SYLLABUS AND COURSE GUIDE

WC-007-020510-11
Archive

Release Date: February 5, 2010
Credit Expiration Date: February 5, 2011
Archive Offered Until: February 5, 2011

Improving the Care of People with Mental Illness in Rural Areas

neuroscience CME

A Free, One-Hour CME/CNE/CEP/NASW/CCMC/CPE ARCHIVE WEBCAST:

www.neuroscienceCME.com/CM435
(free account activation and log-in required)

FACULTY: John C. Fortney, PhD
MODERATOR: Grayson S. Norquist, MD, MSPH

Co-sponsored by Howard University College of Medicine,
Office of Continuing Medical Education and CME Outfitters, LLC

This activity is supported by an educational grant from Lilly USA, LLC.
For further information concerning Lilly grant funding, visit www.lillygrantoffice.com.

INFORMATION FOR PARTICIPANTS

Statement of Need

According to the U.S. Census Bureau, more than 60 million people live in rural areas[1] and it has been well documented that these Americans face specific challenges to accessing, utilizing, and paying for quality healthcare. Despite 20% of Americans living in rural areas, only 10% of the nation's physicians practice in rural areas,[1] with access to and availability of mental health specialists, such as psychiatrists, psychologists, psychiatric nurses, and social workers significantly lacking.[1] Integrating mental and medical health in these rural areas has been a focus of many states to provide access and health education to providers and patients. It is critical that best practices implemented throughout the nation are shared among clinicians so that all providers can collaborate and improve their knowledge and performance, gain insights to the latest evidence, and provide optimal care services to patients and their families. Evolving technology has provided new opportunities to provide access to services and address barriers presented to patients and physicians practicing in remote rural communities. As technology improves, costs decrease and access increases—these forces help to create opportunities for increased collaborative care management. This neuroscienceCME Webcast will present key insights to better integrate primary care and mental health services, and address the unique challenges and performance gaps identified in rural populations.

1 "National Healthcare Disparities Report," US Dept of Health and Human Services, December 2003, Republication Copy.

Activity Goal

To address barriers to care faced by rural populations and to provide awareness to practicing clinicians of opportunities for collaboration and improvement of access and patient outcomes, which are fostered by emerging technology.

Learning Objectives

At the end of this CE activity, participants should be able to:

- Recognize specific challenges and barriers in treating mental illness in rural and underserved populations.
- Identify opportunities for collaboration among healthcare providers to improve access to mental health services.
- Integrate technology into mental health diagnosis and management strategies to improve access and patient outcomes.

Target Audience

Psychiatrists, primary care physicians, and other interested physicians; physician assistants; nurse practitioners; nurses; psychologists; social workers; certified case managers; pharmacists; and other healthcare professionals interested in the improvement of healthcare for rural populations.

CREDIT INFORMATION

CME Credit (Physicians)

Howard University College of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Howard University College of Medicine, Office of Continuing Medical Education, designates this educational activity for a maximum of one (1) *AMA PRA Category 1 Credit*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Note to Physician Assistants: *AAPA accepts Category I credit from AOACCME, Prescribed credit from AAFP, and AMA Category I CME credit for the PRA from organizations accredited by ACCME*

CNE Credit (Nurses)

This continuing nursing education activity was approved by the New York State Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

It has been assigned approval code 7ZDPTZ-10. 1.0 contact hours will be awarded upon successful completion.

CEP Credit (Psychologists)

CME Outfitters is approved by the American Psychological Association to sponsor continuing education for psychologists. CME Outfitters maintains responsibility for this program and its content. (1.0 CE credits)

NASW Credit (Social Workers)

This program was approved by the National Association of Social Workers (provider #886407722) for 1 continuing education contact hour.

CCMC Credit (Certified Case Managers)

This program has been approved for 1 hour by the Commission for Case Manager Certification (CCMC).

