Fairview University Telemedicine Guidelines:

Standards of Care, Policy and Procedure

Definition:

Telemedicine has been defined as "the use of electronic communication and information technologies to provide or support clinical care at a distance." This does apply to advanced communications such as store and forward and interactive video transmissions. Excluding the customary use of telephone conversations between providers when discussing patient care and management.

Telemedicine is a cooperative effort between Fairview Health Services and University of Minnesota. The primary purpose of the Telemedicine network is to develop communications and specialty consultations and visits via interactive video transmissions.

Users:

Transmissions may be provider-to-provider (with or without the patient present) or provider-to-patient. A consent form that states the patient is aware of the potential of the visit may be used for research or later analyzed for quality assurance purposes is to be signed by the patient before the visit with the provider.

Providers will practice Telemedicine within the boundaries of their licenses, credentials, privileges, keeping in mind that the technology is only a tool assisting in the provision of care at a distance and not a substitute for appropriate, responsible decision making. If either of the providers of the patient feel that the transmitted images are insufficient for diagnosis or treatment, the patient may be referred to a consultant at the local facility or a consultant at the University of Minnesota in Minneapolis for direct care. Providers do not need to be employed by the University of Minnesota to use the Telemedicine. In such cases that the Network is unable to attract physicians from the University of Minnesota Physicians Network, physicians outside the Network will be solicited.

Technical requirements/ Uses: The technology and the bandwidth required to transmit images sufficient for a Telemedicine encounter should be determined by the intention of its use. The clinical problems that are most amendable to Telemedicine solutions are largely cognitive in nature i.e. Problems in which a decision directly affecting treatment or disposition can be made by providing the appropriate visual as well as auditory or written data to a remote consultant. While interactive video conferencing at a minimum bandwidth (112/128kps) may be adequate in most encounters, some therapeutic consultations may require broader bandwidth (336/384kps) since the motion distortion at the lower bandwidth may interfere with making an accurate assessment.
**Physician Patient Relationship:**
Responsibility for a patient’s care remains the same as in the traditional practice. During Telemedicine encounters, the patient remains the responsibility of the referring provider. If a specialist sees a patient initially in clinic and then via Telemedicine in follow-up, his/her responsibilities to the patient are the same as if the patient had come to the specialty clinic for the follow-up visit. If the interaction is patient teaching, the provider has the same responsibility as when the patient visits in person.

**Documentation:**
All providers are required to document clinical notes for the consults or visit, as institutional policy and JCAHO Standards require them. The specialist’s note should be kept on file at the consultant’s site and a copy sent to the referring site.

**Privacy and Confidentiality:**
Institutional policies governing Privacy and Confidentiality are in effect for Telemedicine. Transmissions in which the patient is identifiable will be treated the same as having the patient present and the patient will be afforded appropriate privacy.

Protocols will be written by each clinical service using telemedicine identifying requirements specific for each service. These protocols will include: Type of Consultations
Clinic Protocols – Telemedicine Locations

Hub Site

Description:

The hub telemedicine exam room is located on the first floor of the Fairview-University Medical Center - University Campus 420 Delaware Street SE, Minneapolis, MN 55454 Room 2-455, Unit J. It is the main telemedicine room for all specialties except psychiatry. The psychiatry examination room is located at Fairview-University Medical Center - Riverside Campus, located in the Corporate office building first floor, room B. The satellite sites are located at various rural hospitals in the state of Minnesota. The satellite sites consist of an examination room with the necessary equipment and administrative offices.

Hours of Operation:

The telemedicine offices are open for consults from 8:00am - 5:00pm, Monday through Friday. Continuing Medical Education seminars are scheduled in the evenings. Special scheduling sessions can be made with Marshall Hoff.

Recruiting

Dr. Jim House will contact the specialists once an identified need for service is established by the spoke site coordinator and the hub site project coordinator. The Telemedicine Project will be recruiting University of Minnesota Physicians (UMP). In the event that the University Physicians express little or no interest, the telemedicine network medical director will seek private specialist to assist with the telemedicine project.

