NetworkNotes

United Behavioral Health News and Updates UBH Network Clinicians and Facilities SPRING 2010

VP Corner

By Michelle Brennan-Cooke, Ph.D.

With great appreciation for outstanding clinical care, we congratulate the following Campaign for Excellence (CFE) clinicians. Listed here are a small percentage of our Tier 1 clinicians who have achieved Severity Adjusted Effect Size (SAES) scores of 1.02 or greater. It's important to note that an SAES greater than .80 earns a "highly effective" designation. Reflecting their commitment to outcomes-based care, these clinicians also have an average Wellness Assessment submission rate of 80% or greater over two consecutive quarters. We applaud them all! *Please see the article on page 5 to learn about the latest updates to CFE and how you can enroll.*

Clinician	State
Diana M. Gates, LPC	AZ
Karen M. Morse, LPC	AZ
Lisa M. Edin Browning, LCSW	AZ
Mark F. Swanson, LPC	AZ
Theresa Beltran, LCSW	AZ
Donald G. Farmer, MFT	CA
Jeanne Nelson, MFT	CA
Jody Reiss, LCSW	CA
Joyce G. Evans, MFT	CA
Sharon Starr, MFT	CA
Guy R. Mauriello, LPC	CO
Jana M. Cyr, LCSW	CO
Jill B. France, LPC	CO
Sharon M. McCaffrey, LCSW	CO
Victoria J. Peters, Ph.D.	CO
David J. Meiners, LPC	CT
Barbara A. Dorn, Ph.D.	FL
Gliceria Calvo Scott, LMFT	FL
Marilyn S. Baily, LMHC	FL
Marty L. Miller, LMHC	FL
Mary L. Littlefield, LCSW	FL
Lindsey A. Brown, LPC	GA
Magda Tevdoradze, LPC	GA
Virginia V. Allen, LCSW	GA
Barbara M. Hayes, LCSW	IL
Judy B. Gabriel Card, LMHC	MA

Clinician	State
Patrick C. McCarthy, LICSW	MA
Thomas J. Tanguay, LICSW	MA
Karen L. Cotton, Psy.D.	MO
Shirley J. Vandiver, LPC	MO
Catherine C. Matthews, Ph.D.	NC
Mary Daigneault, LCSW	NY
Sue L. Carver, Ph.D.	NY
Barbara M. Hollander, Ed.D.	OH
Daniel L. Phalen, Ph.D.	OH
Diane M. Conn, LISW	OH
Lucy F. Hunter, LPCC	OH
Margaret C. Foley, LISW	OH
Philip M. Paulucci, LPCC, LISW	OH
Roy S. Merwin, Jr., LISW	OH
Timothy Y. Ling, LISW	OH
Karen E. Gruetter, LMFT, LPC	OR
Ella K. Shoemaker, LPC	PA
Deborah A. Johnson, LPC	TN
Debra F. Dayton, Ph.D.	TX
Doreen Lerner, Ph.D.	TX
Ellie M. Chaikind, LPC, LMFT	TX
Gay R. Roper, LCSW	TX
Karen Joanne Cabral, LMFT, LPC	TX
Valette Liedtke Hendrickson, Ph.D.	TX
Craig M. Stull, LMHC	WA
Anne A. Weston, Ph.D.	WI

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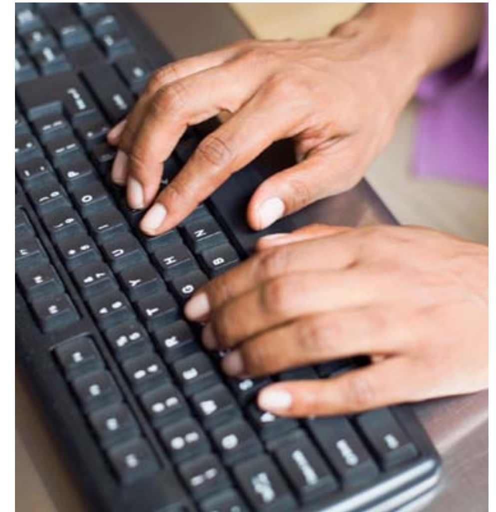

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A Professional's Perspective: Benefits of CAQH®

I have been a clinician for over twenty-five years and recall when managed care became a way of life in the late 1980's. I applied to multiple managed care companies and each one had its own set of questions and forms. It was a nightmare to have to keep up with and fill out a new application for every credentialing and recredentialing cycle.