CPE Credit (Pharmacists)

CME Outfitters, LLC, is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. 1.0 contact hours (0.1 CEUs)
Universal Program Number: 376-999-10-001-H01-P

Activity Type: knowledge-based

All other clinicians will either receive a CME Attendance Certificate or may choose any of the types of CE credit being offered.

Financial Support

This activity is supported by an educational grant from Lilly USA, LLC. For further information concerning Lilly grant funding, visit www.lillygrantoffice.com.

CREDIT REQUIREMENTS

Successful completion of this CE activity includes participating in the recorded activity, reviewing the course materials, and following the instructions below by February 5, 2011:

To complete your credit request form, activity evaluation, and post-test online, and print your certificate or statement of credit immediately (70% pass rate required), please visit www.neuroscienceCME.com and click on the Testing/Certification link under the Activities tab (requires free account activation). This website supports all browsers except Internet Explorer for Mac. For complete technical requirements and privacy policy, visit www.neurosciencecme.com/technical.asp.

There is no fee for participation in this activity. The estimated time for completion is 60 minutes.
Questions? Please call **877.CME.PROS**.

FACULTY BIOS & DISCLOSURES

Grayson S. Norquist, MD, MSPH (Moderator)

Dr. Norquist currently serves as professor and Chair, Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center. Dr. Norquist received his BA with special distinction from the University of Mississippi, his MD magna cum laude from the University's Medical Center, and his MSPH from the UCLA School of Public Health. He completed his psychiatry training at the UCLA Department of Psychiatry, where he was chief resident and a Robert Wood Johnson Clinical Scholar.

Dr. Norquist began his psychiatry career as a UCLA faculty member and assistant dean for student affairs at the UCLA School of Medicine. In addition, he was director of the Mental Health Services for Physicians in Training Program and a consultant for the RAND Corporation from 1987-1990.

Dr. Norquist joined the NIMH in 1990 and in 1992 became deputy director of the Division of Epidemiology and Services Research and associate director for services research at NIMH. In 1998, he was appointed director of the Division of Services and Intervention Research. During his tenure in that position, NIMH initiated the most comprehensive mental health clinical trials ever conducted.

Dr. Norquist currently is a member of the editorial board of Psychiatric Services and has served on the editorial boards of the *Archives of General Psychiatry* and the *Journal of Mental Health Policy and Economics.* He has authored numerous articles and book chapters and is the recipient of the NIH Director's Award, the NIH Special Service Award, the National Alliance for the Mentally Ill Exemplary Psychiatrist Award, and the APA Health Services Senior Career Award.

John C. Fortney, PhD

Dr. Fortney is the Associate Director for Research of the South Central Mental Illness Education and Clinical Center (MIRECC) and a core investigator with the VA Center for Mental Health and Outcomes Research in Little Rock, Arkansas. He is also a Professor in the Department of Psychiatry at the University of Arkansas for Medical Sciences, and Director of the Division of Health Services Research. He has authored or co-authored over 70 peer-reviewed publications in leading medical journals. He has received

funding as principal investigator from both the NIH and the VA and has been a standing member of NIH and VA grant review committees. Over the last 20 yeas, Dr. Fortney's primary research interest has been improving the delivery of mental health services in rural primary care settings. He is a national expert on telemedicine-based interventions to improve mental health outcomes, as well as implementing evidence-based mental health practices in rural primary care clinics. He is currently the PI of a VA HSR&D funded telemedicine intervention study for PTSD, a VA HSR&D funded telemedicine implementation study for depression, and an NIMH-funded telemedicine intervention study for depression. He is also the Co-PI of a VA HSR&D funded hybrid intervention/implementation study for treating depression among HIV patients. All four studies employ web-based decision support systems for nurse care managers.

