

Telemedicine Site Assessment

Date _____

A. Agency Completing Information

1. Agency/Provider Completing Survey: _____
2. Address: _____
3. Town/City: _____ Zip: _____
4. Contact Person/Title: _____
5. Telephone: _____ FAX: _____
6. email: _____

B. Please tell us about your facility:

1. Number of beds: _____
2. Number of acute care beds _____
3. Emergency Room? ___yes ___no
4. Out patient clinic? ___yes ___no
5. Satellite clinics? ___yes ___no
6. Medical Staff
 _____ Number of Physicians
 _____ Number of Specialists
 List specialties _____
 _____ PAs
 _____ Nurses
7. Are physicians employed by the hospital? ___yes ___no
8. If not, how far away from the hospital are the physicians' offices?
9. Insurance statistics
 % of Medicare _____
 % of Medicaid _____
 % Third party payor _____
 % Self pay _____
 % No insurance _____
- 10: Administrative culture:
 - a. Do you have a strategic plan that includes telemedicine? ___yes ___no
 - b. Is your Board of Trustees supportive of telemedicine? ___yes ___no
 - c. Is your CEO supportive of telemedicine? ___yes ___no
 - d. Are there physician champions of telemedicine? ___yes ___no
 - e. Are you currently providing telemedicine services? ___yes ___no
 - f. If so, what are your successes?

g. If not, are you planning to implement telemedicine? ____yes ____no

B, Please tell us about your community:

1. What is the size of your service area? _____
2. In your opinion, is access to primary care an important problem? ____yes ____no
3. In your opinion is access to emergency care an important problem? ____yes ____no
4. In your opinion is access to specialty care an important issue? ____yes ____no
5. In your opinion, what are the most significant medical service shortages in your service area? (check all that apply)

- _____ Cardiology
- _____ Critical Care
- _____ Dermatology
- _____ Emergency/trauma Medicine
- _____ Endocrinology
- _____ Family Practice
- _____ General Surgery
- _____ Gynecology
- _____ Home Health
- _____ Infectious Disease
- _____ Internal Medicine
- _____ Long Term Care
- _____ Mammography
- _____ Neurology
- _____ Obstetrics
- _____ Occupational Therapy
- _____ Oncology
- _____ Ophthalmology
- _____ Otolaryngology
- _____ Pain Management
- _____ Pathology
- _____ Pediatrics
- _____ Pharmacy
- _____ Podiatry
- _____ Psychiatry
- _____ Radiology
- _____ Rheumatology
- _____ Wound Management
- _____ Other – please specify: _____

C. Please tell us your opinion about telemedicine and medical information needs:

1. In your opinion, how important would increasing access to the following services be in strengthening health services in your community?

Very Somewhat Not at all Duplicative

Cardiology
Critical Care
Dermatology
Emergency/trauma
Endocrinology
Family Practice
General Surgery
Gynecology
Home Health
Infectious Disease
Internal Medicine
Long Term Care
Mammography
Neurology
Obstetrics
Occupational Therapy
Oncology
Ophthalmology
Otolaryngology
Pain Management
Pathology
Pediatrics
Pharmacy
Podiatry
Psychiatry
Radiology
Rheumatology
Wound Management

2. If telemedicine services were available, would you be willing to:

| | | |
|-------------------------|---------|--------|
| Refer patients | ___ Yes | ___ No |
| Participate in consults | ___ Yes | ___ No |
| Attend training | ___ Yes | ___ No |
| Acquire equipment | ___ Yes | ___ No |
| Become a provider | ___ Yes | ___ No |

3. Have you ever participated in a telemedicine consultation?
____Yes ____No

D. To what extent do you perceive the following to be barriers to implementing telemedicine in your community?

Significant Moderate Not a barrier

Attitudes of employer
Competition
Confidentiality
Initial costs
Lack of medical staff
Lack of technical staff
Licensure issues
Medical staff resistance
Ongoing costs
Patient acceptance
Reimbursement
Time commitment
Training

