CTRC Telehealth Needs and Readiness Assessment

Part I: Operational Site Assessment

General Facility Information

1. Facility Name:

2. Organization Affiliation / Company:

3. Physical Address:

4. Website:

5. Which type of facility best describes this site (FQHC, CHC, CAH, RHC, Hospital etc.)?

6. For FQHCs or RHCs, what is your current PPS rate?

7. What is your clinic/facility's daily visit average?

8. What is your current no-show rate?

9. What is the estimated payer mix of your current patient population?

   a) % Medicare:
   b)
   c) % Medicaid (Medi-Cal):

   d) % Private Insurance:

   e) % Self Pay / Uninsured:

10. What Medicaid Managed Care Plan(s) does this facility currently have?

    a) Plan 1: % of population:

    b) Plan 2: % of population:

11. What Medicare Advantage Plan(s) does this facility currently have?

    a) Plan 1: % of population:

    b) Plan 2: % of population:

Primary Contact Information

Name:

Title:

Phone:

Email:

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Provider Information

1. How many primary care providers practice in your facility?

   MD: DO: NP: PA:

2. How many specialty care providers practice in your facility? Please list by specialty

Clinical and Administrative Service Needs

Does this facility currently utilize telemedicine as part of its practice? ☐ Yes ☐ No

If yes:

a) When did the program begin?

b Is the telemedicine room(s) in a good location free of noise, have good lighting, seating etc.?

c Is the telemedicine room(s) in a secure location where audio cannot be heard from surrounding areas of the facility?

d For which specialties is telemedicine currently being utilized? Please note if these are being imported or exported, and list partner site

Specialty	Imported: Partner Site	Exported: Parter Site

2. Has this facility ever had a telemedicine program in the past that is no longer running? ☐ Yes ☐ No

   If so, please describe the program, general time frame, and cause for its stall:

3. If there are currently no telemedicine services, has a location been identified for a telemedicine room(s)?

4. Do you plan to implement telemedicine services in the next 12 months? ☐ Yes ☐ No

   If yes, what is your target timeline for implementation?

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5. What telehealth services does the organization wish to implement? Please complete the chart below

For monthly volume: please enter a number in the corresponding column.
For Technology and Model Type, click the box to create a check mark.

	Monthly Volume		Technology			Model		
Specialty	Adult	Pediatric	Live Video	Store & Forward	Remote Monitoring	Provider & Patient to Specialist (Live Video)	Provider to Provider (eConsult)	Direct to Consumer
Asthma/Allergy								
Behavioral Health - Other								
Behavioral Health - Psychiatry								
Behavioral Health - Psychology								
Cardiology								
Chronic Disease Management								
Clinical Education/Training								
Dentistry								
Dermatology								
Dietary/Nutrition								
Endocrinology								
Evidentiary Exams								
Gastroenterology								
Hepatology								
Home Monitoring								
Hospice Care								
Infectious Disease								
Interpreting Services								
Intesive Care								
Nephrology								
Neurology								
Obstetrics & Gynecology								
Occupational Medicine								
Oncology								
Opthalmology								
Orthopedics								
Otolaryngology								
Pain Medication								
Patient Education								
Pharmacy								
Podiatry								
Primary Care								
Pulmonology								
Rehabilitation								
Rhematology								
Speech Pathology								
Stroke								
SUD/OUD								
Triage								
Urgent Care								
Urology								
Wound Care								

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6. Does this facility have a standardized, well defined referral system?

☐ Yes (please describe) No

Existing Technology Infrastructure and Equipment Inventory

1. Do you have internet access in your clinic exam rooms? Check all that apply
   ☐ All rooms
   ☐ Some rooms
   ☐ Via Wall Jack
   ☐ Via Wireless

2. Do you have internet access in the room you use for conferences and staff meetings?
   ☐ All rooms
   ☐ Some rooms
   ☐ Via Wall Jack
   ☐ Via Wireless

3. What is your current internet speed/bandwidth?
   ☐Less than 10Mbps
   ☐ 10Mbps
   ☐ 25Mbps
   ☐ 100 Mbps
   ☐ Greater than 100Mpbs
   ☐ Not sure

4. Who is your internet service provider (ISP)?

5. Do you have access to tech support that is available locally and/or on-call?

   ☐ Yes ☐ No

   If yes, please specify how you are receiving your technical support:

6. If you currently have telemedicine equipment, for what is or was it utilized?
   ☐ Live video
   ☐ Store and forward
   ☐ Remote patient monitoring
   ☐ Other:

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CTRC Telehealth Needs and Readiness Assessment

7. Live video equipment:
   ☐ PC and software
   ☐ Tablet
   ☐ Mobile cart
   ☐ Other:

   High definition or standard? ☐ Standard ☐ High Definition

   Monitor size (not applicable for tablets, PCs or laptops):

   Is this mounted or mobile? ☐ Mounted ☐ Mobile

   Easily moveable from one room to another? ☐ Yes ☐ No

8. Do you have any of the below telemedicine peripherals?
   ☐ General exam camera
   ☐ Electronic stethoscope
   ☐ Otoscope
   ☐ Dermascope
   ☐ Nasopharyngoscope
   ☐ Other:

9. Store and Forward:
   For which specialties do you utilize store and forward technology?

   What software do you use?

