NetworkNotes

United Behavioral Health News and Updates UBH Network Clinicians and Facilities SPRING 2011

Changing to Serve You Better

By Deb Adler

The status quo is certainly familiar and may be comfortable but it's not always effective. Healthcare needs, services and delivery are all changing rapidly. I see this as a great opportunity for all of us to transform the way we do business, exploring technology and tools that can help us work together more efficiently from tele-psychiatry to online and mobile applications that offer you increased convenience. Therefore, I invite you to continually share with us—the Behavioral Network Services team—what we can do to improve services for you our valued providers.

Everyday at UBH we are asking ourselves: should we do this differently or should we do something different? As a Managed Behavioral Healthcare Organization, we have some basic or "must do" aspects of our network operations. For example, we must credential and recredential network providers in a timely way, we must maintain accurate data, and we must keep you informed of operational changes that affect the way you interact with us.

> We are invested in gathering and amplifying the voice of network providers.

In the last few years the voices of regulators, purchasers and consumers have been widely heard and discussed in public forums. As we attend to the requirements and goals expressed by those stakeholders, we are invested in gathering and amplifying the voice of network providers.

Over the last several months we have conducted a variety of Voice of the Customer studies – by phone, online and in person – with individual clinicians, groups and facilities. We learned some things we didn't know, but needed to, and we validated some of what we did know about our strengths and opportunities for improvement. Your voice will help shape our approach to technological, operational and interactive solutions that meet your stated needs as they relate to network services, clinical and claim operations.

What did we hear in our Voice of the Customer surveys? Here are three themes that came through loud and clear:

1) Increase the availability of services through ubhonline allowing providers to complete transactions at the most convenient time, 24 hours a day, 7 days a week.

   — Check out the Electronic Payments and Statements (EPS) program that allows your reimbursement from us to go directly into your bank account. Visit the EPS page on ubhonline for more information. In addition to our existing secure Transactions such as member Eligibility & Benefits look up, we will be adding features to make your interaction with us easier and more efficient. Better for you and better for the individuals we serve.

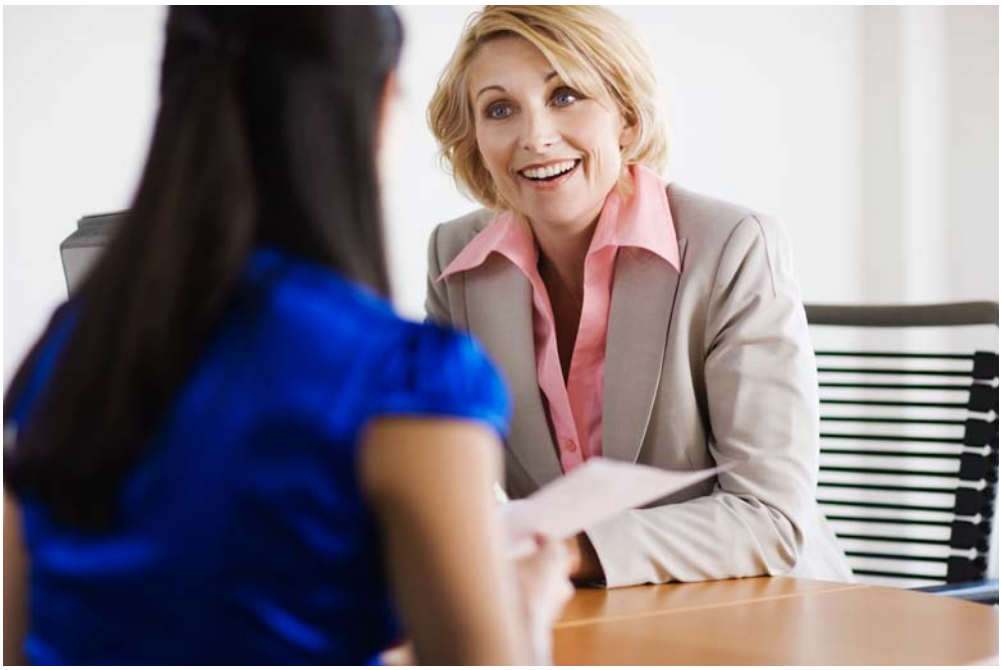
IN THIS ISSUE

2) Offer global solutions that recognize the challenges providers face in a multi-payor environment.

   — We heard strong praise for our continued use of the industry standard credentialing application offered through the Council for Affordable Quality Healthcare (CAQH). We intend to continue to collect key credentialing information from you through this vehicle while exploring other process improvements to speed completion of the credentialing/ recredentialing process.