E. Continuing Education Experience and Needs:

1. Does your medical staff travel to urban communities for continuing education?
____yes ____no
2. Estimate the average number of times per year your staff members travel for continuing medical or nursing education. _____
3. If they do not travel for these needs, are there adequate opportunities for continuing education offered in rural areas? ____yes ____no
4. Are you currently offering continuing medical education to your staff by way of video conferencing? ____yes ____no
5. If so, how frequently? _____
6. If not, would your medical staff be interested in participating in continuing education by video conferencing? ____yes ____no
7. Is your staff aware of video streaming as a mechanism of receiving continuing education over the internet? ____yes ____no

F. Equipment Resources

1. Do you have internet access? ____yes ____no
 - a. If yes, is it a central/shared internet access point? _____
 - b. What is the uplink/downlink rate? _____

2. Do you have a videoconferencing bridge? _____yes ____no

3. If yes, please specify:
 - a. Make/model: _____
 - b. H.323 capacity (X# of sites at Y data rate, i.e. 12 at 384 Kbps)

 - c. Internet IP address: _____
 - d. H.320 capacity: _____
 - e. ISDN Dial-up # _____

4. Videoconference Scheduling Coordinator name, phone and email:

5. Videoconference Technical Coordinator name, phone and email:

6. Network technical support contact information including name(s), phone and email: _____

If you currently have a telemedicine program, please complete the following:

1.0 Clinic Environment:

1.1 *Telemedicine Exam Room Size*

Does the room size accommodate both:

1.1.1. The telemedicine equipment, and _____yes_____no

1.1.2 Healthcare provider, patient
and one additional person? _____yes_____no

If no on 1 or 2 above, describe obstacles and challenges:

1.2 *Telemedicine Exam Room Temperature Control*

Is the temperature controlled centrally in the room to account for

1.2.1 Patient comfort _____yes_____no

1.2.2 Equipment preservation _____yes_____no

If no, explain what needs to be modified, and describe plans to make modifications.

1.3 *Telemedicine Exam Room Dust Control*

Does the exam room provide a dust free environment

1.3.1 for the equipment _____yes_____no

1.3.2 for the peripheral devices _____yes_____no

What measures are implemented to control dust?

1.3.4 _____use of electrical air filter device

1.3.5 _____daily cleaning

1.3.6 _____other (please describe)

1.4 *Telemedicine Exam Room Quality Assurance*

1.4.1 Does the cleanliness of the telemedicine examining room meet quality assurance standards? _____yes_____no_____don't know

1.4.2 If yes, describe QA procedures used by housekeeping staff for monitoring standards:

1.4.3 If no, describe plans to modify staff procedures to ensure QA standards are met.

1.4.4 Does the telemedicine exam room contain an inventory of clinical supplies appropriate to the specialties used by your site? ___yes___no

1.4.5 If no, please explain:

1.4.6 Sanitizing the telemedicine peripheral devices. Check frequency of sanitizing procedures

1.4.7 ___after each use

1.4.8 ___daily

1.4.9 ___weekly

1.4.10 ___monthly

1.4.11 ___other (please list frequency)_____

1.4.12 ___never

2.0 **Telemedicine Exam Room Security and Location**

2.1 Are security measures in place to protect the telemedicine peripherals and equipment? Please check appropriate boxes.

2.1.1 ___all equipment maintained in locked environment

2.1.2 ___some equipment maintained in locked environment

2.1.3 ___no equipment maintained in locked environment

2.1.4 ___all peripherals maintained in locked environment

2.1.5 ___some peripherals maintained in locked environment

2.1.6 ___no peripherals maintained in locked environment

2.1.7 ___If you answered no to any of the above questions, describe security measures currently in place:

2.2 Who has access to the telemedicine room? Check all boxes which apply::

2.2.1 ___all physicians

2.2.2 ___telemedicine physicians only

2.2.3 ___all nursing and/or PA personnel

2.2.4 ___telemedicine nurses and/or PA's only

2.2.5 ___all administrative personnel

2.2.6 ___site coordinator

2.2.7 ___all hospital personnel

2.2.8 ___X-ray technician

2.2.9 ___Patients

2.2.10 ___Patients' families

2.2.11 ___other (please describe)

- 2.3 Is the telemedicine room located in a convenient place for utilization by healthcare professionals within the facility?
- 2.3.1 _____yes
- 2.3.2 _____no
- 2.3.3 _____ If no, describe the nature of the inconvenience:

3.0 **Provider Utilization/Equipment Utilization and Inventory**

- 3.1 Check appropriate boxes to describe types of providers using of the system.
- 3.1.1 _____Number of MDs who have presented a real time telemedicine case
- 3.1.2 _____Number of MDs who have presented a store and forward case
- 3.1.3 _____Number of MDs who have received formal training on case protocols
- 3.1.4 _____Number of MDs requesting additional case presentation training
- 3.1.5 _____Number of nurses, NPs, PAs who have presented a real time case
- 3.1.6 _____Number of nurses, NPs, PAs who have presented a store and forward case
- 3.1.7 _____Number of nurses, NPs, PAs who have received formal training on case protocols
- 3.1.8 _____Number of nurses, Nps, PAs requesting additional case presentation training
- 3.2 Steps taken within the facility to encourage providers to use the telemedicine system
- 3.2.1 _____agenda item at staff meetings
- 3.2.2 _____agenda item at medical staff meetings
- 3.2.3 _____agenda item at nursing/PA/other staff meetings
- 3.2.4 _____agenda item at administrative staff meetings
- 3.2.5 _____system noted on internal calendars
- 3.2.6 _____system discussed in internal newsletters
- 3.2.7 _____other (please describe)

3.3 Equipment Utilization and Inventory

Please indicate utilization patterns for all telemedicine equipment and peripheral devices at your facility:

| <u>Equipment Identifier</u> | <u>Often Used</u> | <u>Seldom Used</u> | <u>Never Used</u> |
|-----------------------------|-------------------|--------------------|-------------------|
|-----------------------------|-------------------|--------------------|-------------------|

| <u>Peripheral Identifier</u> | <u>Often Used</u> | <u>Seldom Used</u> | <u>Never Used</u> |
|------------------------------|-------------------|--------------------|-------------------|
|------------------------------|-------------------|--------------------|-------------------|

4.0 Equipment/Software Locator Information

4.1 Is all your telemedicine equipment/software located in a single room (e.g., patient exam room)_____yes_____no

If you answered no to question 4.1, please respond to the following questions.
Provide name of location for the following equipment:

4.2 Store and forward equipment_____

4.3 Real time video unit_____

4.4 Peripheral devices listed on page 4_____

4.5 Telemedicine Protocol Manual_____

4.6 Telemedicine patient forms_____

4.7 Telemedicine evaluation/satisfaction forms_____

4.8 Equipment manuals and documentation_____

4.9 Equipment software_____

4.10 Telemedicine room keys_____

5.0 Administration

5.1 Does your facility’s administrative staff support telemedicine patient care?
_____yes_____no If yes, please describe:

5.2 What would you like to see your administrative staff do to enhance your Telemedicine capacity? Please describe:

5.3 Has your facility’s administrative staff initiated a business plan which allows for fiscal sustainability of the program?

5.3.4_____yes

5.3.5_____no

5.3.6 If no, please discuss:

5.4 Does your administration contribute financially to the telemedicine program?
____yes____no

If yes, how much money is appropriated annually to support your telemedicine program?

____Under \$10,000

____\$10,000-\$20,000

____\$20,000-\$30,000

____Over \$30,000

5.4 Is the telemedicine program contributing to the financial stability of your facility? ____yes____no____don't know

6.0 Community Relations

6.1 Does the facility currently reach out to the community to promote the telemedicine activities? ____yes____no If yes, check the appropriate boxes:

6.1.2 ____community talks by facility personnel____yes____no

6.1.3 ____press releases generated to local media____yes____no

6.1.4 ____other (please describe)

6.2 Would training of facility personnel in how to market the program in the community be worthwhile? ____yes____no

7.0 Clinical Aspects

7.1 Are there plans for expanding the clinical aspects of the telemedicine program within the facility?____yes____no If yes, describe below

7.2 Are there plans for expanding the clinical aspects of the telemedicine program to additional communities or facilities? ____yes____no If yes, describe below

7.3 Has the telemedicine program enabled you to collaborate with other telemedicine sites? ____yes____no

8.0 **Telemedicine Billing**

8.1 Are procedures in place for patient registration and gathering of insurance information? ____yes____no If yes, describe them below

8.2 Are patients being educated on the billing procedures for telemedicine? ____yes____no If yes, describe how in the space below