Credentialing

The Credentialing process will be handled by the organization the physician works for and the spoke site (clinic or hospital) directly where services are being performed.

Joint Commission standards states:

**MS.XX** Practitioners who diagnose or treat patients via telemedicine link are subject to the credentialing and privileging processes of the organization that receives the telemedicine service.

**MS.XX.1** The medical staff recommends the clinical services to be provided by the telemedicine.

Intent of MS.XX through MS.XX.1
Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may now be performed via telemedicine link. The medical staff determines which clinical services are appropriately delivered through this medium, according to a commonly accepted quality standard.

If a telemedicine practitioner prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient, the telemedicine practitioner is credentialed and privileged through the medical staff mechanisms set forth in MS.5 through MS.5.15.7 by the organization receiving the telemedicine service. An organization may use credentialing information from another Joint Commission accredited facility that is receiving the telemedicine service.

It will be the responsibility of the site coordinator to give the spoke site's specialist list to the hospital-staffing department.

**Preparing the Hub Site Room for a Telemedicine Consult**

1. Arrive 15 minutes before scheduled specialty.
2. Turn both monitors on by pressing the buttons labeled power.
3. Adjust the camera to the specialist chair and use the preset setting for the appropriate zoom.
4. Perform an audio/video test to ensure the equipment is working properly.
5. Organize the practitioner's paperwork that has been faxed to the hub site on the secured fax machine.
6. Log the telemedicine event on the Interactive Audio/Video Usage Log (see attached).
7. Mute the volume until the practitioner arrives and is ready for the patient's appointment.

**Scheduling a Telemedicine Clinic**

The participating specialist will notify the telemedicine schedule coordinator with the available times and dates for telemedicine services. The times and dates are then posted on the web-based calendar for the telemedicine staff.

**Medical Records**

The specialist's designed office personnel and the spoke site is responsible for the maintenance of the patient's medical record.
# Conference/Equipment Use Log

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Spoke Site - Telemedicine Clinic:

I. Identifying the Patient

1. Patient requires a referral from a primary physician to initiate a consult with a specialist via telemedicine.
2. Referrals for telemedicine may be accepted as orders, written or verbal, from physician, nurse practitioner and/or physician assistant.
3. Referrals are logged in a Telemedicine Referral Log (See Attachment Log 1) date of referral, patient’s name, home & work numbers, patient’s condition, symptoms, problems, referring provider, specialist assigned, date patient contacted by TM Nurse, date of scheduled appointment, comment field to track messages, unable to reach or other pertinent information.
4. Each specialist has an assigned date book of schedules. The referral information is then logged in the appropriate specialist’s schedule book.

II. Scheduling a Clinic

1. Determining Date of clinic:
   Contact the specialist or his office secretary or the Outreach nurse and confirm date, time and consultant’s availability.
2. After the date and time are established, contact the Technical Coordinator, Marshall Hoff, to advise him of the clinic.

III. Preparing for the Clinic

1. Call the patient to remind him/her of the appointment time and location of the consultation (usually occurs 1 week prior to scheduled clinic).
2. Using the specialist’s schedule book, compile a list of all patients scheduled for that particular telemedicine session included In this list: patients name, patient’s condition, symptoms, problems, referring provider, patient’s date of birth, patient’s home & work phone numbers, patient’s date of injury, date of service, assigned TM Identification #.
3. Assign each patient an identification number, different from the medical record number or hospital identification number. This number will be used exclusively for the telemedicine office and each patient will be assigned only one number. A repeat patient uses the originally assigned number, regardless of the specialist or specialty. The number is used on the telemedicine evaluation forms.

