

Network Notes

News and Updates for UBH Contracted Clinicians

Spring 2007

In This Issue: Updates pg. 2 | The Beginning of ALERT® pg. 4 | Health Plan Partnership Updates pg. 7 | Clinical Learning Updates pg. 8 | Resources For You pg. 9

VP Corner

By Michelle Brennan-Cooke, Ph.D.

After a year of growth in 2006, United Behavioral Health is well underway toward a successful integration of Arnett Health Plan, Neighborhood Plan, MAMSI, Oxford, and PacifiCare. In addition to these health plans, the following customers joined UBH: Capital District Physicians' Health Plan (CDPHP), Geisinger Health Plan, HealthAmerica and HealthAssurance, Railroad Employees National Health and Welfare Plan, the State Health Benefit Plan (SHBP) of Georgia, Southern Health Services, Inc., Wells Fargo, and many others.

Let me take this opportunity to say again how much we appreciate the role that you play in helping members reach their health and wellness goals. I will outline here some of what you can expect in this exciting new year of initiatives at UBH.

While maintaining a solid base in MH/SA and EAP services, 2007 brings an expansion into the public sector. With TennCare in middle Tennessee, UBH will offer a host of new services in the Medicaid arena. We are also working closely with our sister

organizations: Evercare, AmeriChoice and SecureHorizons. You will also see developments in the LifeSolutions Program and a greater emphasis on the coordination of care in the area of co-morbid behavioral and medical conditions.

Adjustments are being made in several areas of UBH/Clinician interfaces to accommodate the rollout of the National Practitioner Identifier (NPI) in compliance with HIPAA. You'll find more detail regarding these changes in this edition of Network Notes.

This year the Clinical Learning Department is offering an outcomes-focused curriculum. You'll see opportunities to learn more about outcomes-based strategies in treatment. Most of these programs are free and are available in multiple formats for your convenience. A few select programs are available exclusively to UBH network clinicians. Courses on law and ethics are also offered to help you meet your ongoing licensing requirements. The 2007 CEs are presented in detail in this edition of Network Notes.



Our outcomes assessment program, ALERT® is our best answer yet to the question of transparency in a consumer-driven health care market. We are excited to share this process with you. July 1st will begin the national implementation of this project focusing on treatment outcomes. On a broader scale, we are moving toward an active program of evaluating treatment outcomes and clinical success. As you strive to maintain the highest quality interventions, customers and members are seeking to make informed decisions. Using a composite of information, we will be able to share with potential new clients the value of UBH behavioral health treatment. The Clinician Quality Index (CQI) is presently in the early stages and we will be working closely with you on the development and roll out.

As always, we value your contribution in our efforts to show the quality in the services you provide.

May 23, 2007 National Provider Identifier (NPI) Deadline is Fast Approaching!

Beginning May 23, 2007, UBH-contracted clinicians who file electronic claims will be required to include NPI information on those electronic claims, in compliance with the Health Insurance Portability and Accountability Act (HIPAA). In addition to all electronically submitted claims, some states (including MN and AZ) mandate that the NPI be used on **all** claims (whether paper or electronic submission is used). Failure to submit NPI information on any Medicare or Medicaid claim (paper or electronic) after May 23, 2007 may result in delayed claims payment.

Obtaining Your NPI

You may apply for an NPI online at <https://nppes.cms.hhs.gov>. For a paper application, call 1-800-465-3203 (or TYY 1-800-692-2326), send an e-mail to customerservice@npienumerator.com, or mail a request to the following address.

NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059

Sending Your NPI to UBH

Once your NPI is obtained, we urgently need you to send us your NPI information in order to update our systems and ensure prompt, efficient claims payment. Visit www.ubhonline.com and look for the bullet point in the "what's new" section entitled "UBH's Adoption and Use of National Provider Identifier (NPI)". Click on the link marked "Learn more" to open the NPI resource page. In the Forms section, locate the NPI Clinician Data Collection Form or the NPI Facility Data

Collection Form, whichever is applicable. Once you have completed the form, please fax it to the number listed on the form **as soon as possible**. To ensure uninterrupted quality service to you and our members, UBH made a business decision to initially accept transactions sent to us without NPI information or with incorrect NPI information. We are considering a timeframe after which we will reject transactions that come in without complete NPI labeling. Analysis of this timeframe will partially be based on the overall industry readiness and implementation of NPI for the May 23, 2007 compliance date. We will notify you and our business partners regarding any changes to our current policy for accepting transactions without NPI.

