Telemedicine Pre - Implementation Survey

The following questions will allow us to determine the best approach to implementation of a Telemedicine Program specific to your facility needs. Please respond as best as possible and contact us if you have any questions.

Facility Name _____

Facility Street Address _____

Town / City _____, County,_____ Zip Code _____

Facility Phone # _(____)_____

Facility Website _____. ____

Facility Levels of Care and Services Please Check all that apply:

( ) Skilled Nursing ( ) Assisted Living ( ) Independent Living ( ) Hospice ( ) Home Care

( ) TBI ( ) Behavioral ( ) HIV/Aids ( ) Adult Home Other please describe _____

CEO _____ Email _____Phone Ext. _____

Administrator _____ Email _____Phone Ext. _____

CFO _____ Email _____ Phone Ext._____

Medical Director _____ Email _____Phone Ext.____

Director of Nursing _____ Email _____Phone Ext. ____

IT Director _____ Email _____ PhoneExt._____

Please provide the following information from facility cost reports, census information, medical records programs and Quality Assurance data:

Facility Capacity by level of care _____ _____ _____

Annual # of Admissions by level of care _____ _____ _____

Average Length of Stay by level of care _____ _____ _____

% of Payor Sources Private_____ Medicare _____ Medicaid _____ Managed Care_____

Veterans _____ other _____

Please list Managed Care Referral Sources _____

_____ _____ _____ _____

Annual # of Transfers to Emergency Rooms _____

If possible please provide specific information as to the time of day and days of the week transfers and discharges are most prominent by shift and weekday or weekend.

_____

_____

Please list the most frequent reasons for transfer :

_____ _____ _____ _____ _____

Does your facility routinely send an employee with the resident during a transfer to a hospital until admission is determined?

Please explain your
policy :_____

_____

Annual # of Re Admissions to Hospitals in less than 30 Days post admission _____

Please list the most frequent reasons for Re-Admissions to Hospitals:

_____ _____ _____ _____ _____

Please provide the number of consultations provided on an annual basis by specialty and indicate wether these consultations are on or off facility premises:

# of Psychiatric on premises _____ off premises _____

# of Psychological on premises _____ off premises _____

# of Pain Management on premises _____ off premises _____

# of Orthopedic Follow Up on premises _____ off premises _____

# of Infectious Disease on premises _____ off premises _____

# of Endocrinologist on premises _____ off premises _____

# of Wound Care on premises _____ off premises _____

# of Dermatologist on premises _____ off Premises _____

# of Cardiologist on premises _____ off premises _____

# of Neurologist on premises _____ off premises _____

# of Urologist on premises _____ off premises _____

# of Pulmonologist on premises _____ off premises _____

Dietician/Nutritionist on premises _____ off premises _____

Substance Abuse on premises _____ off premises _____

Please list any other high volume consultations your facility may be experiencing other than those listed above :

_____ on premises _____ off premises _____

_____ on premises _____ off premises _____

Are there any consultation specialties that you are currently having difficulty in providing in your

area? Please List : _____ _____ _____

Please indicate the the average waiting time for consultations wether on or off premises that your facility is experiencing in scheduling appointments and which of the specialty areas seem to be the most difficult to get a prompt appointment.

_____

_____

Please describe the frequency that a facility employee, escort, CNA accompanies residents to off premises consultations as well as the average time these staff members are off premises with the residents for a typical consultation:

_____

_____

_____

Please indicate the number of portable diagnostic services you are experiencing annually for:

Xray _____ Doppler _____ Cardiogram _____

other _____

Name of portable diagnostic company providing services _____

Please describe the Medical Services at your facility indicating whether you have a closed medical group or individual community physicians attending your residents and indicate the number of attending physicians that are currently providing services to your residents.

Please also indicate wether or not your facility utilizes Physician Assistants and Nurse Practitioners.

_____

_____

_____

_____

Please indicate the name and location of the hospitals that you receive referrals from and transfer or discharge to:

_____

_____

_____

_____

If your facility does not have its own Home Care Program please indicate the name and contact information of the Home Care Service you commonly refer to upon community discharges:

Name of Home Care Service_____ Phone # _____

Name of Home Care Service_____ Phone #_____

Does your facility currently utilize any Telemedicine, Telehealth, or video conferencing services?

If yes please describe your current remote care capabilities. _____

_____

_____

Does your facility currently have the ability to allow family members to participate in a medical care conference or consultation wether the family resides in or out of the area ? ( ) Yes ( ) No

Please indicate wether the employees at the facility have medical coverage benefits and list the insurance companies currently providing coverage. We ask this because Telemedicine on premises could reduce employee absenteeism.

# of Management Employees covered _____

Name of Insurance Company_____

Type of Policy _____

If there are Union Employees;

# of Union Employees _____

Name of Union _____

Any additional information you would like us to know: _____

_____

_____

_____

_____

_____.

THANK YOU FOR YOU INPUT AND TIME :)