8.3 Are procedures in place for obtaining prior authorizations from insurance companies? ____yes____no If not, please explain:

9.0 **Referrals**

9.1 Are referral protocols in place with PROVIDER ____yes____no

9.2 Other tertiary hospitals in your network ____yes____no

9.3 What are your normal referral patterns for non-telemedicine patients?

10.0 Follow Up Visits

10.1 Are procedures are being followed for follow-up visits recommended by the telemedicine consultant? ____yes____no If yes, describe below

11.0 Forms

11.1 Do you have a demographics form? If so, is it being filled out completely? ____yes____no If not, please explain

11.2 Are patient satisfaction forms (SF) being completed? ____yes____no If no, please explain

11.3 Are patient satisfaction forms (RT) being completed? ____yes____no If no, please explain

11.4 Are referring clinician satisfaction forms being completed? ____yes____no If no, please explain

11.5 Do you have other forms being completed for telemedicine encounters? ____yes____no If yes, please explain

11.6 Are protocols in place for reviewing and updating the patient information form on follow-up visits? ____yes____no If no, please explain

12.0 Records

12.1 Are telemedicine forms being integrated into the patient record?____yes____no If no, please explain

12.2 Are telemedicine patient records being integrated into the patient's medical record located at the facility for non-telemedicine encounters? ____yes____no

If no, please explain

12.3 Are steps taken to ensure patient privacy and confidentiality? ____yes____no
If no, please explain

12.3 Are any of the following telemedicine forms being used?

Telemedicine Patient Consent Form ____yes____no

Demographics Form - Referral Site ____yes____no

Patient History Form for Internal Medicine Case ____yes____no

Patient History Form for Non-Internal Medicine Case ____yes____no

Patient History Form for Echocardiography Case ____yes____no

Patient History Form for Initial Psychiatric Consultation ____yes____no

Patient History Form for Psychiatric Follow-up Consultation ____yes____no

Patient History Form for Native American Cardiology Program ____yes____no

Pediatric Cardiology Initial Visit ____yes____no

Consent to Present Patient (Real-Time Teleconsultation) ____yes____no

12.4 Are there informed consents on each patient encounter? ____yes____no

12.5 Are final reports being received in a timely manner? ____yes____no

12.6 Are final reports being communicated to the healthcare professional?
____yes____no Please explain your answer

12.7 Are final reports being placed in the patient's file? ____yes____no

13.0 Continuing Medical Education

13.1 Does your facility have a continuing medical education coordinator?
____yes____no If yes, who is that person? _____

13.3 Does your facility have a monthly master calendar listing educational offerings at the facility? ____yes____no

13.4 List what types of people receive the calendar?
____all hospital personnel
____all hospital medical personnel
____targeted groups (list below)

13.5 Are telemedicine CME events promoted at regularly scheduled staff meetings?
____yes____no

13.6 Is the telemedicine room unlocked for scheduled events? ____yes____no

13.7 Who unlocks the telemedicine room and sets up equipment for ATP educational programs? _____please name

13.8 If this person is unavailable, who is the back-up person assigned to the telemedicine room for programs?
_____please name

13.9 Has back-up person received training in how to use the telemedicine equipment? ____yes____no

13.10 Has someone been assigned responsibility for participating in the pre-program check-in 30 minutes prior to scheduled CME events to insure equipment is operating? ____yes____no If yes, please name_____ If no, please explain

13.2 Does the CME portion of the telemedicine program contribute to the financial stability of the facility and/or healthcare professional? ____yes____no If yes, please explain how:

13.3 Are there plans for expanding the educational aspects of the telemedicine program within the facility? ____yes____no If yes, please describe

13.4 Are CME evaluation forms being completed and returned to the telemedicine hub site? ____yes____no

13.5 Are the educational topics offered of interest to your facility personnel ____yes____no If no, list below the topics which you believe will be beneficial to your staff members.

