



Tools

TELEMEDICINE SITE ASSESSMENT TOOL

Date _____ Date assessment completed _____

Section I.

Name and title of person completing this section _____

1.0. Hospital or Agency Completing Information

1.1 Hospital/Agency/Provider Completing Survey

1.2 Provider # _____

1.3 Address _____

1.4 Town/City _____ State _____ Zip Code _____

1.5 Contact Person and Title _____

1.6 Telephone # _____ Fax # _____

1.7 E-mail Address _____

2.0. Describe your facility.

2.1 Number of beds _____

2.2 Number of acute care beds _____

2.3 Emergency room? ____yes ____no

2.4 Outpatient clinic? ____yes ____no

2.5 Satellite clinics? ____yes ____no

2.6 Medical Staff

_____ Number of Physicians

_____ Number of Specialists

List specialties _____

_____ Number of Nurses

2.7 Are physicians employed by the hospital? ____yes ____no

2.8 If not, how far away from the hospital are the physicians' offices? Estimate the percentage and distance.

<u>% of Physicians</u>	<u>Distance from Facility</u>
_____	Less than 1 mile
_____	1-3 miles
_____	3-5 miles
_____	5-10 miles
_____	>10 miles

2.9. Insurance statistics

- % Medicare _____
- % Medicaid _____
- % Third party payer _____
- % Self-pay _____
- % No insurance _____

2.10 Administrative culture

- 2.10.1 Do you have a strategic plan that includes telemedicine? ___yes ___no ___not sure
- 2.10.2 Is your Board of Trustees supportive of telemedicine? ___yes ___no ___not sure
- 2.10.3 Is your CEO supportive of telemedicine? ___yes ___no ___not sure
- 2.10.4 Are there physician champions of telemedicine? ___yes ___no ___not sure
- 2.10.5 Are you currently providing telemedicine services? ___yes ___no
- 2.10.6 If so, what are your successes? What are your barriers? Failures?

2.10.7 If not, are you planning to implement telemedicine? ___yes ___no

3.0 Please tell us about your community.

- 3.1 What is the size of your service area? Square miles _____ Population served _____
- 3.2 In your opinion, is access to primary care an important problem? ___yes ___no
- 3.3 In your opinion is access to emergency care an important issue? ___yes ___no
- 3.4 In your opinion is access to specialty care an important issue? ___yes ___no
- 3.5 Do you have "traveling specialists" coming to your community? If so, what specialties and at what frequency do they come? _____

3.6 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: _____



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

4.1 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				

4.2 If telemedicine services were available, would you or your medical staff be willing to do the following?

- | | | | |
|-------------------------|---------|--------|--------------|
| Refer patients | ___ Yes | ___ No | ___ Not Sure |
| Participate in consults | ___ Yes | ___ No | ___ Not Sure |
| Attend training | ___ Yes | ___ No | ___ Not Sure |
| Acquire equipment | ___ Yes | ___ No | ___ Not Sure |
| Become a provider | ___ Yes | ___ No | ___ Not Sure |

4.3 Have you, or anyone you know from your medical staff, ever participated in a telemedicine consultation?
 Yes No

5.0 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			

6.0. Continuing Education Experience and Needs

- 6.1. Does your medical staff travel to urban communities for continuing education? yes no
- 6.2. Estimate the average number of times per year your staff members travel for continuing medical or nursing education. _____
- 6.3. If they do not travel for these needs, are there adequate opportunities for continuing education offered in rural areas? yes no
- 6.4. Are you currently offering continuing medical education to your staff by way of video conferencing? yes no
- 6.5. If so, how frequently? _____
- 6.6. If not, would your medical staff be interested in participating in continuing education by video conferencing? yes no
- 6.7. Is your staff aware of video-streaming as a mechanism of receiving continuing education over the Internet? yes no



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7.0 Equipment Resources

- 7.1 Do you have Internet access? ____yes ____no
 - 7.1.1 If yes, is it a central or shared Internet access point? _____
 - 7.1.2 What is the uplink and downlink rate? _____
- 7.2 Do you have a video-conferencing bridge? ____yes ____no
- 7.3 If yes, please specify:
 - 7.3.1 Make/model _____
 - 7.3.2 H.323 capacity (X# of sites at Y data rate, e.g., 12 at 384 Kbps)

 - 7.3.3 Internet IP address _____
 - 7.3.4 H.320 capacity _____
 - 7.3.5 ISDN Dial-up # _____
- 7.4 Video-conference Scheduling Coordinator name, telephone, and e-mail address: _____

- 7.5 Video-conference Technical Coordinator name, telephone, and e-mail address: _____

- 7.6 Network technical support contact information including name(s), telephone, and e-mail address: _____



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

Section II.