Revised Claims Forms

The National Uniform Claim Committee (NUCC) has revised the CMS-1500 Claim Form. This new version of the CMS-1500 includes fields for the reporting of NPI information. This version should be used by all clinicians submitting paper claims starting June 1, 2007.

The NUCC has also released the UB-04 Claim Form, which is replacing the UB-92 Claim Form. Facilities were able to begin using the UB-04 on March 1, 2007 during the initial transition period. This form should be used by all facilities beginning no later than May 23, 2007.

Getting an NPI is FREE – Not Having One Can Be Costly.

Do You Have Expertise in Autism Spectrum Disorders?

UBH is engaged in a unique initiative that provides health care coverage for the treatment of Autism Spectrum Disorders under a supplemental benefit plan for a national customer. We are excited at the opportunity to provide an industry-leading comprehensive approach to autism treatment, and our network's expertise in this area is essential to its success.

The UBH network consists of 3,400 clinicians identified as specialists in Pervasive Developmental Disorders. For this project we are interested particularly in experience in the assessment and treatment of Autistic Disorder. We would love to hear from you regarding your autism expertise and the various treatment modalities you utilize. We welcome your input and appreciate the services you may be able to provide in the implementation of this exciting initiative.

If you are interested in learning more about this opportunity, please contact UBH at rmreed@uhc.com to discuss your autism expertise and your participation in this essential project.

Screening for Common Behavioral Health Concerns

Employers are increasingly concerned with behavioral health services for their employees. One sign of this emphasis is that the National Business Coalition on Health utilizes eValue8 in an effort to quantify up-to-date information that will drive value-based purchasing for the business consumer. This tool is presently geared toward assessing managed care companies in the areas of screening for depression and the misuse of alcohol. UBH and PBH also now participate in this measure. To this end, presented here for your consideration are two sensitive and specific screens that are accurate and easy to use.

The Whooley Screen (Whooley et al., 1997) uses two simple questions to identify people with depressive symptoms:

1. During the past month, have you often been bothered by feeling down, depressed or hopeless?
2. During the past month, have you often been bothered by little interest or pleasure in doing things?

An answer of YES to either question may indicate possible depression.

The CAGE-AID screen for alcohol and other drug abuse (Brown & Rounds, 1995) includes four questions to identify chemical dependency issues:

1. Have you ever felt you should **cut down** on your drinking or drug use?
2. Have people **annoyed** you by criticizing your drinking or drug use?
3. Have you ever felt bad or **guilty** about your drinking or drug use?

4. **Eye opener:** Have you ever had a drink or use drugs first thing in the morning to steady your nerves or to get rid of a hangover?

Answers of YES for two or more questions are considered a positive test and indicate further assessment is warranted.

You may direct questions or comments about this article to Anthony Heath, Ph.D., Director of Quality Improvement, UBH Chicago. You may contact him at anthony_w_heath@uhc.com.

References

- Brown, R.L., and Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal* 94:135-140, 1995.
- Whooley MA, Avins AL, Miranda J, Browner WS. Case-finding instruments for depression: Two questions are as good as many. *J Gen Intern Med* 1997; 12: 439-45.

Measuring Therapy Techniques in Depression Treatment

UBH is pleased to announce results from the second and final stage of the Outpatient Depression Care study conducted by the Behavioral Health Science Department. This study, originally launched in 2004, was conducted in partnership with the MacArthur Foundation and the RAND Corporation to understand the variety of psychotherapy techniques UBH clinicians' use for treatment of Depression in adults. There is relatively little research to guide quality improvement for psychotherapy in the private mental health sector, so the study breaks new ground in attempting to assess commonly used psychotherapy techniques among evidence-based practices.