Disclosure Declaration

It is the policy of Howard University College of Medicine and CME Outfitters, LLC, to ensure independence, balance, objectivity, and scientific rigor and integrity in all of their CE activities. Faculty must disclose to the participants any relationships with commercial companies whose products or devices may be mentioned in faculty presentations, or with the commercial supporter of this CE activity. Howard University College of Medicine and CME Outfitters, LLC, have evaluated, identified, and attempted to resolve any potential conflicts of interest through a rigorous content validation procedure, use of evidence-based data/research, and a multidisciplinary peer review process. The following information is for participant information only. It is not assumed that these relationships will have a negative impact on the presentations.

Dr. Norquist has no disclosures to report.

Dr. Fortney has no disclosures to report.

Unlabeled Use Disclosure

Faculty of this CE activity may include discussions of products or devices that are not currently labeled for use by the FDA. The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational uses (any uses not approved by the FDA) of products or devices.

Howard University College of Medicine, CME Outfitters, LLC, the faculty, and Lilly USA, LLC, do not endorse the use of any product outside of the FDA labeled indications. Medical professionals should not utilize the procedures, products, or diagnosis techniques discussed during this activity without evaluation of their patient for contraindications or dangers of use.

Activity Slides

The slides that are presented in this activity are available for download and printout at the neuroscienceCME website: **www.neuroscienceCME.com.** Activity slides may also be obtained via fax or email by calling **877.CME.PROS**.

Abbreviation List

ACT	Assertive Community Treatment
AHCPR	Agency for Health Care Policy and Research
AHRQ	Agency for Healthcare Research and Quality
APN	Advanced practice nurse
FDA	Food & Drug Administration
HRSA	Health Resources and Services Administration
LPC	Licensed professional counselor
MH	Mental health
NCS-R	National Comorbidity Study Replication
NHIS	National Health Interview Survey
OMB	Office of Management and Budget
RAC	Rural Assistance Center
SAMHSA	Substance Abuse and Mental Health Services Administration
USDA	United States Department of Agriculture

This activity is co-sponsored by CME Outfitters, LLC, and Howard University College of Medicine, Office of Continuing Medical Education.

This activity is supported by an educational grant from Lilly USA, LLC. For further information concerning Lilly grant funding, visit www.lillygrantoffice.com.

Improving the Care of People with Mental Illness in Rural Areas

Supported by an educational grant from Lilly USA, LLC. For further information concerning Lilly grant funding, visit www.lillygrantoffice.com.

Moderator:
Grayson S. Norquist, MD, MSPH

Professor and Chairman
Department of Psychiatry
and Human Behavior
University of Mississippi Medical Center
Jackson, MS

Grayson S. Norquist, MD, MSPH
Disclosures

- Dr. Norquist has no disclosures to report

John C. Fortney, PhD

Professor, Department of Psychiatry
and Behavioral Sciences
Assistant Professor, Department of Health Policy
& Management, College of Public Health
Director, Division of Health Services Research,
Department of Psychiatry
University of Arkansas for Medical Sciences

Research Health Scientist
Central Arkansas Veterans Healthcare System

Associate Director for Research
VA South Central MIRECC

Little Rock, AR

John C. Fortney, PhD
Disclosures

- Dr. Fortney has no disclosures to report

The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational uses (any use not approved by the FDA) of products or devices.

Howard University College of Medicine/Howard University Hospital, CME Outfitters, and their staffs are not responsible for injury or illness resulting from the use of medications or modalities discussed during this educational activity.

Learning Objectives

- Recognize specific challenges and barriers in treating mental illness in rural and underserved populations
- Identify opportunities for collaboration among healthcare providers to improve access to mental health services
- Integrate technology into mental health diagnosis and management strategies to improve access and patient outcomes

The course guide for this activity includes slides, disclosures of faculty financial relationships, and biographical profiles.

For additional copies of these materials, please visit neuroscienceCME.com/435 or call 877.CME.PROS.

To receive CE credits for this activity, participants must complete the post-test and evaluation online at neuroscienceCME.com/test.

neuroscience CME

Improving the Care of People with Mental Illness in Rural Areas

Supported by an educational grant from Lilly USA, LLC. For further information concerning Lilly grant funding, visit www.lillygrantoffice.com.