Name and title of person completing this section _____

1.0 Clinic Environment

1.1 Telemedicine Exam Room Size

Does the room size accommodate the following?

1.1.1 The telemedicine equipment _____yes _____no

1.1.2 Health care 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 the following.

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 for the following?

1.3.1 Equipment _____yes _____no

1.3.2 Peripheral devices _____yes _____no

What measures are implemented to control dust?

1.3.3 _____use of electrical air filter device

1.3.4 _____daily cleaning

1.3.5 _____other (please describe)

1.4 Telemedicine Exam Room Quality Assurance (QA)

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 How often are the telemedicine peripheral devices sanitized? Check frequency of sanitizing.

1.4.6.1 _____ after each use

1.4.6.2 _____ daily

1.4.6.3 _____ weekly

1.4.6.4 _____ monthly

1.4.6.5 _____ other (please list frequency)

1.4.6.6 _____ 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 physician assistant (PA) personnel
- 2.2.4 telemedicine nurses and/or PAs 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 health care 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 the system during the past 12 months.

- 3.1.1 Number of physicians who have presented a real time telemedicine case
- 3.1.2 Number of physicians who have presented a store and forward case
- 3.1.3 Number of physicians who have received formal training on case protocols
- 3.1.4 Number of physicians requesting additional case presentation training
- 3.1.5 Number of nurses, nurse practitioners (NPs), or PAs who have presented a real time case
- 3.1.6 Number of nurses, NPs, or PAs who have presented a store and forward case
- 3.1.7 Number of nurses, NPs, or PAs who have received formal training on case protocols
- 3.1.8 Number of nurses, NPs, or PAs requesting additional case presentation training

3.2 Steps taken within the facility to encourage providers to use the telemedicine system (please check those that apply)

- 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, and 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	Used Often	Seldom	Never

Peripheral Identifier	Used Often	Seldom	Never



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4.0 Equipment and 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 person responsible and location for the following equipment.

4.2 Store and forward equipment _____

4.3 Real time video unit _____

4.4 Peripheral devices listed above _____

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?

5.3.1 ___yes

5.3.2 ___no

5.3.3 If no, please discuss.

5.4 Are you near a state border? ___yes ___no

Is your staff referral pattern such that patients are referred to specialists in the adjoining state? Please describe.

5.5 Does your facility have liability coverage for telemedicine services? ___yes ___no

5.6 Does your facility 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 to \$20,000

___ \$20,000 to \$30,000

___ More than \$30,000

5.7 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 your facility currently reach out to the community to promote the telemedicine activities? ___yes ___no If yes, check the appropriate boxes following.

6.1.1 ___community talks by facility personnel

6.1.2 ___press releases generated to local media

6.1.3 ___other (please describe)



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6.2 Would training of facility personnel in how to market the program in the community be worthwhile? ____yes ____no If no, why not?

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 telemedicine patient registration and gathering of insurance information? ____yes ____no If yes, describe 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 authorization for telemedicine services from insurance companies? ____yes ____no If not, please explain.



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9.0 Referrals

- 9.1 Are referral protocols in place with your facility providers? ____yes ____no
- 9.2 Are referral protocols in place with other tertiary hospitals in your network? ____yes ____no
- 9.3 What are your standard referral patterns for non-telemedicine patients?

10.0 Follow-up Visits

- 10.1 Are procedures being followed to assure compliance with 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? ____yes ____no
If yes, 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 why not.

- 11.3 Are referring clinician satisfaction forms being completed? ____yes ____no If no, please explain why not.