3) Respect our profession and empower us with tools to best support our clients.

   — We couldn't agree more. We have launched a campaign to help all of our employees keep this in the fore-front of their interactions and are re-evaluating our complaint procedures and other processes to make sure they are focused on serving providers in a more customer-focused manner.



We are not changing for the sake of change. We see value in strategic transformation now and over the next several years that will meet current and future needs within the healthcare system. This includes meeting the needs of those providing direct care.

You can locate Network Management contact information for your state on the Contact Us page of ubhonline. Let us hear from you!

PsyCare Finds that Web-based Transactions are "more helpful than ever" in Today's Changing Healthcare Environment

The healthcare industry is changing rapidly, and OptumHealth℠ Behavioral Solutions[1] is committed to supporting the latest technological solutions to bring greater efficiency and effectiveness to healthcare. OptumHealth's online provider web site, ubhonline.com continues to be a time-saving technological solution across the spectrum of providers, from individual clinicians to large groups and facilities. With a wide variety of transactions available online, providers can efficiently submit and receive the information that they need most when interacting with OptumHealth around Members' care.

PsyCare, a large multi-disciplinary group with six office locations in San Diego County, relies on the ubhonline web site extensively for their daily operations. PsyCare staff complete look-up and submission activities online related to all levels of care, including outpatient services, intensive outpatient programs, and inpatient care. As Chief Operating Officer, Mary Joe Wagner, LCSW, describes, "Using the web portal is quick and easy and saves us lots of time." PsyCare staff cite time-savings around benefit and eligibility look-up, authorization requests, claim status verification, and looking up remittance advice. "Phone calls can take 20 minutes to verify information; we love being able to do all of this online".

In addition, according to Milliman Technology and Operations Solutions and their 2006 study, *Electronic Transaction Savings Opportunities for Physicians*, electronic transactions can provide a 50-90% savings over manual transactions.

OptumHealth supports continually improving our online presence to help our providers, like PsyCare, in their quest to help people lead healthier lives.

1 OptumHealth Behavioral Solutions is a service mark of United Behavioral Health

New, Exciting Benefit for Clinicians Recognized by CFE!

Our Campaign for Excellence (CFE) and the International Center for Clinical Excellence (ICCE) have partnered to offer CFE recognized clinicians, rated "Effective"*, an exciting opportunity to network and collaborate with like-minded clinicians around the world.

Feedback from CFE participants has consistently shown that our top-performing clinicians relish opportunities to connect and share ideas with colleagues who are equally committed to the pursuit of excellence in their profession. Through our partnership with the ICCE, we are delighted to offer recognized clinicians access to a world-wide community of practitioners, health care managers, educators, and researchers dedicated to promoting excellence in behavioral health care services.

This online community facilitates peer-to-peer sharing of knowledge and skills specifically designed to improve behavioral healthcare practice thereby allowing practitioners and managers to achieve their personal best as helping professionals.

On the site, CFE recognized clinicians can connect and share with other top performing professionals, participate in a wide range of forums and discussion groups, search and download articles from a large and growing library of publications, watch videos uploaded by community members, and even start and lead your own forum! Not only will these clinicians have access to the collective wisdom of thousands of professionals worldwide but also cutting edge tools the ICCE have developed to help you achieve clinical excellence. Importantly, you will not be bombarded with email or inundated with advertisements. You choose what information you receive and how (e.g., e-mail, RSS, text, or nothing).

CFE recognized clinicians will soon receive an e-mail with site and access information.

The Campaign for Excellence appreciates commitment to excellent clinical outcomes in the care of members. We trust that this new opportunity will contribute to your continued clinical development.

Please contact cfe@uhc.com with any questions or feedback.

* Clinicians rated "Effective" must have 10 or more UBH patients meeting the clinical threshold for Global Distress and have an Severity Adjusted Effect Size (SAES) with lower confidence limit greater than or equal to .50 based on a 90% confidence level.

Coverage Determination Guidelines

Benefit coverage for health services is determined by the individual's specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or Summary Plan Description, and applicable laws that may require coverage for a specific service.

United Behavioral Health (UBH) has developed and posted Coverage Determination Guidelines (CDGs) to ubhonline. They can be found under Guidelines/Policies located on the Quick Links menu of the home page.

UBH's Coverage Determination Guidelines are intended to standardize the interpretation and application of terms of the Member's Benefit Plan including terms of coverage, Benefit Plan exclusions and limitations. They are available on ubhonline or you may request a paper copy by contacting Network Management.

