

## Bree Collaborative Draft Recommendations

Updated: March 2<sup>nd</sup>, 2021

### 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<sup>1</sup>. 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.

Focus Area	Key questions to lead to concrete clinical Steps
Appropriate Service	Strong opportunity for success What types of services are good fits for telehealth (video or audio-only)
Patient Characteristics	Patient preference for in-person vs. virtual Consent process How can the care team make sure the patient is set up to optimize outcomes
Person-centered Interactions	Clearly identify self Effective Professionalism Integrated into medical record
Measurement and Follow-up	What needs to be measured or tracked to ensure equitable, high-quality care was delivered?

### Clinical Checklists

Providers

etc

### 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

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<sup>1</sup>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](https://www.medicaid.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-COVID-19-snapshot-data-through-20200630.pdf)

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<p>Dental procedures such as extractions or simple oral surgery (e.g., graft, implant).</p>	<ul style="list-style-type: none"> <li>• Prescribe a nonsteroidal anti-inflammatory drug (NSAID) or combination of NSAID and acetaminophen for mild to moderate pain as first-line therapy.</li> <li>• 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.</li> <li>• For more specific guidance, see the Bree Collaborative <a href="#">Dental Guideline on Prescribing Opioids for Acute Pain Management</a>.</li> </ul>
<p>Procedures such as laparoscopic appendectomy, inguinal hernia repair, carpal tunnel release, thyroidectomy, laparoscopic cholecystectomy, breast biopsy/lumpectomy, meniscectomy, lymph node biopsy, vaginal hysterectomy.</p>	<ul style="list-style-type: none"> <li>• Prescribe non-opioid analgesics (e.g., NSAIDs and/or acetaminophen) and non-pharmacologic therapies as first-line therapy.</li> <li>• 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.</li> </ul>
<p>Type II – Expected medium term recovery</p>	
<p>Procedures such as anterior cruciate ligament (ACL) repair, rotator cuff repair, discectomy, laminectomy, open or laparoscopic colectomy, open incisional hernia repair, open small bowel resection or enterolysis, wide local excision, laparoscopic hysterectomy, simple mastectomy, cesarean section.</p>	<ul style="list-style-type: none"> <li>• Prescribe non-opioid analgesics (e.g., NSAIDs and/or acetaminophen) and non-pharmacologic therapies as first-line therapy.</li> <li>• Prescribe ≤7 days (e.g., up to 42 pills) of short-acting opioids for severe pain. Prescribe the lowest effective dose strength.</li> <li>• 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.</li> </ul>
<p>Type III – Expected longer term recovery</p>	
<p>Procedures such as lumbar fusion, knee replacement, hip replacement, abdominal hysterectomy, axillary lymph node resection, modified radical mastectomy, ileostomy/colostomy creation or closure, thoracotomy.</p>	<ul style="list-style-type: none"> <li>• Prescribe non-opioid analgesics (e.g., NSAIDs and/or acetaminophen) and non-pharmacologic therapies as first-line therapy.</li> <li>• Prescribe ≤14 days of short-acting opioids for severe pain. Prescribe the lowest effective dose strength.</li> <li>• 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.</li> </ul>

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