11.4 Do you have other forms being completed for telemedicine encounters? ____yes____no
If yes, please explain what they are.

11.5 Are protocols in place for reviewing and updating patient information form on follow-up visits? ____yes____no If no, please explain why not.

12.0 Records

12.1 Are telemedicine progress notes or consult forms being integrated into patient medical records? ____yes____no If no, please explain.

12.2 Are telemedicine patient medical records being integrated into those records located at the facility and available for non-telemedicine encounters or admissions? ____yes____no If no, please explain why not.

12.3 Are steps taken to ensure patient privacy and confidentiality? ____yes____no If yes, please briefly describe what these steps are.

- 12.4 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 |
- 12.5 Are there informed consents obtained on each patient encounter? ___yes ___no
- 12.6 Are final reports being received by the referring provider and facility in a timely manner? ___yes ___no If not, why not?
- _____
- _____
- _____
- 12.7 Are final reports being communicated to the health care professional? ___yes ___no
 Please explain your answer.
- _____
- _____
- _____
- 12.8 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, what is the title of that person? _____

13.2 Does your facility have a monthly master calendar listing educational offerings at the facility? ___yes___no

13.3 List which staff members receive the calendar.

___all hospital personnel

___all hospital medical personnel

___targeted groups (list below)

13.4 Are telemedicine CME events promoted at regularly scheduled staff meetings? ___yes___no

13.5 Is the telemedicine room unlocked for scheduled events? ___yes___no

13.6 Who unlocks the telemedicine room and sets up equipment for ATP educational programs or other CME events? _____(give title). Has this ever been a problem? ___yes___no

If yes, why?

13.7 If this staff member is unavailable, which staff position is assigned as the back-up to the telemedicine room for programs? _____(give title)

13.8 Has back-up person received education on use of the telemedicine equipment? ___yes___no

13.9 Has someone been assigned responsibility for participating in the pre-program check-in 30 minutes prior to scheduled CME events to ensure equipment is operating and to register attendees? ___yes___no If yes, please give the position title _____

If no, please explain how it works.

13.10 Does the CME portion of the telemedicine program contribute to the financial stability of the facility and/or health care professional? ____yes____no
If yes, please explain how.

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

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

13.13 Are the educational topics offered of interest to your facility personnel? ____yes____no
Do your personnel have input for topic selection? If no, list below the topics which you believe will be beneficial and of interest to your staff members.

14.0 Personnel

14.1 Has there been sufficient telemedicine education of personnel and health care professionals at the facility? ____yes____no If no, please explain.

14.2 If yes to above, describe how the education occurs.

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 _____ more than 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
- 14.4.6 _____ more than 30 hours

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

What is the position title of the backup? _____

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

What is the position title of 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 remote site medical director?

_____yes_____no If no, please explain what is desired.

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

15.4 How are network and/or equipment problems communicated to ATP telemedicine program staff? Please describe.

15.5 Is telemedicine 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 and 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 What position titles have access to the above 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 telephone 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

If yes, is the UPS on Emergency Power ___yes ___no

16.5.2 Ethernet Hub ___yes ___no ___NA

If yes, is the UPS on Emergency Power ___yes ___no

16.5.3 Router ___yes ___no ___NA

If yes, is the UPS on Emergency Power? ___yes ___no

16.5.4 T1 Line Extender ___yes ___no ___NA

If yes, is the UPS on Emergency Power ___yes ___no

17.0. Telemedicine technology resources

17.1 Videoconferencing. Do you have the following capability?

17.1.1 H.323 (Video over IP): ___yes ___no

17.1.2 H.323 video data rate supported via site's WAN connection ___yes ___no

17.1.3 H.320 (via ISDN or leased line): ___yes ___no

17.1.4 H.320 data rate: _____

17.2 List your videoconferencing system make/model.

H.323 IP address:

H.320 ISDN #:



Tools

18.0 What is your Store and Forward software platform? (e.g., Second Opinion)

19.0. Other

List other modalities (e.g., specialized systems such as digital radiology modalities)

19.1 Give the network and program including the following information for each location.

A. Site name, address, telephone number:

B. Telemedicine coordinator name, telephone, and e-mail address:
