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:

Equipment Identifier	Often Used	Seldom Used	Never Used
_____			
_____			
_____			
_____			
_____			
_____			

Peripheral Identifier	Often Used	Seldom Used	Never Used
_____			
_____			
_____			
_____			
_____			
_____			

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 **Form**s

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 clinican satisfaction forms being completed? ____yes____no If no, please explain

11.5 Do you have other forms being completed for telemedicine encounteres? ____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? ____y es____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 telemedicie 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?