   What camera?

10. Remote Patient Monitoring:
    Please describe active telehealth RPM program, if applicable

    What hardware is used?
    ☐ Blood glucose monitor
    ☐ Digital thermometer
    ☐ Blood pressure monitors
    ☐ Pulse Oximeter
    ☐ Scales
    ☐ Tablets
    ☐ Other:

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11. eConsult
    Does your clinic currently utilize eConsult? ☐ Yes ☐ No

    If yes, please list platform utilized:

12. Does your organization utilize an EHR? ☐ Yes ☐ No

    If so, please list brand:

13. Does your EHR support telehealth encounters via live video?
    ☐ Yes ☐ No

Leadership Support and Clinical Buy-In

1. Which of the following do you perceive to be barriers to implementing and sustaining your telemedicine program? (Check all that apply)
   ☐ High level buy-in
   ☐ Competition
   ☐ Confidentiality
   ☐ Initial costs
   ☐ Lack of medical staff
   ☐ Lack of dedicated coordinator staff
   ☐ Lack of technical staff
   ☐ Lack of specialty access
   ☐ Licensure access
   ☐ Medical staff resistance
   ☐ Start up and/or Ongoing costs
   ☐ Patient acceptance
   ☐ Reimbursement
   ☐ Time commitment
   ☐ Training
   ☐ Other:

2. Please list other perceived barriers and/or expand upon those checked above.

Do you currently have any grant funding to support a telehealth program? ☐ Yes ☐ No

If yes, please identify source of funding, duration of support and provide a brief description of the project:

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4. Is there an institutional funding commitment? ☐ Yes ☐ No

   If yes, please provide pertinent details of funding commitment:

   Will this funding support ongoing operations, staffing, equipment and technical infrastructure?

   ☐ Yes (please explain below) ☐ No

5. Do you have staff capacity to manage additional services? ☐ Yes ☐ No
6. Do you have an organizational plan in place to accommodate the additional services generated by the delivery of telemedicine (additional volume, ancillary tests, specialty relationship maintenance, etc.) ☐ Yes ☐ No
7. Are staff encouraged to express their ideas when faced with organizational changes?
8. Describe the level of clinical provider buy-in
9. Are your clinical providers willing to incorporate telehealth into daily practice? Including patient identification, referral, presentation and follow up? ☐ Yes ☐ No
10. Please list clinician champion(s)
11. Please list IT champion(s)
12. Please list leadership champion(s)
13. Are any of the below barriers to administrative or clinical provider buy-in?

    ☐ Identified champion(s)
    ☐ Decision maker interest
    ☐ Support for initiative
    ☐ Project Approval
    ☐ Stakeholder (i.e. patient) Education / Program Perception
    ☐ Other:

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Existing and Potential Relationships with Specialty Providers

1. Please list your current telemedicine specialty provider relationships (if any).

2. Please list any potential or desired specialty provider relationships you are aware of.

3. Are there any providers within your organization, practicing at a different location, that provides or could provide telemedicine services? ☐ Yes (please describe) ☐ No

Organizational Assessment

1. Have there been discussions within your organization concerning readiness for telemedicine? ☐ Yes ☐ No

2. Have you established goals or a desired change that will come from implementing telemedicine? ☐ Yes ☐ No

   If yes, are the goals / desired changes clearly defined? ☐ Yes (please list) ☐ No

3. Does your organization readily accept change, or prefer to maintain the status quo?

4. Has your organization previously formed successful collaborative partnerships? ☐ Yes ☐ No

5. Does your organization have a well-established method for communicating with staff? ☐ Yes ☐ No

6. Is your organization aware of examples of telehealth being used in similar organizations or communities?

   ☐ Yes (please list) ☐ No

7. Does a telehealth project align with the organization's vision and approach to achieving goals & objectives?

   ☐ Yes ☐ No

   If yes, please explain how:

   If no, please list barriers to alignment:

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Part II: On-Site Technical Assessment

Physical:

1. Number of rooms:
2. Ethernet drops in every room? ☐ Yes ☐ No
   Notes:
3. Telemedicine equipment:

Network:

1. CTN circuit? ☐ Yes ☐ No
2. Other circuits:
3. LAN speeds:
4. Wireless:
5. Wiring closet:
6. Patch Panel / Exam room jacks labeled and match? ☐ Yes ☐ No
   Notes:
7. Firewall:
8. UPS? ☐ Yes ☐ No
   Notes:
9. HVAC in MPOE? ☐ Yes ☐ No
10. DR
11. Any future plans?
12. Met with following staff:
13. Notes / recommendations:

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