IV. Patient Contact
1. Call the patient at number given to schedule an appointment.
2. Identify yourself and the department.
3. Obtain medication information from the patient. If the patient is unsure of the name of the prescription, have the patient bring all medications with him/her to the telemedicine session.
4. Explain the telemedicine procedures and answer any questions the patient may have.
5. Schedule the patient for a date and time when the appropriate specialist is available.
6. Inform patient of directions to the clinic/hospital.
7. Give the patient thorough instructions as to when the patient arrives for the appointment and where he/she needs to register.

V. Record Preparation

1. Use the telemedicine consult sheets for each patient.
2. Clinic or hospital charts are obtained and record preparations begin.
3. Obtain history from patient’s medical record.
4. Utilizing the patient’s medical record;
   a. Obtain information about the patient’s presenting problem(s) and history of problems i.e. using dictations, consults, lab reports, MRI, CT, etc. Copy all pertinent information.
   b. Obtain the provider’s referral letter, if any, and copy.
   c. Obtain a copy of the most recent consult dictation with previous specialist or primary care provider. **FUMC does not have access to the patient’s charts. It’s important to include a copy of all necessary information.
5. All data collected is written on the specialty specific telemedicine consult sheets.
6. Records and consults forms are faxed to the designated location for the telemedicine session. The FUMC staff or technical coordinator secures the information. In some cases, the information is faxed directly to the specialist.
7. If the patient has been injured on the job and identified as a worker’s compensation case, the work ability report must be faxed to the specialist, completed by the specialist and faxed back to the originating location.

VI. Patient Registration

1. Telemedicine patient list is generated on the computer. The list includes specialty, specialist, date and time of the clinic.
2. The telemedicine clinic patient list is then distributed to:
   a. the clinic - enables telemedicine staff to obtain each patient’s medical record
   b. front desk – registration check-in point
c. Occupational therapy, physical therapy & respiratory therapy- a representative from each department is present during specific telemedicine clinics.
d. X-ray - identifies clinic times in the event patient will need x-ray per specialist request.

3. The patient enters the clinic and registers at the front desk (site-specific). Patient demographics are verified. The patient is then brought to the telemedicine office where the consent forms; evaluation form and triage are completed.

VII. Post Visit

1. Orders are taken verbally for medications, lab tests, X-rays, diagnostic tests and ordered accordingly.
2. The presenting nurse arranges for tests to be done locally or at the nearest facility to the patient that performs the required testing.
3. Medications are phoned verbally to the pharmacy from the presenting nurse.
4. Workman’s Compensation approvals are obtained for patients that need additional diagnostic tests visits surgeries, etc.
5. If surgery is required (a) the presenting nurse calls the secretary of the specialist and schedules an appointment. The demographic and orders are faxed to the specialist’s office for their file. (b) The presenting nurse schedules with the patient an appointment for pre-op physical and education.
6. Patient education on the diagnostic findings and tests are done.
7. The patient completes post-visit evaluation section of the evaluation form.
8. If the patient required a recheck it is determined at the end of the telemedicine clinic by the specialist at which time the patient is scheduled for a follow-up appointment. If a specialty clinic is not yet scheduled for this future period of time, the nurse than logs the information in the follow-up file by month by specialty. Included in the log is the name of the patient, date of birth, phone numbers, identification number assigned by the TM staff, and reason for another appointment. The appointment scheduler will call the patient to confirm the date once a specific date is determined.

VIII. Medical Records

1. Every medical record generated from a telemedicine consult is kept alphabetically in the telemedicine office.
2. 3 books for each provider are kept in the telemedicine office.
   a. Schedules book – includes past, present and future schedules, blank report of workability forms, OT & PT referral sheets, lists all rechecks and follow-up patients.
   b. Current book – includes the past 3 months consultations including client list of patients
c. Old Telemedicine Book – patients that have been seen in the past 12 months by the specialist and will not be returning unless new problem develops.

3. The following receive records of the telemedicine patient:
   a. Hospital or clinic where TM services were performed - receives the original signed dictation consent form, and registration.
   b. Referring provider’s medical records – receives a copy of the signed dictation
   c. Telemedicine office – copies of demographics, consent, evaluation, workability report, Nurse’s notes, telemedicine consult form.
   d. Workman’s Compensation – copies of the workability report.