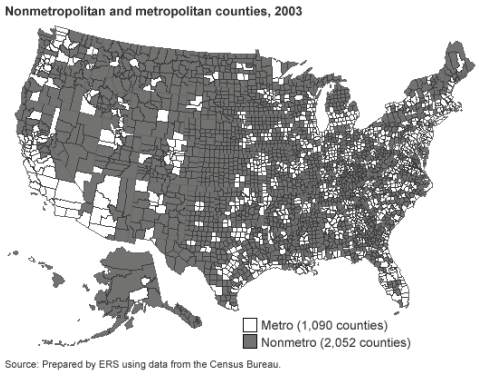
Learning Objectives

- Recognize specific challenges and barriers in treating mental illness in rural and underserved populations
- Identify opportunities for collaboration among healthcare providers to improve access to mental health services
- Integrate technology into mental health diagnosis and management strategies to improve access and patient outcomes

Learning Objective 1

Recognize specific challenges and barriers in treating mental illness in rural and under-served populations

Rural America



Rural-Urban Differences in Prevalence of Psychiatric Disorders

- National Comorbidity Study Replication (NCS-R)
  - No significant rural-urban differences in the 12-month prevalence of psychiatric disorders[1]
- National Health Interview Survey (NHIS)
  - No significant rural-urban difference in 12-month prevalence of major depressive disorder[2]

1. Kessler RC, et al. *Arch Gen Psychiatry* 2005;62:617-627.
2. Probst JC, et al. *Fam Med* 2006;38:653-660.

Quality of Care

- Receipt of adequate care is associated with better outcomes for depression[1]
- A third of patients with depression/ anxiety disorders receive adequate care[2]
- Receipt of adequate care is significantly greater in specialty settings than primary care[2,3]
- Travel time to providers is significant predictor of receiving adequate care[3]

1. Fortney J, et al. *Psychiatr Serv* 2001;52:56-62.
2. Young AS, et al. *Arch Gen Psychiatry* 2001;58:55-61.
3. Fortney J, et al. *Med Care* 1999;37:884-893.

How Is Rural Defined by the Federal Government?

- OMB Metropolitan and Micropolitan Statistical Areas
  - The basic unit of these statistical areas is the county
  - Metropolitan statistical areas
    - Core urban area with a population of 50,000
    - A micropolitan area contains an urban area with a population of 10,000 (but less than 50,000)
    - All other areas are considered rural
- Census Bureau's Urbanized Area or Urban Cluster
  - The Census Bureau designates census tracts—blocks or block groups—into urbanized areas and urbanized clusters
  - Urbanized areas have cores with populations of 50,000 or more, urban clusters have cores with populations ranging from 2500 to 49,900
  - All other areas are rural
- USDA Definitions
  - Rural Urban Continuum Codes - Classifies U.S. counties by urbanization and nearness to a metropolitan area
  - Rural Urban Commuting Area Codes - Classifies U.S. census tracts using measures of urbanization, population density, and daily commuting
  - Urban Influence Codes - Classifies U.S. counties by size of the largest city and nearness to metropolitan and micropolitan areas

OMB= Office of Management and Budget

What Does Rural Really Mean?

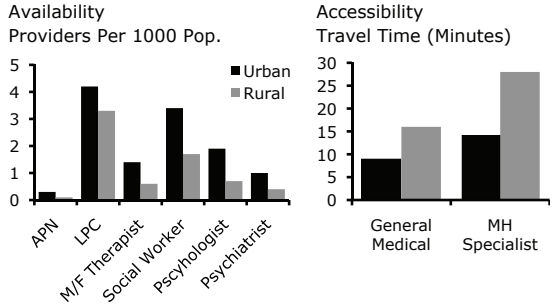
- "Rural" is not just about population density
- Complex multi-dimensional concept:
  - Socio-demographics
  - Access to care
  - Social networks
  - Culture (attitudes, beliefs, preferences, norms)

Rural-Urban Differences in Socio-Demographics

- Lower incomes[1,2]
- Lower educational levels[1,2]
- Older[1,3]

1. Ricketts TC III, et al. 1999. Populations and places in rural America. In: Rural Health in the United States. New York: Oxford University Press: 7-24.
2. Baugher E, Lamison-White L. 1996. Poverty in the United States: 1995. Washington, D.C.: U.S. Department of Commerce, Bureau of the Census.
3. Norton CH, McManus MA. *Health Serv Res* 1989;23:725-756.

Rural-Urban Differences in Geographic Access



APN = Advanced Practice Nurse; LPC = Licensed Professional Counselor; MH = Mental Health

Ellis A, et al. *Psychiatr Serv* 2009;60:1315–1322.

Rural-Urban Differences in Social Networks

- Social networks comprise family members, friends, neighbors, and co-workers with whom individuals interact/communicate on a regular basis
- In rural areas, social networks are more likely to be:
  - Smaller
  - Denser
  - Of greater duration, i.e., individuals in a person's social network remain part of the network for a longer period of time
- Rural social networks may have a larger impact on help seeking

Rural-Urban Differences in Culture

- Culture represents shared values and behaviors
- Rural culture may:
  - Delay identification/awareness of mental health problems
  - Discourage use of formal services
  - Encourage use of informal services (e.g., ministers, traditional healers)
- Rural culture may result in greater:
  - Self reliance
  - Stoicism
  - Stigma

Stigma

- Public stigma - general public's perception of labeled individuals including:
  - Prejudicial attitudes
  - Discriminatory behaviors
- Provider stigma - providers' negative perceptions that result in:
  - Delivering fewer services
  - Delivering lower quality services
- Self-stigma - internalization of public and provider stigma

Rural-Urban Differences in Stigma

- Stigma is a greater barrier to treatment in rural areas[1,2]
- Why?
  - *Public* stigma is the same in rural and urban[3]
  - *Provider* stigma is the same in rural and urban[3]
  - *Self*-stigma is likely the same in rural and urban
  - Anonymity is lower in rural than urban[1,3,4]

1. Hoyt DR, et al. *Am J Community Psychol* 1997;25:449-470.
2. Rost K, et al. *J Rural Health* 1993;9:57-62.
3. Fortney J, et al. *J Behav Health Serv Res* 2004;31:418-429.
4. Rost K, Fortney J, et al. *J Rural Health* 1999;15:308-315.

Learning Objective 2

Identify opportunities for collaboration among healthcare providers to improve access to mental health services

Primary Care

- Advantages
  - Primary care providers are available and accessible in rural areas
  - The primary care setting is less stigmatizing for patients
- Disadvantages
  - Large panel sizes and lack of time during encounters
  - Lack of resources and expertise in mental health treatment
  - Competing demands of acute and chronic physical health illnesses

Practice-Based Collaborative Care

- 20/28 randomized trials of collaborative care significantly improved depression outcomes[1]
- Components of collaborative care[2]
  - Patient screening
  - Patient education, activation, and self-management
  - Regularly scheduled follow-up assessments
  - Delegation of key clinical activities to non-physicians
  - Ready access to mental health specialists

1. Williams J, et al. *Gen Hosp Psychiatry* 2007;29:91-116.
2. VA Health Administration. Collaborative Care for Depression in the Primary Care Setting. A Primer on VA's Translating Initiatives for Depression into Effective Solutions (TIDES) Project. 2008.

