

WMC Retrospective Research Findings and Early Insights

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I have been asked to give you a little bit of background on the processes that we're going through, the obstacles that we're up against, and the learning that is occurring on this project.

We started with 279 subjects participating in our earlier intervention. This is a small number. With the prospective study, we'll have about 1600. So the results that we're seeing at this point are going to be just a small indication of what we hope to see with the prospective study.

With the Human Resource Data, we lost 74 employees who began the intervention. This was primarily because they were no longer with the company, and therefore, no longer in their data system. With the managed care organization data, we lost about 50 people. These included people who did not participate in the plan, name changes, or different spellings of the name. Of the 220 subjects that we studied, we received a file that told us month-by-month whether they were actively enrolled with the MCO, in order that we could control whether or not they would have actually had any claims.

We'll go through the data that we were able to collect and work with from our three departments. With the Employee Assistance Program we have a date of first appointment, which will be important when we track what has happened throughout the course of the study. A person who comes into the EAP for a particular problem is allowed six visits for that problem, and then a new episode would begin.

We also have information on whether or not individuals were referred out, to where they were referred, and whether it was to a care giver in the managed care organization, or some other type of provider. We're particularly interested in provider specialty so that we can look at individuals who use behavioral health services. We have three ICD-9 codes that we're able to look at, so we can look at primary diagnosis, or secondary or tertiary diagnosis. We've

got CPT codes, and then finally the financial outcome information. We're going to be able to look at the billed amount, which is the amount that the provider billed, and the liability amount, which is the amount that was paid out in combination by the MCO and the policyholder.

With CPT codes, we were interested in looking at the number of office visits versus hospital visit, or other psychotherapy. In these preliminary runs, it looks like we're finding the greatest number of hits in the areas of psychiatric services and psychopharmacologic treatment. A lot of individuals that we're seeing with CPT codes of interest are for psychopharmacology treatment.

Psychiatric diagnosis, although preliminary, is more common in anxiety and depression than in the other categories, which isn't terribly surprising.

We have behavioral health visits mapped out by quarter. Within each quarter, a person who was active for at least one of the three months was considered active for that period and was included in that denominator.

The Stress Management Control Group has a higher incidence of behavioral health claims, and we don't see the same with the other three groups. We also did a preliminary look at EAP visits. Many people in the stress management classes were using EAP services. We are assuming that the people who attend stress management classes are those who are at greater risk for problems or who currently have more problems than the average person. We are hopeful that our intervention with substance abuse prevention messages may short-circuit or bypass needing more behavioral services, or going to other providers.

We're not seeing the same pattern with psych-related diagnosis. This is a different subject pool, in the sense that it is not restricted to people who only went to a BHR provider. So these are ICD-9 codes for our entire population. We don't know if there may be some differences related to individuals going to other than BHR providers to manage cases.

In summary, the increased utilization of behavioral services in the control group was comparable to that of the experimental group. The provision of psychiatric services showed patterns similar to those for BHR services.

Now we can begin planning for our next group. We would like to add a control group of workers that did not participate in the intervention. We are in the process of obtaining those files now. We would also like to look at medical conditions that are typically associated with ICD-9 diagnosis for alcohol and drug-related problems. Philagra, psoriasis, and cardiomyopathy are examples of conditions that we did not include with our diagnosis of alcohol- and drug-related conditions.

We would also like to conduct analysis on the number of persons versus number of claims. And as a preliminary step to our prospective study, we would like to look at the 1996 and 1997 data for all employees at the intervention and control sites.