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. 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:

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Key questions to lead to concrete clinical Steps</th>
</tr>
</thead>
</table>
| Appropriate Service         | • Criteria for determining that outcomes for service is generally similar to in-person (clearly appropriate)  
                                 • Criteria for determining service is similar enough  
                                   o 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 |

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

<table>
<thead>
<tr>
<th>Type I – Expected rapid recovery</th>
</tr>
</thead>
</table>
| Dental procedures such as extraction 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. |

<table>
<thead>
<tr>
<th>Type II – Expected medium term recovery</th>
</tr>
</thead>
</table>
| 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.

<table>
<thead>
<tr>
<th>Type III – Expected longer term recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedures such as lumbar fusion, knee replacement, hip replacement, abdominal hysterectomy, axillary lymph node resection, modified radical mastectomy, ileostomy/colostomy creation or closure, thoracotomy.</td>
</tr>
</tbody>
</table>

- 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.