TO ENROLL IN CFE – PLEASE FOLLOW THESE STEPS:

For Non-Registered Users of ubhonline:

Please register before enrolling in CFE. To become a registered user of ubhonline.com, 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:

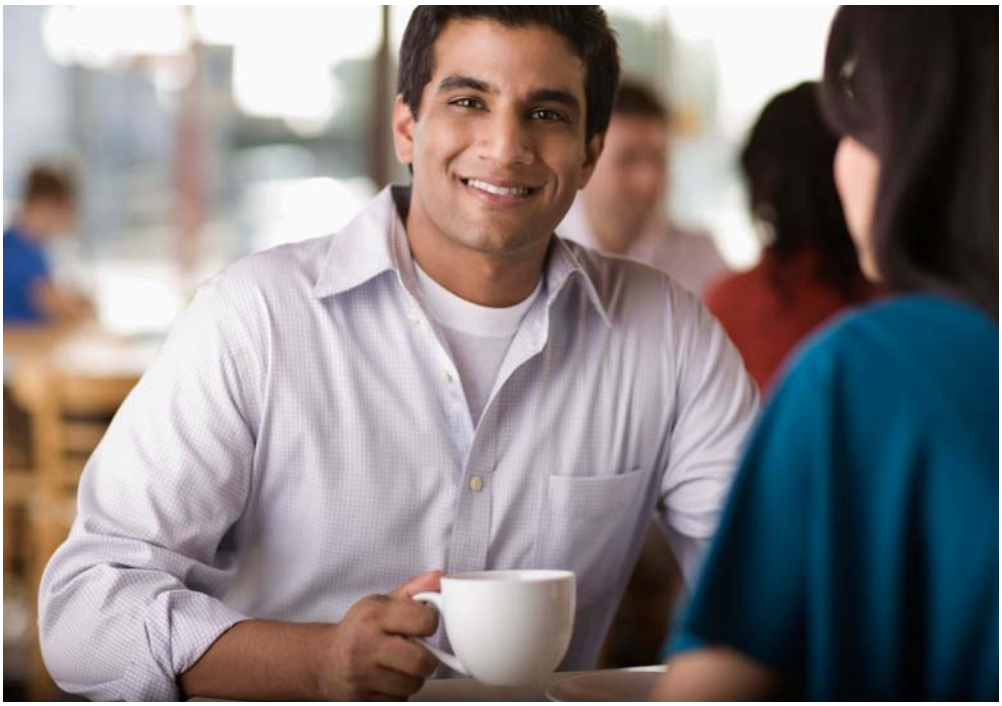
Go to www.ubhonline.com and log in

- 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

Welcome to Specialty Networks!

Specialty Networks is a new department within Performance Improvement, led by Theresa Carter and currently made up of three Network Managers. The Specialty Network team is responsible for coordinating and rolling out new specialty networks in conjunction with product development and other internal teams. Some of these specialty networks are already in the works including TeleHealth and Autism /Applied Behavior Analysis (ABA). At this time, Autism / ABA is the primary focus of the team at this point.

We are in the process of building a network of specialists to provide ABA for the treatment of autism. ABA is the most common and most recommended treatment method for children with autism, so much so that states are now mandating that health plans cover these services for their members. ABA uses the principles of reinforcing appropriate behavior and building skills including both life and social skills. It is a very intensive level of treatment and can involve many hours a week depending on clinical severity. ABA is primarily provided in the home environment and includes the family thereby supporting consistent application of the ABA principles.



In response to both state mandates and clinical need, we are building an ABA Network of solo Board Certified Behavior Analysts (BCBAs) and ABA Agencies across the country. Our team of three Autism/ABA Network Managers coordinates with the dedicated Autism/ABA Care Advocacy teams to help members live their lives to the fullest. We have developed credentialing criteria and a contracting model for these unique specialists, along with ABA specific audit criteria. The 2011 Supplemental ABA Tool is posted to the Autism Corner page. Our Autism Corner, launched in January of this year, contains a number of additional helpful resources including Frequently Asked Questions, Care Advocacy Documents, a Join Our Autism / ABA Network feature and an Autism/ABA Provider Orientation.

Please stay tuned for more exciting news from Specialty Networks!

AmeriChoice by UnitedHealthcare has a new name, UnitedHealthcare Community Plan

UnitedHealthcare offers health benefits for people of every age and all walks of life under a variety of brands. In New York, for example, they have offered Medicaid, Child Health Plus, Family Health Plus and some Medicare benefits under the AmeriChoice by UnitedHealthcare brand. Now, the branding across the country has been simplified and soon all AmeriChoice products and services will be offered under the UnitedHealthcare brand.

Along with UnitedHealthcare Community Plan, we remain committed to the individuals we serve and to the communities where they live.

Why Risk Assessment Matters

Risk assessments play a vital role in treatment of patients at all levels of care including outpatient and intensive outpatient. Completion of a risk assessment allows you to intervene and address any issues which could lead to decompensation and the need for a higher (and more restrictive) level of care. Whenever risk issues are identified, they need to be addressed as part of that treatment session. This may include development and implementation of a crisis plan. Patients (and, when applicable, family members) should be involved in the process to address the risk issues, including the development of crisis plans, removal of means to harm and other safety measures appropriate to the individual and the situation. Referral for an evaluation for a higher level of care may be indicated by the patient's level of risk combined with an inability to implement an appropriate safety or crisis plan.

Risk assessments need to consider more than the presence or absence of suicidal or homicidal ideations. The assessment also needs to evaluate the plans related to those ideations including lethality of the plans, and availability of means to execute the plans. A thorough risk assessment also reviews any self-injurious behaviors, any "risky" behaviors (non-compliance with medications, sexual promiscuity, excessive spending of money, etc.), impulsivity, substance use or abuse, and the presence of any psychosis. Further, consideration of current psychosocial stressors including but not limited to legal or financial problems or recent losses may have an impact on the overall assessment of risk.

A risk assessment should be conducted at the initiation of treatment, throughout the treatment process, and prior to discharge. Crisis plans should be updated as needed. On-going risk assessment is essential because a patient may deny thoughts of self harm at the initiation of treatment, but self harm may become an issue during treatment.

Risk assessments should not be limited to mental health services; they need to be completed for individuals receiving treatment for substance abuse or dependency as well. This is especially important if a patient has a history of becoming suicidal or homicidal when he or she drinks or uses drugs.

It is also important that you document your assessments. You may review documentation standards in the network manual.

Introducing UBH Network Lease Partners

UBH has implemented a new product for customers who desire access to UBH network discounts while retaining operational responsibility for administering their own benefit plans. Such arrangements are now being executed and these customers are known as Network Lease Partners. All claims for Members accessing your services through these arrangements are processed, paid by and the responsibility of the Network Lease Partners and not UBH. Please submit claims directly to these Network Lease Partners for processing. Claims submission information is available on the back of the Member's insurance card. The following customer list indicates our current Network Lease Partners:

- Bluegrass Family Health TPA – effective 1/1/11
- 35,000 members in KY, IN, TN

Claim Submission Information

Feedback from the most recent clinician satisfaction survey indicated that clinicians may want more detailed instructions regarding "How to Submit a Claim." UBH supports multiple ways of submitting claims for service.

The ubhonline ClaimTips page includes resources on how to submit claims properly. You can access this section using "Claim Tips" under the Quick Links of the home page.

We encourage you to take advantage of this resource, which also includes information on common submission errors that may result in processing delays.

Please visit www.ubhonline regularly for important updates and information.

Treating Bipolar Disorders in the Outpatient Setting

There are unique challenges encountered when treating an individual with any of the Bipolar disorders in the community setting. Among these challenges are:

- Arriving at an accurate diagnosis
- Treating for cycling
- Addressing resistance to use of Mood Stabilizers
- Determining which psychotherapies have efficacy

These challenges, along with potential means of overcoming them, are considered below.

Arriving at an accurate diagnosis

According to the National Institute of Mental Health, Bipolar Disorders affect 2.6 percent of adults in the U.S. in any given year. An accurate diagnosis is essential to appropriate psychopharmacological treatment of Bipolar disorder. This can be challenging, especially in the patient whose depressive cycles are long. A wide variety of questions may assist with differential diagnosis, for example: Was the person ever manic? Are they hesitant to identify a productive period as problematic? How can this hesitancy be overcome? Can you get additional information from a family member? Is there a family history of bipolar illness? What were the age of onset and the frequency of mood episodes?

In addition, the following symptoms may be more likely to occur in Bipolar depression or mixed states than in unipolar depression:

- Severe fatigue
- Hypersomnia
- Marked irritability
- Severe anxiety
- Racing thoughts

Treating for cycling

Patients with Bipolar may be resistant to the notion of cycling. They may see their hypo-manic or manic periods as productive, "normal" and even enjoyable. If these periods have not had a negative or destructive impact it may difficult for some people to view hypomania as part of the disorder. Instead, they may consider that these periods were when they felt good, or were at their best. Patients are often quite reluctant to accept that cycling is occurring and that both the depression and the cycling must be treated.