About five years ago, a colleague of mine told me about the Council for Affordable and Quality Healthcare (CAQH), a universal provider application source that allows me to enter information, free of charge, into an online application. This single application meets the requirements of many managed care companies, hospitals, and health plans.

I have to say that initially, I was a little intimidated by the online process. After looking into it, I found that I did not have to do the application online, but could request a hard copy, which I did. When I received the packet, however, it was too much paper for me. So I decided to try the online process. I am so happy I did! I finally have all my information in one place, and, in most cases, when I join a new network, I can request that they get my credentialing and recredentialing information from CAQH.

Now, I love it. Every 120 days, I get an e-mail notice to re-attest to my information, thus assuring my information is continuously current for needed recredentialing activities. A pop-up screen lets me know exactly what I need to do, and the good news is that it takes me only 10 minutes to complete. I highly recommend this time-saving resource to all clinicians.

Note: CAQH is designed to ease the administrative burden associated with credentialing and recredentialing. It is still necessary that you update UBH directly within 10 calendar days of any changes to your practice information. This ensures that information we need to complete referrals, send communications and process claims is current between recredentialing cycles. (See article below regarding how to contact UBH and CAQH.)

Both UBH and CAQH Require Separate Notification

A change of address or other data requires separate notification of both UBH and the Council for Affordable Quality Healthcare (CAQH). Within ten (10) calendar days of an address or other change in your profile, contact UBH and CAQH. Taking advantage of online portals is most efficient in terms of your time and verification of records.

UBH	CAQH
www.ubhonline.com From secured Transactions, select "My Practice Info" then, Log on and update Or From "Contact Us" select "Provider Record Maintenance – Demographic and Tax Identification Number (TIN) Changes and Updates" then complete and fax the Clinician Add/Change form to the Network Management team for your state Note: to find the fax number for your state, use the "Search for Network Management Staff" feature provided under the Provider Record Maintenance link.	https://upd.caqh.org/oas/ Log on and update Or Call the Provider Help Desk: (888) 599-1771

Working Together: Clinician Satisfaction Surveys

UBH regularly conducts a satisfaction survey of a representative sample of clinicians delivering behavioral health services to UBH members. This survey obtains data on clinician satisfaction with UBH services including intake, care advocacy, clinician services, and claims administration.

In the fall 2009 edition of the newsletter we reviewed some of the changes we were making to improve our service delivery to you. We want to provide a few updates on our response to your feedback on last year's Clinician Satisfaction Survey.

We are continuing both global and specific training for intake and customer service representatives to ensure accuracy of information provided to you. In addition, we have implemented a program to centralize intake operations and claims customer service so that information is shared across roles to reduce the need to transfer calls to another unit.

To assist with access to your network management teams, we have implemented a phone structure to improve "live answer" time and we have added contact options to the "Contact Us" page on ubhonline.

We have added some tips for claim filing on ubhonline to address common submission errors that result in processing delays. Please visit ubhonline regularly for important updates and information.

Our annual Clinician Satisfaction Survey will be sent out in the near future.

NOW AVAILABLE: Online, self-service resources for many routine facility transactions

In response to facility requests, we are pleased to deliver enhancements to online services. Simply by registering for a username and password, network facilities can gain access to the following secured online transactions:

- **Claim Status** – look up status of facility claims
- **Eligibility & Benefits** – search for member eligibility and benefits in real-time
- **Electronic Payments and Statements (EPS)** – enroll for and receive electronic payments and statements – including electronic 835 downloads

To register, facilities simply go to www.ubhonline.com and click on the First-time User link at the top right of the page.

Coming Soon: *Facility Scorecards to be posted to ubhonline, accessible only through secure transactions.*

ubhonline®

Culture and Behavioral Health Services

Sensitivity to the influence of culture on experience and interpretation of experience is important to the work of behavioral health clinicians. Individuals may identify with more than one cultural influence (e.g., by professional affiliation, regional differences, ethnicity, age, etc) and situational factors may effect which influence is most salient at a given time.

Cultural factors may play a role in whether people seek help or where they turn for assistance. In addition, culture can affect how people talk about their concerns and what they consider important to report. Culture has implications for use of social supports, coping mechanisms or styles and sense of stigma associated with behavioral health issues. All of these cultural factors are brought into treatment settings by patients as well as by clinicians.