IX. Billing

The specialist providing consultative or follow-up care will bill the patient’s insurance carrier for the service through UMP Billing Office. If the insurance carrier denies payment, the Office of Advancement for Telehealth Grant will supplement the physicians at a predetermined rate per patient until August 30, 2003. This would include all patients without insurance. If the insurance carrier makes payment, no payment will be made by the grant funds. The hub and spoke site will continue to negotiate coverage for these services with payers in the area of service sites.
Orthopedic Telemedicine Protocols

I. Identifying the Patient

1. Patient requires a referral from a primary physician to initiate a consult with a specialist via telemedicine.
2. Referrals for telemedicine may be accepted as orders, written or verbal, from physician, nurse practitioner and/or physician assistant.
3. Referrals are logged in a Telemedicine Referral Log (See Attachment Log 1) date of referral, patient’s name, home & work numbers, patient’s condition, symptoms, problems, referring provider, specialist assigned, date patient contacted by TM Nurse, date of scheduled appointment, comment field to track messages, unable to reach or other pertinent information.
4. Each specialist has an assigned date book of schedules. The referral information is then logged in the appropriate specialist’s schedule book.

II. Scheduling a Clinic

1. Determining Date of clinic:
   Contact the specialist or his office secretary or the Outreach nurse and confirm date, time and consultant’s availability.
2. After the date and time are established, contact the Technical Coordinator, Marshall Hoff, to advise him of the clinic.

III. Preparing for the Clinic

1. Call the patient to remind him/her of the appointment time and location of the consultation (usually occurs 1 week prior to scheduled clinic).
2. Using the specialist’s schedule book, compile a list of all patients scheduled for that particular telemedicine session included In this list: patients name, patient’s condition, symptoms, problems, referring provider, patient’s date of birth, patient’s home & work phone numbers, patient’s date of injury, date of service, assigned TM Identification #.
3. Assign each patient an identification number, different from the medical record number or hospital identification number. This number will be used exclusively for the telemedicine office and each patient will be assigned only one number. A repeat patient uses the originally assigned number, regardless of the specialist or specialty. The number is used on the telemedicine evaluation forms.

IV. Patient Contact
1. Call the patient at number given to schedule an appointment.
2. Identify yourself and the department.
3. Obtain medication information from the patient. If the patient is unsure of the name of the prescription, have the patient bring all medications with him/her to the telemedicine session.
4. Explain the telemedicine procedures and answer any questions the patient may have.
5. Schedule the patient for a date and time when the appropriate specialist is available.
6. Inform patient of directions to the clinic/hospital.
7. Give the patient thorough instructions as to when the patient arrives for the appointment and where he/she needs to register.

V. Record Preparation

1. Use the telemedicine consult sheets for each patient.
2. Clinic or hospital charts are obtained and record preparations begin.
3. Obtain history from patient’s medical record.
4. Utilizing the patient’s medical record:
   a. Obtain information about the patient’s presenting problem(s) and history of problems i.e. using dictations, consults, lab reports, MRI, CT, etc. Copy all pertinent information.
   b. Obtain the provider’s referral letter, if any, and copy.
   c. Obtain a copy of the most recent consult dictation with previous specialist or primary care provider. **FUMC does not have access to the patient’s charts. It’s important to include a copy of all necessary information.
5. All data collected is written on the specialty specific telemedicine consult sheets.
6. Records and consults forms are faxed to the designated location for the telemedicine session. The FUMC staff or technical coordinator secures the information. In some cases, the information is faxed directly to the specialist.
7. The following information is faxed for an Orthopedic consult:
   a. Telemedicine Consult Sheet
   b. MRI, CT reports
   c. Past dictation or clinic notes
   d. Demographics
8. If the patient has been injured on the job and identified as a worker’s compensation case, the work ability report must be faxed to the specialist, completed by the specialist and faxed back to the originating location.
9. It is necessary to bring the patient’s previous X-rays and MRI’s to the patient’s telemedicine appointment in case the Orthopedist wants to view them.
10. If the patient is present for follow-up visit, bring all diagnostic test results for the specialist.
VI. **Patient Registration**