The following tips can help to obtain information about a patients cycling, ask about:

- Times they felt at their best
- Whether these periods followed by irritability
- Times when they felt at their worst
- Duration of these best and worst times

Effectiveness of and Resistance to Mood Stabilizers

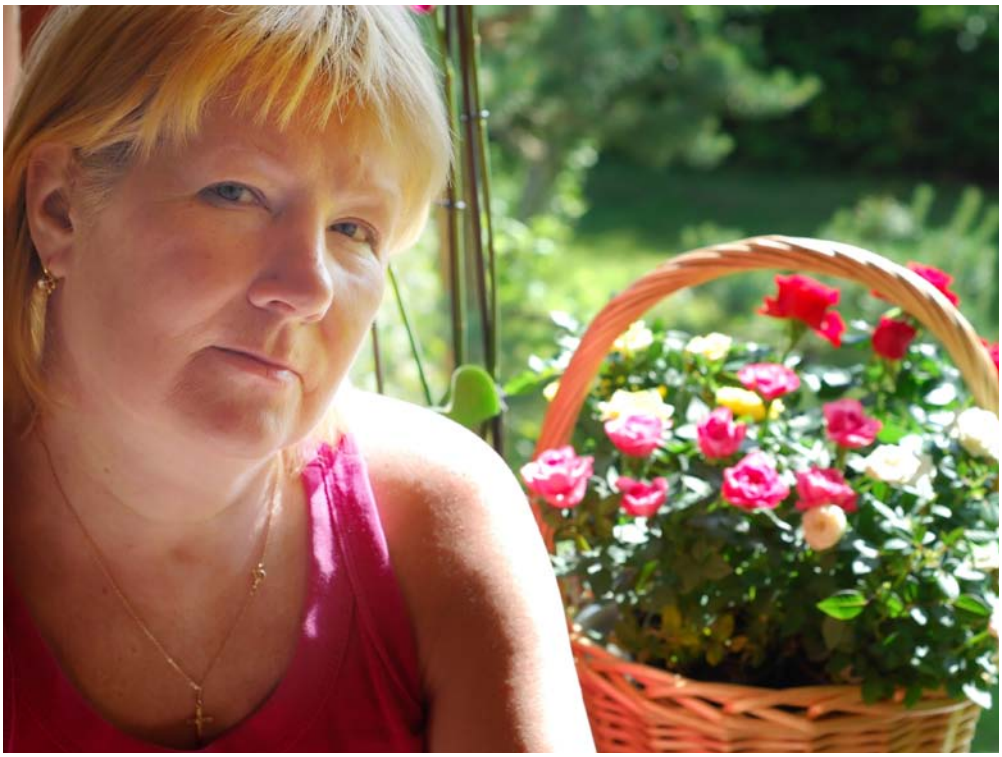
While Mood Stabilizers are the most effective means of treating Bipolar Disorder, patients may fear that the treatment of their hypomania may reduce their productivity and positive feelings. This can lead to resistance to treatment recommendations, particularly to one of the mood stabilizing medications.

Address resistance to mood stabilizers by providing:

- Education about the importance of treating the cycling to increase recovery and to reduce relapse.

Intensive psychotherapy efficacy

In 2007, The Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) study funded by the National Institute of Mental Health (NIMH), looked at several treatments to identify efficient and effective outpatient treatments for Bipolar Depression. When the



study was released, NIMH Director Thomas R. Insel, M.D. stated, "STEP-BD is helping us identify the best tools—both medications and psychosocial treatments—that patients and their clinicians can use to battle the symptoms of this illness." Furthermore, former National Institute of Health Director, Dr. Elias A Zerhouni noted that the results suggest that "adding specific, targeted psychotherapy to treatment with medication may help give patients a better shot at lasting recovery."

Concurrent with the STEP-BD study, David Miklowitz, Ph.D., and colleagues looked at the effectiveness of three types of standardized, intensive, nine-month-long psychotherapies compared to a control group that received a three-session psychoeducational program.

The following intensive psychotherapies were found to be more effective than brief psychoeducational intervention in treating Bipolar Depression:

- Family-focused therapy (family participation was required), with goals centered on improving family coping, communication and problem-solving;
- Cognitive behavioral therapy, identified and addressed distortions in thinking and activity, with patients learning new coping strategies; and
- Interpersonal and social rhythm therapies directed patients' attention toward stabilizing daily routines and sleep/wake cycles, and to intervening on relationship problems.

Study results indicated that patients who received one of the intensive psychotherapies:

- Achieved symptom recovery in 64 percent of cases compared with 52 percent of patients receiving brief pyshoeducation.
- Attained symptom recovery more quickly, an average 110 days sooner than those in the psychoeducation group.
- Were one and a half times more likely to have symptom recovery during any month of the one-year study than those receiving psychoeducation.

