TRANSCRIPT

Exploring the Technology Connection with Dr. Arjun Venkatesh

Dr. Todd Mandell:

Welcome, Dr. Venkatesh. There are certainly existing metrics and treatment protocols for conditions such as cardiac care and sepsis. How can information technology and decision-making tools help to measure and deliver the best opioid use disorder, or OUD, care?

Dr. Arjun Venkatesh:

Yeah, thanks for having me. You know, I think that when people talk about cardiac care or acute MIs, or sepsis care, we in many ways take for granted what has been the growth of our learning health care system over the past decade. Both those conditions had remarkably high mortality rates, and clinical evidence from randomized trials showed us that there was an evidence-based way to deliver that care. We developed metrics that allowed us to improve care, and we've seen remarkable improvements in outcomes in the last 10 years, and the same is ready and can be true for the opioid use disorder.

I think, you know, if we apply the same principles of a learning health care system to OUD, we can very rapidly implement best practices and evidence that we have today using tools that exist and are ready today to make significant impacts on the epidemic, which seems to only be getting worse both year by year but also month by month recently.

So, the things that we need are metrics that can help people and patients start care and stay in care, and we need a whole set of incentives in the health care system that support that learning health care system. And so, that could look like new alternative financial payment models that support the care transitions from somebody having an overdose being in an emergency department, starting buprenorphine and treatment for OUD in order to get to that warm handoff and care in the next position from either a primary care doctor or an addiction specialist, and then that person having a system around them that allows keeping that person in treatment for weeks, months, and years following that. What's impressive now is that we're in a system where we can use our electronic health records to measure those metrics and support those care transitions for people.

Dr. Todd Mandell:

Dr. Venkatesh, do electronic health records help with expediting assessment and treatment of patients who present with opioid use disorders?

Dr. Arjun Venkatesh:

Sure. You know, where I practice at Yale, we use the Epic electronic health record. It’s probably one of the most widely used electronic health records nationally and one of the tools that has come from prior NIDA-supported work was a project that was called EMBED and created a clinical decision support tool that’s integrated within the electronic health record. It’s a very simple tool, and it's now available at any Epic installation around the country. It simply has to be turned on or off by a local chief medical information officer.

If you turn the tool on when patients present to the emergency department, it provides guidance on how to calculate a COWS score, risk stratify somebody's degree of withdrawal, as well as their risk of potential harm, and then in the simple few clicks, it allows you to document—which is one of the biggest burdens physicians face today—your risk stratification and treatment plan for the patient. It allows you to quickly click for a referral for care, and most importantly, in a few clicks, it gets you the correct dose, duration, and everything to prescribe buprenorphine either for ED induction or for take home and at-home induction of treatment. These kinds of tools make it almost easier to treat a patient than it does to the alternative, which is, you know, do a bunch of tests or provide care that may not be the primary reason that patient’s in the emergency department that day.

The similar side is we need financial tools that also support this. One of the things that the Department of Health and Human Services has really put out is a shift towards what's called value-based payment, getting away from fee-for-service payments and paying for each visit. As these value-based payments promote keeping people in treatment and getting people in treatment, it will I think make it easier for health systems and communities to really help make the investments and the kinds of resources that favor getting people in treatment and avoiding future ED visits rather than being in a revolving door of emergency department visit after visit.

Dr. Todd Mandell:

Very interesting. Now what about the role of quality indicators? We have these for other conditions that commonly present in the emergency department such as cardiovascular conditions or diabetes.

Dr. Arjun Venkatesh:

So, quality indicators can be used in a variety of different ways. I think probably their first and most important use is in a very local way, driving quality improvement projects within a given emergency department or within a given hospital. There are published plot indicators that have come from the American College of Emergency Physicians from work that we've done through our Emergency Quality Network or measures that we have nationally available through the Clinical Emergency Data Registry. Much of that work comes from work that NIDA funded to

create opioid use disorder data elements in these big national registries. Those metrics don't have to be about pay-for-performance; you could just use those metrics to look at whether or not patients with overdose get appropriate screening, whether patients with an overdose get prescribed naloxone for harm reduction or dispensed naloxone harm reduction, and whether or not they get prescribed buprenorphine at ED discharge.

Now what's interesting is that some of those measures are now available in this registry for pay-for-performance programs. And so, if your ED has programs being implemented, if you're supporting those physicians locally to help get them engaged in treatment, then they can actually measure the quality of that care, report it to CMS [the Centers for Medicare & Medicaid Services] every year, and get a potentially, either avoid a payment penalty or even get a performance payment bonus for doing well on those metrics as part of the national MIPS [Merit-Based Incentive Payment System] program.

Dr. Todd Mandell:

To continue the thought, how can these electronic health record tools and quality indicators support OUD follow-up once a patient leaves the emergency department?

Dr. Arjun Venkatesh:

You know, I think this is where there's a term that gets used a lot in the quality measurement world of having what's called horizontal alignment, and in a simple way, that the phrase people often use is we want all of our ships heading in the same direction, and I think that could not be more true when it comes to OUD care and health systems.

We want to have metrics and registries that support the highest quality OUD care in the emergency department, just as we want the same to be true in the primary care settings and those registries and in addiction medicine and in follow-up. And one of the ways to do that is to, you know, have each local clinical activity and setting focus on these metrics. The other is for our payers: State Medicaid agencies, CMS as Medicare, or via CMMI [Center for Medicare and Medicaid Innovation], even private payers to start providing metrics when they do their contracting that favor getting patients into treatment and stay in treatment when they contract with hospitals and health systems. I think that's where there's a lot of opportunity for shared interest and alignment for health systems who want to do a better job of taking care of OUD to go to those payers and say, you know, this year, help us have financial incentives to get people and keep them in treatment and when that type of alignment exists, then people can locally make the right kinds of decisions, put into place the right kinds of QI projects, invest in all kinds of resources and people to do that type of care.

Dr. Todd Mandell:

So, to recap, what's the takeaway for hospital leaders?

Dr. Arjun Venkatesh:

I think the biggest one is that it's really, really important to reassess the reality of where we're at and the opportunity for impact in care for opioid use disorder.

I think there's a tremendous amount of both, sort of, mental futility because people feel like we don't have ready treatments, people feel like it's too difficult to do care from hospitals, people feel like there's too many barriers, that the social determinants of health are overwhelming, and while that may have been the case a decade ago, we live in a different world today. We have science-based treatments that work; there are low-barrier, low-effort ways to get people into treatment and keep them in treatment, and I think that if we take instead, think of the world from a place of abundance and we recognize that opportunity, that if I'm a health system CEO, I want to act now. I want to put these programs into place today. I don't want to wait for the financial system to change. I don't want to wait for any more research. We have enough today to start.

Dr. Todd Mandell:

Thank you, Dr. Venkatesh. Great to talk to you today.

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