The first phase of the study involved developing and testing, with over 700 high volume network clinicians, a new survey that measured the frequency with which clinicians used cognitive-behavioral (CBT), interpersonal (IPT), and psychodynamic (DT) techniques in the course of treating adults with Depression. The survey was modified in the second phase to survey members (and clinicians) in order to get both perspectives. In sum, psychometric

results on the clinician scale replicated the original findings reported in the Spring 2006 edition of Network Notes.

The second phase began in March 2006. We identified members who recently were diagnosed with Major Depression, and who were being treated by a high-volume network clinician (MDs, PhDs, and MSWs). We found over 2400 eligible member and clinician dyads. We first surveyed all eligible members, but we only surveyed clinicians for whom we had member permission to contact. Surveys were returned by over 400 members (17.4% response rate), and by 159 clinicians (47.9% response rate).

Of the adult depressed members, 70% were female, 54% were 35-55 years old, 46% were college graduates, and 73% were White. Psychometric results of the three scales (CBT, IPT, and DT) were promising for both a long (30 items) and a short (16 items) version of the member tool (reliability coefficients ranging from .75 to .94). An important preliminary finding showed that member reports were reasonably similar to clinician reports. For example, there were strong positive

associations between member and clinician reports for CBT items found in both tools. Furthermore, members whose clinicians reported the highest use of CBT techniques also had the highest CBT scale scores.

Among the high-volume network clinicians, 64% were female, 70% were 55 years old or younger, 71% were MSWs (12% were M.D.s, and 17% were Ph.D.s), and average years practice was 15.4. Fifty percent of clinicians reported that their primary orientation was CBT, 12% DT, 9% IPT, and 29% were eclectic/integrative. Psychometric results of the three scales (CBT, IPT and DT) were also promising for the clinician tool (reliability coefficients ranged from .73 to .82). CBT-oriented clinicians scored highest on the CBT scale (and lowest on the DT scale) compared to other clinicians. Similarly, DT-oriented clinicians scored highest on the DT scale (and lowest on the CBT scale) compared to other clinicians.

Currently, we are conducting final psychometric analyses of the member and the clinician tools, as well as examining any possible correlation between CBT, IPT

and DT scale scores with quality-of-care indicators (e.g., number of sessions and therapeutic alliance). These results taken together with our earlier findings will add to the understanding of the quality of evidence-based practices. This in turn will aid UBH in its overall quality improvement initiatives in an effort to ensure quality of care and positive outcomes. You can find more information about this study by contacting BHS, Greg Greenwood, Research Scientist at gregory_l_greenwood@uhc.com, or 415-547-5427.

New! Clinician Quality Index

UBH/PBH will launch the Clinician Quality Index (CQI) in 2007. CQI involves a system to collect quality indicators for the purpose of establishing benchmarks for the network. In today's highly competitive healthcare environment, transparency is in high demand. Initial data to be taken into consideration will include utilization and population data, claims submission and best practice adherence. In addition, CQI will

monitor ALERT participation and will eventually include patient outcome data. The clinician composite will be available to you this year. Ultimately it will be available for consumers to make better informed behavioral health choices.

Clinician feedback is crucial, and we will offer several avenues for you to provide your input on this new initiative. Together, we can position UBH and our contracted clinicians as the source for high quality clinical service in the consumer-driven marketplace.

July 1, 2007 Marks the Beginning of ALERT®

ALERT (Algorithms for Effective Reporting and Treatment) goes beyond the PacifiCare Health System's ALERT program and UBH's Enhanced Outpatient Model. The new ALERT program is a strong combination of these two models, creating a new approach to managed care that is consumer-driven, outcomes-based and supports cost-effective treatment decisions.

The system, now being piloted in select markets, utilizes member responses to a validated survey tool, the one-page Wellness Assessment (WA). Claims data is also incorporated. This information provides a baseline measure of member functioning

to help reflect change in member function over time. It is also processed to determine a member's behavioral health status in relation to a set of algorithms. These algorithms support the identification of members who may be at moderate to high risk for poor clinical outcomes.

The main process factors are as follows:

- The one-page WA is completed in your office at several points in treatment.
- Member responses are processed along with claims through our unique set of algorithms designed to screen for certain behavioral health risks.

- Care Advocate outreach will occur if any risk for the member is identified; you will receive an ALERT letter or a phone call, depending on the identified risk.

You will soon be receiving a letter regarding the introduction of ALERT. Teleconferences are scheduled to provide further details about ALERT (see below). Registration is available at www.ubhonline.com or by calling 1-800-287-9849, ext 3494. General information and Wellness Assessment forms will be available at ubhonline.com in May in preparation for the July effective date. For specific questions or concerns, contact Network Management.

Date	Time	Phone Number
June 19, 2007	12:00 P.M. EDT/ 11:00 A.M. CDT/ 9:00 A. M. PDT	1-800-552-8408
June 28, 2007	2:00 P.M. EDT/ 1:00 P.M. CDT / 11:00 A.M. PDT	1-800-552-8408
July 10, 2007	12:00 P.M. EDT / 11:00 A.M. CDT / 9:00 A.M. PDT	1-800-552-8408
July 20, 2007	2:00 P.M. EDT / 1:00 P.M. CDT / 11:00 A.M. PDT	1-800-552-8408

We are committed to partnering with you to achieve optimal therapeutic outcomes for the individuals we mutually serve. We appreciate your continued dedication in providing quality clinical services to achieve the best outcomes.

Outcomes-Informed Curriculum — Teleconferences and Self Study Programs

UBH is offering a 17-hour curriculum on outcomes-informed clinical interventions in support of our new consumer-directed, outcomes-based clinical model. The curriculum includes five of this year's lectures delivered by teleconference, five self-study programs based on published research, and two CD-ROMs. You may register for the teleconferences and order the CD-ROMs by accessing the "clinical learning" link on www.ubhonline.com. UBH network clinicians who are registered users of ubhonline can access the self-study programs from the secured section of the site. To register for ubhonline, please call the ubhonline support center toll free at 1-866-209-9320 from 7:00 am to 9:00 pm Central time to request your user ID and password.

Effective Treatment of ADHD

Attention-Deficit/Hyperactivity Disorder (ADHD) is one of the most commonly diagnosed childhood behavioral health disorders; affecting an estimated three to nine percent of school-age children. These children exhibit inattentiveness and may also appear hyperactive and impulsive. Many children exhibit these common behaviors periodically, but a child with ADHD exhibits these behaviors persistently, intensely, and in a variety of settings. Boys are diagnosed with ADHD between two and three times as often as girls. Symptoms are usually first noticed in preschool or early elementary school years. The effects of this disorder frequently persist into adolescence and adulthood. ADHD is often associated with other conditions, such as Mood and Anxiety Disorders, Conduct Disorder, Substance-related Disorders, and Personality Disorders, such as Antisocial Personality Disorder.

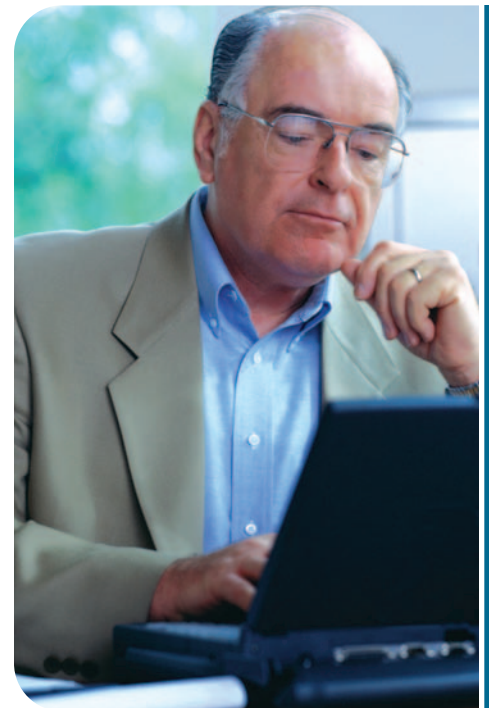
The appropriate diagnosis of ADHD requires a comprehensive medical evaluation to rule out potential physical conditions. The reliability of diagnosing ADHD improves when appropriate guidelines are used, and when additional history is collected from both parents and teachers.