Although rates of recovery were higher for those in the family-focused therapy group, it was not found to be significantly more effective than the other two intensive approaches.

Dr. Miklowitz stated that intensive psychotherapy, in conjunction with medications "should be considered a vital part of the effort to treat bipolar illness."

With today's information and clinical tools, we are better able to meet the many challenges encountered in the treatment of the patient with Bipolar disorders. Patients need not wait years for an accurate diagnosis. Educating patients on the cycling nature of the disorder and the impact of not treating cycling is vital. Discussing the efficacy of mood stabilizers in the control of symptoms offers many patients hope for their future. And, by implementing one of the intensive psychotherapies studied, patient recovery can be achieved.

References

Miklowitz D. et al. Psychosocial Treatments for Bipolar Depression. Archives of General Psychiatry. Apr 2007; 164.

Shelton, Richard C. Treating Bipolar Depression: newly diagnosed patients may resist taking mood stabilizer, Journal of family Practice, March 2003

In-Home Behavioral Health Services

We continue to look for ways to identify and eliminate barriers to treatment access for our membership. We anticipate seeing a growing need for in-home services for Behavioral Health. This includes both therapy and nursing/medication management. Beyond access, the ability to obtain a more extensive assessment of a patient's support, resources and surroundings can lead to better treatment outcomes.

If you are interested in providing this type of service, please let us know by contacting your Network Manager. From the ubhonline.com home page, select "Contact Us" then select "Submitting Network Applications and All Other Network-Related Questions". The Network Manager for your state can discuss the codes and rates that will support reimbursement, and answer any other billing questions you may have. To support referrals for this service, Network Managers can assist with updating your expertise profile to include this service.

IMPORTANT REMINDERS

HIPAA 5010/ICD-10 Readiness.

We are beginning testing with Electronic Data Interchange (EDI) clearinghouses as part of our HIPAA 5010 readiness. No testing is required for claims filed directly on ubhonline. More information on HIPAA 5010 and ICD-10 is available online.

Quality of Care Initiative: Screening for Common Behavioral Health Concerns

Many behavioral health issues that go undetected can be easily identified early using simple screening tools. In alignment with the U.S. Preventive Services Task Force (USPSTF) recommendation that primary physicians screen patients for depression and alcohol misuse, we ask you to screen all your clients, including adolescents, for undetected depression and alcohol abuse. As we know, these common disorders often adversely affect family quality of life and clinical outcomes. Screening for these disorders in all clinical settings is key to treatment as it can contribute to readiness to change and appropriately focus treatment. Screening doesn't replace diagnosis, but it can illuminate issues that contribute to sound diagnosis.

To support you in this quality of care initiative, UBH has identified sensitive and specific screens which are accurate and easy to use. For depression, we encourage use of the PHQ-9/Prime MD. Other tools are also available, such as the Whooley Depression Screen (Whooley et al., 1997), the Beck Depression Inventory, the Zung depression scale, the HAM-D, and the CES-D.

For alcohol, UBH encourages use of the AUDIT-C screen for hazardous drinking and alcohol use disorders (Saunders, Aasland, Babor, de la Fuente, & Grant, 1993). The AUDIT-C is a reliable 3-question tool that can help you identify hazardous drinking or alcohol use disorders including alcohol abuse or dependence. Other screening tools include the NIAAA Two Question Screen, MAST/BMAST, CAGE, and the CAGE-AID.

Clients who score positively for hazardous drinking can benefit from a simple Brief Intervention (BI). BI is a skill set defined by researchers and described more fully in the reference below. The essence of BI is four steps, taken over the course of one to four visits:

1. Express concern about the patient's drinking
2. Link the client's drinking to his/her health concerns
3. Offer explicit advice to stay below recommended limits
4. Follow-up at the next visit

To get a copy of the PHQ-9/Prime MD or the AUDIT-C, e-mail your request to BHInfo@uhc.com. For more information on these disorders, you and your patients may access the liveandworkwell.com web site designed for members.

For more information on screening and BI, visit this web site: http://www.bu.edu/act/index.html. The Alcohol Clinical Training (ACT) Project, established by the Boston Medical Center and Boston University Schools of Medicine and Public Health, disseminates the latest research on alcohol and teaches pragmatic clinical skills to screen and conduct brief intervention for alcohol problems. While this site is directed to primary physicians, it speaks to us as well.

References

Fleming, M and Baier Manwell, L. Brief intervention in primary care settings: A primary treatment method for at-risk, problem, and dependant drinkers. Alcohol Research and Health 23: 128-137.

