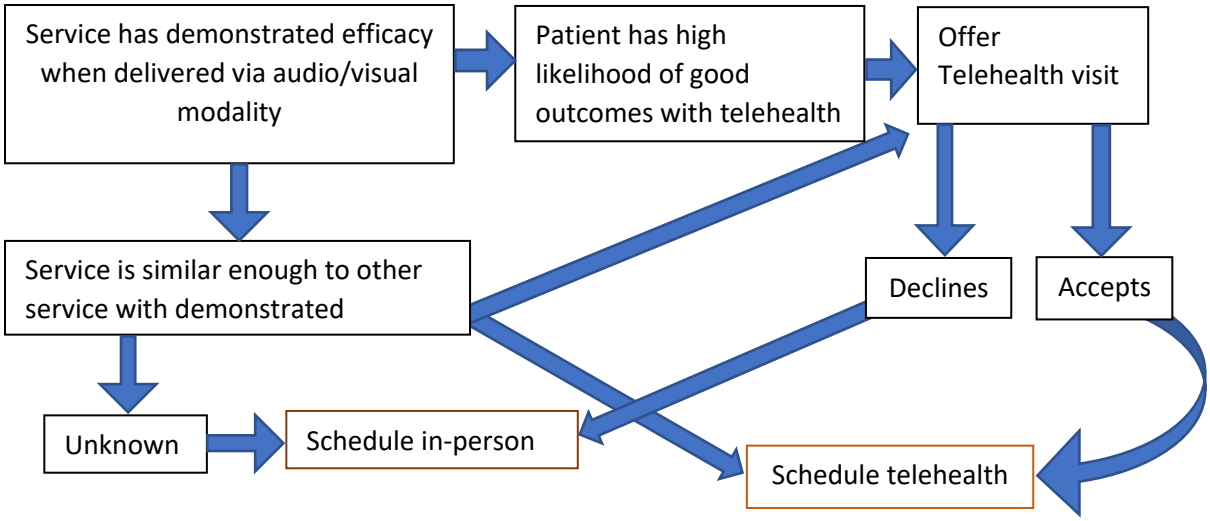
Bree Collaborative Draft Recommendations
Updated: March 26, 2020

Background

Telehealth utilization has increased significantly since the onset of the COVID-19 pandemic. Approximately 34.5 million telehealth services were delivered to Medicaid and CHIP beneficiaries from March through June 2020, representing an increase of 2,632% compared to March through June 2019[1]. Rapid acceleration of telehealth has identified a knowledge gap among physical and behavioral health providers in appropriateness of telehealth care delivery, and highlights issues related to confidentiality and access.

How to determine if a service should be offered via telehealth:



Focus Area	Key questions to lead to concrete clinical Steps
Appropriate Service	• Criteria for determining that outcomes for service is generally similar to in-person (clearly appropriate) • Criteria for determining service is similar enough ○ Strong opportunity for success
Patient Characteristics	• Criteria for determining patient characteristics associated with high likelihood of good outcomes • Setting person up to optimize outcomes (expectations) • Patient preference for in-person vs. virtual • Consent process

[1]Centers for Medicare and Medicaid Services. Services Delivered via Telehealth Among Medicaid & CHIP Beneficiaries During COVID-19. Accessed: January 2021. Available: www.medicaid.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-COVID-19-snapshot-data-through-20200630.pdf

Person-centered Interaction	• Steps within a virtual visit associated with positive interaction and good outcomes
	  ○ Clearly identify self
	  ○ Professionalism
	  ○ Integrated into medical record
	• Care coordination

Measurement and Follow-up	What needs to be measured or tracked to ensure equitable, high-quality care was delivered?

I. Appropriate Service

Thinking about the word from the outside in comment for how to scope this to specific health services, I am reminded of a similar conversation in our post operative opioid prescribing talks in which we were in need to categorizing a diverse array of surgeries in relation to their need to opioids. Our framework is below and may be useful as we think about what services fit well with telehealth

Type I – Expected rapid recovery	
Dental procedures such as extractions or simple oral surgery (e.g., graft, implant).	• Prescribe a nonsteroidal anti-inflammatory drug (NSAID) or combination of NSAID and acetaminophen for mild to moderate pain as first-line therapy. • If opioids are necessary, prescribe ≤3 days (e.g., 8 to 12 pills) of short-acting opioids in combination with an NSAID or acetaminophen for severe pain. Prescribe the lowest effective dose strength. • For more specific guidance, see the Bree Collaborative Dental Guideline on Prescribing Opioids for Acute Pain Management.
Procedures such as laparoscopic appendectomy, inguinal hernia repair, carpal tunnel release, thyroidectomy, laparoscopic cholecystectomy, breast biopsy/lumpectomy, meniscectomy, lymph node biopsy, vaginal hysterectomy.	• Prescribe non-opioid analgesics (e.g., NSAIDs and/or acetaminophen) and non-pharmacologic therapies as first-line therapy. • If opioids are necessary, prescribe ≤3 days (e.g., 8 to 12 pills) of short-acting opioids in combination with an NSAID or acetaminophen for severe pain. Prescribe the lowest effective dose strength.
Type II – Expected medium term recovery	
Procedures such as anterior cruciate ligament (ACL) repair, rotator cuff repair, discectomy, laminectomy, open or laparoscopic colectomy, open	• Prescribe non-opioid analgesics (e.g., NSAIDs and/or acetaminophen) and non-pharmacologic therapies as first-line therapy. • Prescribe ≤7 days (e.g., up to 42 pills) of short-acting opioids for severe pain. Prescribe the lowest effective dose strength.

incisional hernia repair, open small bowel resection or enterolysis, wide local excision, laparoscopic hysterectomy, simple mastectomy, cesarean section.	• For those exceptional cases that warrant more than 7 days of opioid treatment, the surgeon should re-evaluate the patient before a third prescription and taper off opioids within 6 weeks after surgery.
Type III – Expected longer term recovery	
Procedures such as lumbar fusion, knee replacement, hip replacement, abdominal hysterectomy, axillary lymph node resection, modified radical mastectomy, ileostomy/colostomy creation or closure, thoracotomy.	• Prescribe non-opioid analgesics (e.g., NSAIDs and/or acetaminophen) and non-pharmacologic therapies as first-line therapy. • Prescribe ≤14 days of short-acting opioids for severe pain. Prescribe the lowest effective dose strength. • For those exceptional cases that warrant more than 14 days of opioid treatment, the surgeon should re-evaluate the patient before refilling opioids and taper off opioids within 6 weeks after surgery.