Treatment works best with a team approach when behavioral health clinicians, doctors, parents, teachers, and other healthcare professionals, along with the family and child, all work together. The treatment plan usually includes behavioral therapy, medication, parent training, and education. This combination aids the child to focus his or her attention and to control any behavior issues. It is important to monitor the child's progress. Visits with a behavioral health clinician are recommended at least monthly until optimal results are achieved.

For participating health plans, the National Committee for Quality Assurance (NCQA) rates performance on the following HEDIS measures for children with ADHD between 6-12 years old:

- The percentage with a new prescription dispensed for ADHD medication that had one follow-up visit with a practitioner with prescriptive authority within 30 days of the initiation of treatment (Initiation Phase)
- The percentage with a prescription dispensed for ADHD medication that remained on the medication for at least 210 days and had at least two additional follow-up visits with a practitioner within nine months after the Initiation Phase ends

For ADHD information and resources, including Best Practice Guidelines and the UBH Mental Health Condition Center on ADHD, visit www.ubhonline.com.



Antidepressant Medication Management: Improving Treatment Adherence

While Depression is the most common behavioral health condition affecting adults, it is also the most treatable. The National Committee for Quality Assurance (NCQA) has established a set of measures to monitor treatment adequacy for patients diagnosed with Depression who are prescribed antidepressant medication. These measures promote follow-up care in conjunction with medication management, are based on established research, and are reflected in many treatment guidelines. The indicators of adherence are:

- The percentage of patients that receive three follow-up visits in the 84-day period after starting on antidepressant medications (at least one of the follow-up

visits needs to be with the prescribing clinician, but the other two can be with a therapist or counselor)

- The percentage of patients that stay on the antidepressant medication for at least 84 days
- The percentage of patients that stay on the antidepressant medication for at least 180 days

A major barrier to treating Depression is patient non-compliance with treatment recommendations made by the prescribing clinician. One way to increase patient compliance is through education at the beginning of the treatment episode. Patients need to understand the following:

- How antidepressants work
- The benefits of antidepressant treatment and the expectation of remission of symptoms
- How long the medications should be used
- Coping with side effects of the medication

In addition, prescribing clinicians making referrals to therapists or counselors early in the treatment episode addresses the recommended three follow-up contacts within 84 days. This also encourages the compliance of patients in taking the antidepressants as prescribed.

Inpatient Discharge Follow-up

Timely follow-up after hospitalization promotes continuity of care and supports a member's return to baseline functioning. That's why the National Committee for Quality Assurance (NCQA), in collaboration with health-care purchasers, established HEDIS measures for follow-up after hospitalization for mental illness. Participating health plans are rated nationally and regionally according to their performance on these measures:

- Follow-up with a behavioral health clinician within seven days of discharge
- Follow-up with a behavioral health clinician within 30 days of discharge

Follow-up within seven days is optimal. Care Advocates work closely with hospital discharge planners to ensure that before a member leaves the hospital, a timely post-discharge follow-up appointment has been scheduled with a clinician. This is especially important for those members who did not have a relationship with a behavioral health clinician prior to their hospital admission. Without this prior relationship, an initial appointment may otherwise be difficult to obtain in a seven-day time period.

We appreciate the efforts of behavioral health clinicians to accommodate requests for appointments within seven days of discharge from psychiatric hospitalization. Your partnership with us in this initiative helps to improve the lives of the individuals we mutually serve.