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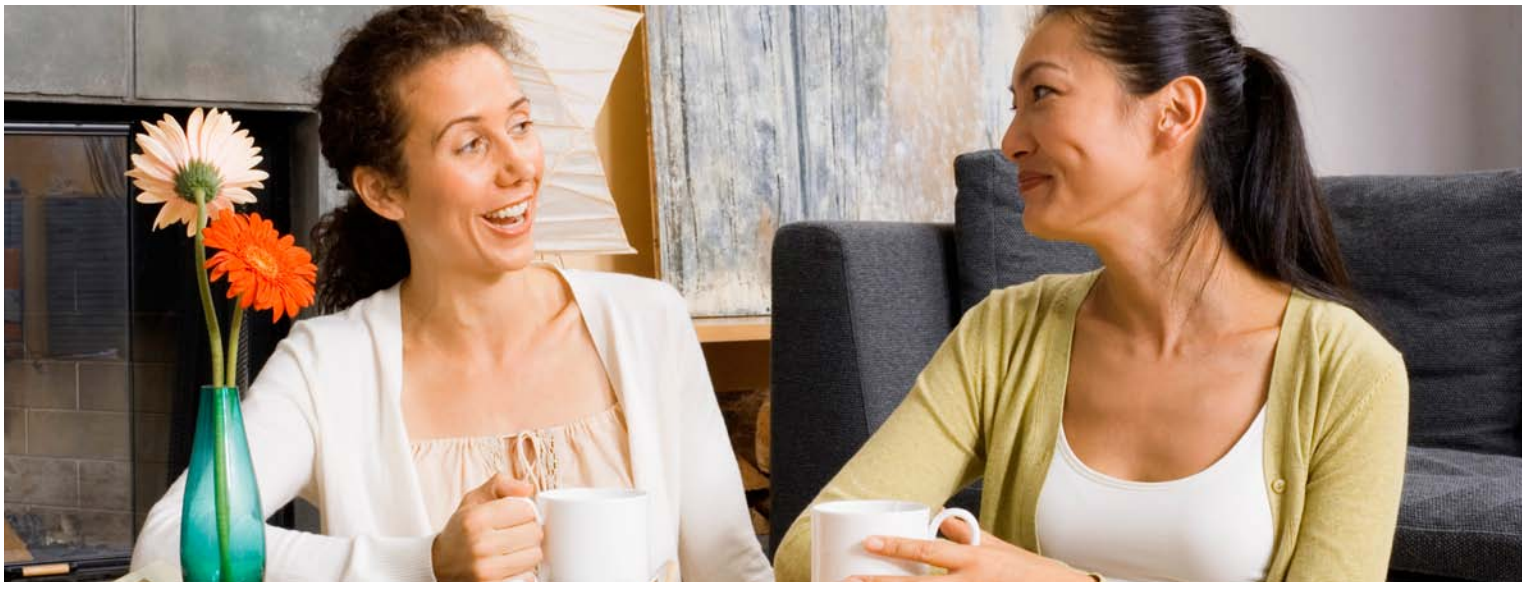


Measuring the Impact of Specialty Behavioral Healthcare Treatment on Patients with Medical Comorbidity

OptumHealth Behavioral Solutions[1] (OptumHealth) is pleased to announce that findings from a pilot study of the impact of specialty behavioral healthcare on patients with medical-behavioral comorbidity have recently been published in Psychiatric Annals (Cate, Bolstrom, McCulloch, & Azocar, 2010). The study was a collaborative effort by OptumHealths's Behavioral Health Sciences Department and Behavioral Informatics Department. Study results suggested that despite greater initial impairment and a different pattern of utilization among patients with a chronic medical condition compared to those without, patients with a medical condition who utilized specialty behavioral health treatment showed significant improvement in outcomes over time.