14.0 **Personnel**

14.1 Has there been sufficient telemedicine training of personnel and healthcare professionals at the facility? ____yes____no If no, please explain

14.2 If yes, describe how the training is taking place

14.3 How many hours per week is the site coordinator involved in telemedicine activities?

14.3.1 _____ under 10 hours

14.3.2 _____ under 15 hours

14.3.3 _____ under 20 hours

14.3.4 _____ under 25 hours

14.3.5 _____ under 30 hours

14.3.6 _____ over 30 hours

14.4 How many hours per week is the telemedicine director involved in telemedicine activities?

14.4.1 _____ under 10 hours

14.4.2 _____ under 15 hours

14.4.3 _____ under 20 hours

14.4.4 _____ under 25 hours

14.4.5 _____ under 30 hours

14.4.7 _____ over 30 hours

14.5 Is there backup coverage available for the site coordinator? _____yes_____no
Who is the backup?_____

14.6 Is there backup coverage available for the telemedicine Director?
_____yes_____no

Who is the backup?_____

14.7 Describe the accountability of the site coordinator for telemedicine activities?

15.0 Hub – Site Communication

15.1 Is there sufficient communication between your hub site and the site coordinator?
_____yes_____no If no, please explain what is desired.

15.2 Is there sufficient communication with the hub site staff and the site medical director?
_____yes_____no If no, please explain what is desired

15.3 Is there sufficient communication with the site and appropriate telemedicine vendors? _____yes_____no If no, please explain what is desired

15.4 How is network and/or equipment problems communicated to ATP staff?
Please explain

15.5 Is personnel turnover _____high_____average_____low?
If high, please explain

16.0 Network Environment

16.1 Access Control. Is the network equipment listed below in a secure location protected from unauthorized physical access?

16.1.1 CellPath 90 ATM WAN Mux: _____yes_____no

16.1.2 Ethernet Hub _____yes_____no_____NA

16.1.3 Router _____yes_____no_____NA

16.1.4 T1 Line Extender _____yes_____no_____NA

16.2 Who has access to this equipment?

16.3 Environment: Is the environment appropriate for this equipment in terms of temperature and dust?

16.3.1 CellPath 90 ATM WAN Mux: ___yes___no

16.3.2 Ethernet Hub ___yes___no___NA

16.3.3 Router ___yes___no___NA

16.3.4 T1 Line Extender ___yes___no___NA

16.4 Management Access: Is the network equipment listed below connected to a dial-up phone line for emergency access by hub site personnel for diagnostics in the event of a failure of the network connection?

16.4.1 CellPath 90 ATM WAN Mux: ___yes___no

16.4.2 Ethernet Hub ___yes___no___NA

16.4.3 Router ___yes___no___NA

16.4.4 T1 Line Extender ___yes___no___NA

16.5 Power: Does a UPS protect the network equipment listed below?

16.5.1 CellPath 90 ATM WAN Mux: ___yes___no

16.5.1.1. If yes, is the UPS on Emergency Power ___yes___no

16.5.2 Ethernet Hub ___yes___no___NA

16.5.2.1 If yes, is the UPS on Emergency Power ___yes___no

16.5.3 Router ___yes___no___NA

16.5.3.1 If yes, is the UPS on Emergency Power ____yes____no

16.5.4 T1 Line Extender ____yes____no____NA

16.5.4.1 If yes, is the UPS on Emergency Power ____yes____no

7. Telemedicine technology resources:
 - a. Videoconferencing:
 - b. H.323 (Video over IP): (Y/N)
 - c. H.323 video data rate supported via site's WAN connection
 - d. H.320 (via ISDN or leased line): (Y/N)
 - H.320 data rate:
 - Videoconferencing system make/model:
 - H.323 IP address:
 - H.320 ISDN #:

4. What is your Store and forward software platform? (i.e. Second Opinion):

5. Other: (i.e. specialized systems such as digital radiology modalities)

a. network/program including the following information for each location:

(1) Site name, address, phone #:

(2) Telemedicine coordinator name, phone & email: _____

(3) Technical contact for establishing VPN access with this site - name, phone, email

(4) Site's Wide Area Network (WAN) access characteristics:

(5) WAN Date Rate: _____

(6) Symmetrical WAN connection (same uplink and downlink rates) (Y/N)

(7) If not symmetrical, please specify uplink and downlink rates:

(8) Site internet access characteristics for telemedicine communications:

(a) Site has own dedicated Internet access? (Y/N)

(b) If yes, please specify uplink and downlink rates

(c) Site shares Internet access with other network sites: (Y/N)

(d) If yes, what are the uplink/downlink rates of the connection?