Prompt Notification of Changes to Your Practice

This is a reminder that you should notify UBH in writing within ten calendar days of any changes to:

- The status of your practice, including changes in practice location, billing address, telephone or fax number (or changes in facility ownership)
- The status of your professional licensure and/or certification such as revocation, suspension, restriction, probation, termination, reprimand, inactive status, voluntary relinquishment, or any other adverse action
- The status of your professional liability insurance
- Your potential legal standing (any malpractice action or notice of licensing board complaint filing)
- Your Tax Identification Number (TIN) used for claims filing
- The programs you offer (services you provide must continue to meet our credentialing criteria)

Your information can be updated either:

- Online at www.ubhonline.com (click on update practice info" link on the right side of the home page)
- By fax at 763-732-6260
- By mail to
UBH Clinical Network
Services – Updates
P.O. Box 1459
Minneapolis, MN 55440-1459

You may also contact the Network Management for your state to provide your updated information.

Level of Care Guidelines Notification

PBH has adopted new Level of Care Guidelines effective April 15, 2007. If you have not already done so, please take a moment to review them. Level of Care Guidelines are used to assist in clinical decision-making and coverage determinations. The guidelines can be found at www.ubhonline.com under the heading "clinical resources". Select "guidelines/policies" and scroll down to the Level of Care Guidelines.

For authorization and claims submission, please continue to refer to the member's health plan identification card for the appropriate contact information.

Member Initiated Certification Online

Beginning April 5, 2007 UBH is introducing Member Online Certification for routine, outpatient, in-network behavioral health services prior to receiving those services. You may accept members presenting a computer-printed certification with confirmation numbers. Check www.ubhonline.com for details, and advise your intake staff to watch for these new documents.

Health Plan Partnership Updates

Non-Discrimination of UBH and PBH Members

All UBH and PBH members will be provided care in the same manner, on the same basis, and in accordance with the same standards offered to all other patients. Covered services will be available and accessible to all members, independent of rates of reimbursement.



Free Clinical Learning Seminars in 2007

You are invited to participate in our upcoming teleconference seminars for behavioral health clinicians. These seminars contribute to UBH's effort to provide clinically effective, evidence-based solutions that improve the well-being of the individuals we jointly serve.

Recognized and approved by APA, NASW, NBCC, and several state nursing boards, these learning programs adhere to UBH's strict clinical standards and are presented by industry leaders in behavioral health.

Decreasing Morbidity through Behavioral Health Interventions: Collaborating with Medical Providers

Carl Isihara, M.D.

Tuesday, May 1, 2007 4:00 pm Eastern,
3:00 pm Central and 1:00 pm Pacific

Thursday, May 17, 2007 4:00 pm Eastern,
3:00 pm Central and 1:00 pm Pacific

Chronic Pain: An Overview of Effective Behavioral Health Interventions

Kimeron Hardin, Ph.D.

Monday July 9, 2007 12:00 noon Eastern,
11:00 am Central and 9:00 am Pacific

Wednesday July 25, 2007 12:00 noon Eastern,
11:00 am Central and 9:00 am Pacific

The Empirical Evidence: What Works in Therapy

Scott Miller, Ph.D.

Monday July 16, 2007 3:00 pm Eastern,
2:00 pm Central and 12:00 noon Pacific

Monday July 30, 2007 3:00 pm Eastern,
2:00 pm Central and 12:00 noon Pacific

Translating Research into Clinical Practice

Bruce Wampold, Ph.D.

Wednesday, August 1, 2007 1:00 pm Eastern,
12:00 noon Central and 10:00 am Pacific

Tuesday, August 28, 2007 1:00 pm Eastern,
12:00 noon Central and 10:00 am Pacific

Bariatric Surgery: Behavioral Health Considerations

Melissa Kalarchian, Ph.D.

Monday, September 10, 2007 12 noon Eastern,
11:00 am Central and 9:00 am Pacific

Thursday, September 27, 2007 3:00 pm Eastern,
2:00 pm Central and 12:00 noon Pacific

How Clients Make Therapy Work

Barry Duncan, Psy.D.

Tuesday, September 11, 2007 1:00 pm Eastern,
12:00 noon Central, 10:00 am Pacific

Monday, September 24, 2007 1:00 pm Eastern,
12:00 noon Central, 10:00 am Pacific

Using Outcome Feedback to Improve Clinical Effectiveness

Scott Miller, Ph.D.