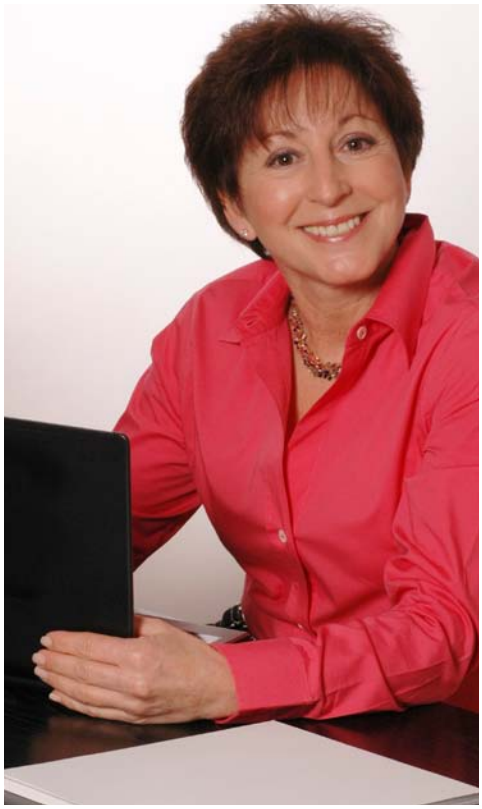
Research on medical-behavioral comorbidity to date has focused primarily on prevalence rates of behavioral health conditions among medical patients, the multitude of treatment issues facing comorbid patients, and the association between mental health conditions and total medical healthcare costs. However, there has been little research on the effects of co-occurring medical and behavioral conditions on behavioral health symptoms and specialty behavioral health treatment utilization and cost, or on the comparative impact of specialty behavioral health treatment on outcomes for those with and without medical conditions.

OptumHealth's pilot study set out to explore the impact of self-reported medical comorbidity on psychological distress, workplace productivity (absenteeism and presenteeism), and specialty behavioral health treatment use and cost among patients accessing specialty behavioral health care.

Using a retrospective design, this study examined data from 13,417 adult patients who completed an OptumHealth Wellness Assessment (WA) during their initial visit with a network clinician between July 1, 2007, and August 30, 2008 as part of OptumHealth's ALERT® program (Time 1), and who then completed a follow-up WA approximately 4 months later (Time 2). WA items were used to measure the presence of medical comorbidity, psychological distress (the Global Distress scale), absenteeism (work days missed in the past month because of physical or mental health), and presenteeism (work days cut back in the past month because of physical or mental health). Behavioral health claims were used to examine specialty behavioral health utilization and cost.

Results indicated that those who reported a chronic medical condition showed greater initial impairment (as measured by their Time 1 WA) compared to those without a medical condition, reporting more psychological distress, greater absenteeism, and greater presenteeism compared to those without a medical condition.

The two groups also differed in their patterns of specialty behavioral health service utilization and costs. Patients who reported a chronic medical condition used more outpatient behavioral heath treatment and incurred greater behavioral health treatment costs over the total 8 month study period (4 months prior to and including the initial WA visit, and 4 months after the initial WA visit) than those without. However, those without a medical condition showed a greater increase in behavioral health treatment in the 4 months after their initial WA visit than those with a medical condition, suggesting these patients



might be better able to focus on their behavioral health treatment without the competing health demands faced by those with a medical condition.

Analysis of outcomes (change in psychological distress and workplace impairment from Time 1 to Time 2), suggested a positive impact of specialty behavioral health care on both groups. Though patients without comorbidity experienced a greater decrease in psychological distress (35%), those with a medical comorbidity still experienced a significant decrease of 27% over time. There was a 24% decrease in the proportion of patients without comorbidity who reported any absenteeism, while the decrease in proportion among those with medical comorbidity was 18%. Both groups showed an average decrease of 1/2 a

day of work missed. Those without medical comorbidity showed a decrease of 20% in the proportion who reported any presenteeism, with an average decrease of nearly 1 day cut back, while the decrease in proportion among those with medical comorbidity was 18%, with an average decrease of 1 day cut back.

These results provide additional evidence for the usefulness and importance of screening and monitoring treatment outcomes through programs like OptumHealth's ALERT program. Early identification of medical comorbidities may help inform specialty behavioral health treatment. Results suggest that medically comorbid patients may show greater behavioral health impairment when they first enter treatment, and that the combination of medical and behavioral conditions may result in more workplace problems. In addition, patients with medical comorbidity may have multiple types of medications and healthcare visits that compete for their time and attention, and may take longer to show improvement in their behavioral health. Therefore, comorbid patients may benefit from motivational interviewing and other techniques that help them engage and comply with treatment.

Encouraged by these pilot findings, OptumHealth is currently designing a much broader study database that will include not only the WA and behavioral health claims data, but also medical and pharmacy claims, and will extend the study timeframe to include claims 6 months prior to and 18 months after the initial WA. This database will allow much more in-depth analyses of the impact of medical-behavioral comorbidity on total healthcare costs, as well as the impact of specialty behavioral heath treatment on outcomes compared to behavioral health treatment delivered in the medical setting.

You can find more information about the pilot study by contacting Rebecca Cate, Ph.D., Senior Research Consultant with Behavioral Health Sciences (Rebecca.Cate@optumhealth.com, or 415-547-6142).

1 OptumHealth Behavioral Solutions, a service mark of United Behavioral Health

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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.