness for patients	2	2	V
	Trial period	1	1	R
Other important factors		22	8	T
	Avoiding turnover	10	4	V
	Proximity and accessibility	6	4	V
	Insurance	3	3	V
	Availability of providers and appointments	1	1	R

Note: G = General, T = Typical, V = Variant, R = Rare. The total number of core ideas in each category will sometimes be greater than the total number in each category's respective subcategories, as some core ideas only fit into the broad category level and were not placed into a subcategory. Thus, the number of core ideas in a category reflects the total number of core ideas in its respective subcategories and the number of core ideas that only fit at the broader category level.

Table: Domain 6: Relative valuing of mental health care preferences/considerations

Category	Subcategory (When Applicable)	No. of Core Ideas	No. of Cases	Typicality
Most important factor		21	12	T
	Interpersonal characteristics	5	5	V
	Skill or competence	5	5	V
	Proximity/accessibility	4	2	V
	Insurance	3	2	V
	Preferred or matched provider	2	2	V
	Demographics	1	1	R
	Experience (years worked)	1	1	R
Considers a combination of factors		11	9	T
Experience less important than other factors		2	2	V
Willing to compromise on factor(s) for most valued factor		2	2	V
Lists multiple factors as equally important		1	1	R

Note: T = Typical, V = Variant, R = Rare.