Monday, October 1, 2007 3:00 pm Eastern,
2:00 pm Central and 12:00 noon Pacific

Tuesday, October 16, 2007 3:00 pm Eastern,
2:00 pm Central and 12:00 noon Pacific

Assessment and Treatment Issues for Eating Disorders

Walter Kaye, M.D.

Wednesday, October 10, 2007 3:00 pm Eastern,
2:00 pm Central and 12:00 noon Pacific

Thursday, October 18, 2007 3:00 pm Eastern,
2:00 pm Central and 12:00 noon Pacific

Practice Based Evidence as Evidence Based Practice

Barry Duncan, Psy.D.

Monday, November 5, 2007 1:00 pm Eastern,
12:00 noon Central, 10:00 am Pacific

Monday, November 12, 2007 1:00 pm Eastern,
12:00 noon Central, 10:00 am Pacific

Please visit www.ubhonline.com prior to the event to download materials, confirm the teleconference schedule, and find out about additional learning programs. Each of these seminars is free and represents one CE. Seminars are subject to change without notice.

Podcasts of every lecture will be available within one month of the lectures. For details on accessing podcasts, please review the information posted at www.ubhonline.com.

Discover All the Time-saving Features Offered at www.ubhonline.com.

Now you can get answers to claims issues through the new Live Chat function. This feature allows UBH network clinicians who are registered users of ubhonline® to ask questions, such as how a claim was processed, or to request an adjustment to a previously processed claim. This is just the latest addition to the benefits of submitting claims through ubhonline.

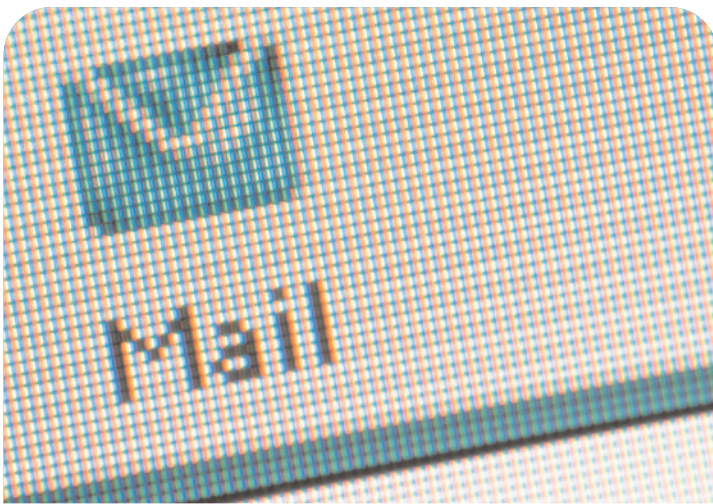
Performing electronic claim submission on ubhonline offers distinct benefits:

- It's fast — eliminates mail and paper processing delays

- It's convenient — easy set-up and intuitive process, even for those new to computers
- It's secure — data security is higher than with paper-based claims
- It's efficient — electronic processing helps catch and reduce pre-submission errors, so more claims auto-adjudicate
- It's complete — you get feedback that your claim was received by the payer
- It's cost-efficient — you eliminate mailing costs, the solutions through ubhonline are free

UBH strongly encourages the use of electronic transactions between clinicians and payers for claim submission and other routine interactions. For more information, visit www.ubhonline.com. From the homepage, select "Administrative Resources" located on the fly-out menu. Then click on the link "electronic/edi info".

To register for ubhonline, select "view information" for first-time visitors located on the log-in box on the homepage, or call toll-free [1-866-209-9320](tel:1-866-209-9320) to request a user ID and password.



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We welcome your comments on this issue and suggestions for future editions. Please contact Debra Court at debra_s_court@uhc.com.

For paper copies of any UBH documents mentioned in this newsletter, **please contact your designated network manager**. A searchable directory of network managers by state is available at <http://www.ubhonline.com/html/contactUs.html>.

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