Culture also affects clients' evaluation of the services they receive. UBH monitors satisfaction with services for every type of health plan including commercial, Medicare and Medicaid product lines. A typical satisfaction question is: "I was able to find care that was respectful of my language, cultural and ethnic needs." While most members rate these items favorably, some have expressed dissatisfaction.

UBH encourages clinicians to continue to expand clinical skills related to cultural diversity. It's necessary to function effectively within the context of cultural beliefs, behaviors, and needs presented by individuals and their communities. "Cultural competence" involves the ability to work effectively within the cultural context of the individuals and communities we serve. Educational programs in cultural competence are widely available. Included below is a small sampling of the resources available online for professionals. They are listed in no particular order:

- The U.S. Department of Health & Human Services, The Office of Minority Health
- Dartmouth University
- Georgetown University
- University of Michigan Health System

Cultural differences must be respected to ensure that all individuals receive behavioral health care tailored to their needs. In some cases, you may determine that a referral to another clinician is necessary to meet the needs of your patient. In those instances, please call UBH for a specialized UBH network clinician referral or go to the online clinician directory. The link to the directory is accessible through ubhonline under "Our Network".

References and Resources

Achieving Cultural Competence in the Management of Bipolar Disorder, computer-based training for professionals, optumhealtheducation.com

Atdjian, S., & Vega, W. A. Disparities in Mental Health Treatment in U.S. Racial and Ethnic Minority Groups: Implications for Psychiatrists. Psychiatric Services, 56(12), 1600-1602; 2008.

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Pumariega, A. J., Rogers, K., Rothe, E. Culturally Competent Systems of Care for Children's Mental Health: Advances and Challenges. Community Mental Health Journal, 41(5), 539-555; 2005.

Schraufnagel, T. J., Wagner, A. W., Miranda, J., & Roy-Byrne, P. P. Treating minority patients with depression and anxiety: what does the evidence tell us? General Hospital Psychiatry, 28, 27-36; 2006.

Unequal Treatment: Confronting Racial and Ethnic Disparities (Board on Health Sciences Policy), [IOM]; 2003.

Campaign for Excellence Enhances Methodology

As Campaign for Excellence (CFE) approaches the first anniversary of the posting of scores, we are pleased to announce enhancements to our Severity Adjusted Effect Size (SAES) methodology effective July 2010. In response to recommendations from our National Advisory Council, composed of Behavioral Health research statisticians, treating clinicians and representatives from professional organizations, we have introduced an enhanced SAES design. Prior to this, we reported the mean clinician SAES. Given the small sample sizes for an individual clinician the mean will fluctuate, therefore the score will not adequately account for the statistical error that is inherent to all measurements.

Working with external statisticians designated by the National Advisory Council, a new methodology that uses hierarchical linear modeling (HLM) with random effects ($SAES_{RE}$) was developed. HLM is a more robust statistical method appropriate for nested data such as patients within a clinician's practice. Random effects methodology is used to draw conclusions about the clinician's effectiveness in the general patient population, not just the specific population for whom we have data. Furthermore, the effectiveness designation is now based on confidence intervals to further strengthen the reliability of the designation. Using a 90% confidence level, clinicians who have an $SAES_{RE}$ lower confidence limit (LCL) greater than or equal to .50 will be designated as effective.

With this new methodology, the "highly effective" category will no longer be used. Instead, the "effective" category will encompass all those clinicians who have a lower confidence limit that is greater than or equal to .50. In addition, those clinicians who do not yet have enough data to generate an effectiveness rating will be designated on ubhonline as Tier 2.

	SAES — OLD METHODOLOGY	
TIER	DESIGNATION	METRIC
1	Highly Effective Effective	SAES >= .80 SAES >= .50
2	Minimally Effective Insufficient Data	SAES < .50 < 10 Clinical cases
3	N/A	N/A – non CFE Enrollees

	$SAES_{RE}$ — NEW METHODOLOGY	
TIER	DESIGNATION	METRIC
1	Effective	LCL >= .50
2	Insufficient Data to Determine Effectiveness	LCL < .50 and UCL >= .50 < 10 clinical cases
3	No Designation	UCL < .50 Non CFE Enrollees

Business Partner Rewards Program

The Campaign for Excellence (CFE) began enrollment in November 2008. Enrollment has increased nearly 200% since the first month. In July 2009, we launched our Business Partner Rewards Program to show our appreciation for your participation in the Campaign for Excellence (CFE). The Business Partner Rewards Program allows clinicians to benefit from discounts and special offers from a variety of national merchants. To date, current business partners include: Office Max®, Hewlett-Packard, Regal Ware, Insight®, Call One, Wells Fargo Employee Financial Solutions, and BarnesandNoble.com®. Based on feedback from CFE enrollees, we will be adding additional merchants in the future.