Learning Objective 3

Integrate technology into mental health diagnosis and management strategies to improve access and patient outcomes

Telemedicine

- Satisfaction for interactive video is similar to face-to-face[1,2]
- Diagnostic reliability is equivalent between interactive video and face-to-face[3,4]
- Pharmacotherapy is equivalent between interactive video and face-to-face[5]
- Psychotherapy is equivalent between interactive video and face-to-face[6]

1. Monnier J, et al. *Psychiatr Serv* 2003;54:1604-1609.
2. Rohland BM, et al. *Psychiatr Serv* 2000;51:672-674.
3. Shore JH, et al. *Am J Psychiatry* 2007;164:115-118.
4. Frueh BC, et al. *Psychiatr Serv* 2000;51:1522-1527.
5. Ruskin PE, et al. *Am J Psychiatry* 2004;161:1471-1476.
6. Bouchard S, et al. *Telemedicine Journal & e-Health* 2004;10:13-25.

Telemedicine Referral Model

- Rural primary care providers refer patients for diagnosis and treatment to urban mental health specialists
  - Routine in the Department of Veterans Affairs
    - Facilitated by shared electronic medical record
  - Reimbursed by Medicare and Medicaid (varies from state to state)
  - Costs continue to decline
    - Interactive video equipment
    - T1 line monthly charges

Telemedicine-Based Collaborative Care

- Practice-based collaborative care is effective in urban clinics (with mental health specialists), but not rural practices (without mental health specialists)[1]
- Telemedicine-based collaborative care involves off-site mental health specialists collaborating with rural primary care providers via telephone, internet, electronic medical records, and interactive video
  - Telemedicine-based collaborative care for depression is superior to usual care[2]
  - Telemedicine-based collaborative care for depression is superior to practice-based collaborative care (without MH specialists)[3]

1. Adams S, et al. *J Rural Health* 2006;22:343-50.
2. Fortney JC, et al. *J Gen Int Med* 2007;22:1086-1093.
3. Fortney J, Pyne J. Comparative Effectiveness Study of Rural Collaborative Care Models: The Outreach Study, NIMH Mental Health Research Conference, Increasing the Efficacy of Research and Mental Health Services Delivery, Washington, DC, July 2009.

Expanded Opportunities for Telemedicine

- Workforce development
  - Training
  - Support
- Improved care
  - Expanded models
    - Virtual ACT teams
  - Continuity of care
  - Consumer peer support

Telemedicine Summary

- Focus on primary care setting (de-stigmatizing)
- Telemedicine referral model
- Telemedicine-based collaborative care model
- Rural workforce development
- Telemedicine facilitated peer support programs

Key Points

- Rural/urban differences
  - Socio-demographic
  - Geographic access
  - Social networks
  - Stigma, i.e., barriers to seeking care and perceived privacy
- Practice-based collaborative care
- Telemedicine
  - Referral model
  - Collaborative care model
  - Workforce development

Resources

- Agency for Healthcare Research and Quality (AHRQ) – Improving health care for rural populations
  - http://www.ahrq.gov/research/rural.htm
  - AHCPR national workshops for State and local health policymakers
- Rural Assistance Center (RAC)
  - http://www.raconline.org/info_guides/mental_health/
- Substance Abuse and Mental Health Services Administration (SAMHSA) National Mental Health Information Center
  - Mental health providers in rural or isolated areas
  - http://mentalhealth.samhsa.gov/publications/allpubs/SMA98-3166/
- Health Resources and Services Administration (HRSA)
  - Telemental Health: Delivering Mental Health Care at a Distance, A Summary Report
  - http://www.hrsa.gov/telehealth/pubs/mental.htm

Bibliography

Adams S, Xu S, Dong F, Fortney J, Rost K. Differential effectiveness of depression disease management for rural and urban primary care patients, *J Rural Health* 2006;22:343-350.

Baugher E, Lamison-White L. *Poverty in the United States: 1995*. Washington, DC: U.S. Department of Commerce, Bureau of the Census; 1996.

Bouchard S, Paquin B, Payeur R, et al. Delivering cognitive-behavior therapy for panic disorder with agoraphobia in videoconference. *Telemed J E Health* 2004;10:13-25.

Ellis A, Konrad T, Thomas K, Morrissey J. County-level estimates of mental health professional supply in the United States. *Psychiatr Serv* 2009;60:1315-1322.

Fortney J, Harman J, Xu S. The association between rural residence and the use, type, and quality of depression care. *J Rural Health* 2009;in press.

Fortney J, Mukherjee S, Curran G, Fortney S, Han X, Booth B. Factors associated with perceived stigma for alcohol use and treatment among at-risk drinkers. *J Behav Health Serv Res* 2004;31:418-429.

Fortney J, Pyne J. Comparative Effectiveness Study of Rural Collaborative Care Models: The Outreach Study. Presented at: NIMH Mental Health Research Conference, Increasing the Efficacy of Research and Mental Health Services Delivery, Washington, DC, July 2009.

Fortney J, Rost K, Zhang M. The impact of geographic accessibility on the intensity and quality of depression treatment. *Medical Care* 1999;37:884-893.

Fortney J, Rost K, Zhang M, Pyne J. The relationship between quality and outcomes in routine depression care. *Psychiatr Serv* 2001;52:56-62.

Fortney JC, Pyne JM, Edlund MJ, et al. A randomized trial of telemedicine-based collaborative care for depression. *J Gen Intern Med* 2007;22:1086-1093.

Frueh BC, Deitsch SE, Santos AB, et al. Procedural and methodological issues in telepsychiatry research and program development. *Psychiatr Serv* 2000;51:1522-1527.

Hoyt DR, Conger RD, Valde JG, Weihs K. Psychological distress and help seeking in rural America. *Am J Community Psychol* 1997;25:449-470.

Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 2005;62:617-627.

Monnier J, Knapp RG, Frueh BC. Recent advances in telepsychiatry: an updated review. *Psychiatr Serv* 2003;54:1604-1609.

Norton CH, McManus MA. Background tables on demographic characteristics, health status, and health services utilization. *Health Serv Res* 1989;23:725-756.

Probst JC, Laditka SB, Moore CG, Harun N, Powell MP, Baxley EG. Rural-urban differences in depression prevalence: implications for family medicine. *Fam Med* 2006;38:653-660.

Ricketts TC III, et al. Populations and Places in Rural America. In: *Rural Health in the United States*. New York, NY: Oxford University Press: 1999, 7-24.

Rohland BM, Saleh SS, Rohrer JE, Romitti PA. Acceptability of telepsychiatry to a rural population. *Psychiatr Serv* 2000;51:672-674.

Rost K, Fortney J, Zhang M, Smith J, Smith GR Jr. Treatment of depression in rural Arkansas: policy implications for improving care. *J Rural Health* 1999;15:308-315.

Rost K, Smith GR, Taylor JL. Rural-urban differences in stigma and the use of care for depressive disorders. *J Rural Health* 1993;9:57-62.

Ruskin PE, Silver-Aylaian M, et al. Treatment outcomes in depression: comparison of remote treatment through telepsychiatry to in-person treatment. *Am J Psychiatry* 2004;161:1471-1476.

Shore JH, Savin D, Orton H, Beals J, Manson SM. Diagnostic reliability of telepsychiatry in American Indian veterans. *Am J Psychiatry* 2007;164:115-118.

Veterans Health Administration. Collaborative Care for Depression in the Primary Care Setting. A Primer on VA's Translating Initiatives for Depression into Effective Solutions (TIDES) Project. 2008. Available at: http://www.hsrd.research.va.gov/publications/internal/depression_primer.pdf.

Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 2005;62:629-640.

Williams JW Jr, Rost K, Dietrich AJ, Ciotti MC, Zyzanski SJ, Cornell J. Primary care physicians' approach to depressive disorders. Effects of physician specialty and practice structure. *Arch Fam Med* 1999;8:58-67.

Young AS, Klap R, Sherbourne CD, Wells KB. The quality of care for depressive and anxiety disorders in the United States. *Arch Gen Psychiatry* 2001;58:55-61.