For more information, visit the CFE page on ubhonline.

ENROLLING IN CFE – A SIMPLE PROCESS

For Non-Registered Users of ubhonline:

Please register before enrolling in CFE.

To become a registered user of ubhonline, network clinicians may use either of the following methods:

- Click online Live chat feature
- Call toll-free 1 (866) 209-9320 to speak with a representative to request a User ID

For Registered Users of ubhonline:

Go to www.ubhonline.com and log in

- Select "Enroll in CFE"
- Required participation elements include:
  - Secure e-mail address (password protected and not accessible by anyone except you)
  - Attestation that you will participate in ALERT® through ongoing use of Wellness Assessments
  - Attestation that you will file claims electronically
- Click Submit

Fraud, Waste and Abuse: A Brief Overview of the False Claims Act

UBH and USBHPC are committed to complying with all federal and state laws and regulations intended to prevent or reduce health care fraud, waste and abuse. Please review this important information related to the False Claims Act including who to contact with concerns about possible fraud, waste or abuse.

What is the False Claims Act?

The False Claims Act is a federal regulation/law that establishes liability for the submission of a claim for payment to the government that is known to be false – in whole or in part. Penalties related to a legal determination of false claim filings can result in damages owed to the federal government of three times the amount of those damages plus fines of $5,000 to $10,000 per false or fraudulent claim.

Qui Tam, also known as Whistleblower, Provisions

The False Claims Act contains qui tam, or whistleblower, provisions. Qui tam is a unique mechanism in the law that allows citizens to sue on behalf of the government. In qui tam cases, individuals filing on behalf of the government may be awarded a portion of the funds recovered, typically between 15 and 25 percent. The Federal False Claims Act and some state false claims acts prohibit retaliation against such individuals.

How to report suspected Fraud & Abuse:

Suspected Fraud and Abuse may be reported either orally or in writing to your UBH/USBHPC Network Management team. Please provide as much information as possible.

Please review the detailed information regarding the administrative process which can be found in the United States Administrative Code 31 USC § 3801 to 3808, available at http://www.gpoaccess.gov/uscode/browse.html. Information is available in "Title 31, Money and Finance", "Subtitle III--Financial Management", Chapter 38, Administrative Remedies for False Claims and Statements.

Please note that several states have enacted false claims laws based on the Federal False Claims Act.

For additional information about this topic, please review the fraud and abuse prevention article on page six of the fall 2009 edition of *Network Notes*. From the Network Notes page, select "Archives", then "Fall 2009".

A Few Key Concepts:

A "claim" is broadly defined to include any submissions that results, or could result, in payment.

Claims "submitted to the government" includes claims submitted to intermediaries such as state agencies, managed care organizations, and other subcontractors under contract with the government to administer healthcare benefits.

Liability can be created by the improper retention of, or failure to return, an overpayment.

Fraud is a false statement - made or submitted by an individual or entity - who knows that the statement is false, and knows that the false statement could result in some otherwise unauthorized benefit to the individual or entity. These false statements could be verbal or written.

Waste generally means over-use of services, or other practices that result in unnecessary costs. In most cases, waste is not considered caused by reckless actions but rather the misuse of resources.

Abuse generally refers to provider, contractor or member practices that are inconsistent with sound business, financial or medical practices; and that cause unnecessary costs to the healthcare system.

It is important to note that fraud is a legal term subject to legal and regulatory definitions.

Examples that may result in a False Claim include, but are not limited to billing:

- twice for the same service
- for services not rendered
- for medically unnecessary services or falsifying certificates of medical necessity
- separately or unbundling for services that should be billed as one
- by a physician without personal involvement for services rendered by medical students, interns, residents or fellows in teaching hospitals

— or —

- creating false medical records or treatment plans to increase payments
- failing to report and refund overpayments or credit balances
- giving and/or receiving unlawful inducements to healthcare providers for referrals for services

Treatment for Members with Addictions

Improving initiation and engagement in treatment for individuals who are diagnosed with chemical dependency helps reduce drug-related illnesses and deaths, overuse of health care services, and the staggering economic and interpersonal burdens associated with substance abuse. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), as established by the National Committee for Quality Assurance (NCQA), tracks improvement in two rates over time:

- **Initiation of Treatment**: the percentage of adolescents and adults diagnosed with Alcohol and Other Drug (AOD) dependence that begin treatment either through an inpatient or outpatient admission or emergency department visit and have any other AOD service within 14 days.
- **Engagement in Treatment**: the percentage of patients who complete two AOD services within 30 days after treatment initiation.

To help your patients with AOD dependence, please consider the following actions:

- Every time a patient receives a primary or secondary diagnosis indicating abuse of alcohol or other drugs, schedule a follow-up visit within 14 days.
- During the second visit, schedule two additional visits and/or schedule the patient to see a substance abuse treatment specialist within the next 14 days.
- Following a hospital discharge for a patient with an AOD diagnosis, schedule two additional visits within 30 days.
- Identify and involve concerned others to increase the rate of the patient's participation in treatment. Welcome calls from family members and other people that the patient approves to support their care. Invite the support persons to help in intervening with the patient diagnosed with AOD dependence.
- Always listen for and work with existing motivation in your patients.

Keep Practice Information Up to Date

Members need to have an accurate and up-to-date list of practitioners who are easily accessible to address their particular clinical needs. As a network clinician, it is your contractual responsibility to notify us when there is a demographic change pertaining to your practice, when your practice is full, or when you are not able to accept new UBH patients for any reason. You may initiate these changes in our system by:

- Submitting the change directly on ubhonline at "my practice info" in the secure "Transactions" available only to registered users
- Select "Contact Us" from the right side of the horizontal menu bar on ubhonline, select "Provider Record Maintencance – Demographic and Tax Identification Number (TIN) Changes and Updates" then complete and fax the Clinician Add/Change form to the Network Management team for your state
- Fax and Phone number information for your Network Management teams are available through the "Search for Network Management Staff" feature on the "Contact Us" page

It is vital that you inform us of any and all changes within your practice so we can provide accurate contact information to individuals seeking behavioral health care services. In addition, notifying UBH of changes to your practice information ensures new patient referrals can reach you and helps to prevent potential claims payment issues.

The following practice information may also be updated directly on ubhonline:

- Changes in practice location, billing address, telephone or fax number
- Your Tax Identification Number (TIN) used for claims filing
- The programs you offer (services you provide must continue to meet our credentialing criteria) and the hours you are available
- Languages you speak and your areas of expertise

Network Management remains the appropriate contact regarding your availability in the UBH Network.

UBH Welcomes

Apple, Inc

Harley-Davidson Motor Company

Public Employee Benefit Board (PEBB Statewide Plan) with the Providence Health Plans in Oregon

Measuring Evidence-Based Therapy Techniques in Depression Treatment

UBH is pleased to announce that the results from our Outpatient Depression Care study, conducted by the Behavioral Health Sciences Department at OptumHealth Behavioral Solutions in collaboration with RAND Corporation and the Network on Mental Health Policy Research, funded by the John D. and Catherine T. MacArthur Foundation, will be published in the joint journal of *Administration and Policy in Mental Health and Mental Health Services Research* in spring 2010. The findings will be a part of a Special Issue titled, "Assessment of Evidence-Based Psychotherapy Practices in Usual Care: Challenges, Promising Approaches, and Future Research Directions." This special issue focuses on measuring evidence-based practices in usual care settings in order to identify practices within usual care settings that are promising, and to advance quality improvement interventions.

Launched in 2004, 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 instrument focuses on CBT and IPT in particular because these approaches have strong empirical support for the treatment of major depression. The instrument asked the clinician to select a single, recently treated adult patient diagnosed with depression. Clinicians were asked to rate the frequency that they used each technique with that patient on a 6-point scale ranging from 'never' (1) to 'always' (6). In an effort to minimize patterned responding or endorsing only items from a particular orientation, technique items were not labeled or grouped by therapy approach.

The 16-item instrument (6 CBT items, 4 IPT items, and 6 DT items), the Psychotherapy Practice Scale – Clinician Depression Care Version (PPS Clinician) demonstrated good psychometric properties, including appropriate item-scale correlations, internal consistency reliability (reliability coefficients were above .70), and a 3-factor structure. Results of this study are reported in the article led by Hepner, Greenwood, Azocar and colleagues (In Press, 2010).

The second phase began in March 2006. We developed a new patient instrument designed to measure the psychotherapeutic techniques used in the treatment of depression from the patient perspective. Content and item development was guided by review of clinical literature and consultation with clinical experts. Items were further refined by conducting cognitive interviews with 12 psychotherapy patients who were in therapy at the time and who had completed the measure. The final questionnaire, the Psychotherapy Practice Scale – Patient Depression Care Version (PPS Patient), includes 30 items (11 CBT items, 11 IPT items, and 8 DT items). The instrument asks the member to think about the treating clinician, and to rate the frequency (using the same 6-point scale as above) with which the clinician used each technique during the course of therapy.

Members who recently were diagnosed with major depression, and who were being treated by a high volume network clinician (MDs, PhDs, and MSWs) were selected. We found over 2400 eligible member and clinician dyads. We surveyed all eligible members using the PPS Patient measure, but we only surveyed clinicians (using the PPS Clinician instrument) 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).

Seventy percent of adult depressed members who responded to the survey 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). Miranda, Hepner, Azocar and colleagues (In Press, 2010) report the results in full.

Sixty-four percent of the 159 high volume network clinicians were female, 70% were 55 years old or younger, 71% were MSW (12% were MDs, and 17% were PhDs), 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. Results are presented in Hepner, Greenwood, Azocar and colleagues (In Press, 2010).

Key research collaborators were Jeanne Miranda, Ph.D., Professor, Department of Psychiatry and Biobehavioral Science (David Geffen School of Medicine, UCLA), M. Audrey Burnam, Ph.D., Senior Behavioral Scientist (RAND Corporation), and Kimberly A. Hepner, Ph.D., Behavioral Scientist (RAND Corporation). This work was funded by the MacArthur Foundation sponsor of the MacArthur

Network on Mental Health Policy Research of which Dr. Miranda, Dr. Burnam and Dr. Saul Feldman (former CEO of UBH) were a part. All the staff work conducted at UBH was provided in kind. We would like to thank Michelle Brennan-Cooke, V.P. of UBH Clinical Network Services, network clinicians and your patients who participated in this study. You can find more information about these studies by contacting BHS, Gregory L. Greenwood, Research Scientist (Gregory.Greenwood@optumhealth.com, or 415-265-7858).

Facility Quality Measure Enhances Scorecard

The Facility Quality Measure (FQM) program continues to be a very successful clinical initiative for UBH and USBHPC. We have recently completed major enhancements to the facility scorecard and facilities who qualify for a scorecard will notice major changes. We have added data from our Medicare and Medicaid business to the scorecard and are reporting those public sector metrics together. Commercial metrics are reported as well, but no longer have Medicare data included. Both sets of data are weighted and combined, resulting in one overall Tier assignment for a facility.

As in previous scorecards, once quality benchmarks are met, the following efficiency measures will be factored into the scorecard:

- Average Length of Stay
- Case-Mix Adjusted Utilization data

The case-mix adjustment methodology was revisited and, as a result, enhanced to include more variables. Facilities will notice just one set of efficiency metrics on the scorecard that encompasses all the reported data.

To qualify for a scorecard, a facility must have 15 or more admissions of either commercial members or Medicare/Medicaid members, or both, in a 12-month data-collection period as well as have sufficient data to be evaluated on each of the quality metrics.

To learn more about FQM, please go to www.ubhonline.com. Select FQM under "Quick Links" on the home page to access more information, including a Frequently Asked Questions (FAQ) document for your reference.

We want to thank our contracted facilities for continuing to offer high quality services to our members.

Facility scores are based on industry standard quality metrics and include:

Metric	Commercial	Medicare/Medicaid
Number of members discharged	•	•
30-day readmission rate	•	•
Percentage of follow-up appointments scheduled to occur within 7 days of discharge	•	
Percentage of follow-up appointments kept within 7 days of discharge	•	
180-day readmission rate		•
Community tenure		•
Comparative geographical data	•	•

News and updates for UBH-contracted clinicians and facilities
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We welcome your comments on this issue and suggestions for future editions. Please contact Debbie Court at debra.court@optumhealth.com

For paper copies of any UBH documents mentioned in this newsletter, **please contact Network Management**. A searchable directory of Network Management by state is available at www.ubhonline.com, or by calling 1-800-711-6089, and selecting option 2, then option 5 followed by option 3.

Please note that clinicians and facilities are ultimately responsible for treatment of service determinations. You should consult your legal advisor as to how the references herein may impact or apply to you in your state.

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