1. Telemedicine patient list is generated on the computer. The list includes specialty, specialist, date and time of the clinic.
2. The telemedicine clinic patient list is then distributed to:
   a. the clinic – enables telemedicine staff to obtain each patient’s medical record
   b. front desk – registration check-in point
   c. Occupational therapy, physical therapy & respiratory therapy – a representative from each department is present during specific telemedicine clinics.
   d. X-ray – identifies clinic times in the event patient will need x-ray per specialist request.
3. The patient enters the clinic and registers at the front desk (site-specific). Patient demographics are verified. The patient is then brought to the telemedicine office where the consent forms; evaluation form and triage are completed.

VII. **Post Visit**

1. Orders are taken verbally for medications, lab tests, X-rays, diagnostic tests and ordered accordingly.
2. The presenting nurse arranges for tests to be done locally or at the nearest facility to the patient that performs the required testing.
3. Medications are phoned verbally to the pharmacy from the presenting nurse.
4. Workman’s Compensation approvals are obtained for patients that need additional diagnostic tests visits surgeries, etc.
5. If surgery is required (a) the presenting nurse calls the secretary of the specialist and schedules an appointment. The demographic and orders are faxed to the specialist’s office for their file. (b) The presenting nurse coordinates with the Outreach Office and schedules an appointment for the patient’s pre-op physical and pre-surgery teaching session.
6. If MRI is ordered, the presenting nurse will schedule it at the facility.
7. If X-rays are needed, write the orders and advise the patient that he/she needs to have those completed prior to the follow-up visit.
8. If casting/splinting is necessary, arrange with the clinic/facility where available to complete.
9. If OT/PT required, complete referrals.
10. If Injections needed, schedule them with appropriate area.
11. If the patient required a recheck it is determined at the end of the telemedicine clinic by the specialist at which time the patient is scheduled for a follow-up appointment. If a specialty clinic is not yet scheduled for this future period of time, the nurse than logs the
information in the follow-up file by month by specialty. Included in the log is the name of the patient, date of birth, phone numbers, identification number assigned by the TM staff, and reason for another appointment. The appointment scheduler will call the patient to confirm the date once a specific date is determined.

VIII. Medical Records

1. Every medical record generated from a telemedicine consult is kept alphabetically in the telemedicine office.
2. 3 books for each provider are kept in the telemedicine office.
   a. Schedules book - includes past, present and future schedules, blank report of workability forms, OT & PT referral sheets, lists all rechecks and follow-up patients.
   b. Current book - includes the past 3 months consultations including client list of patients.
   c. Old Telemedicine Book - patients that have been seen in the past 12 months by the specialist and will not be returning unless new problem develops.
3. The following receive records of an orthopedic telemedicine patient:
   a. Hospital or clinic where TM services were performed - receives the original signed dictation consent form, and registration.
   b. Referring provider’s medical records - receives a copy of the signed dictation.
   c. Telemedicine office - copies of demographics, consent, evaluation, workability report, Nurse’s notes, telemedicine consult form.
   d. Workman’s Compensation - copies of the workability report.
Dermatology Protocols

I. Identifying the Patient

1. Patient requires a referral from a primary physician to initiate a consult with a specialist via telemedicine.
2. Referrals for telemedicine may be accepted as orders, written or verbal, from physician, nurse practitioner and/or physician assistant.
3. Referrals are logged in a Telemedicine Referral Log (See Attachment Log 1) date of referral, patient’s name, home & work numbers, patient’s condition, symptoms, problems, referring provider, specialist assigned, date patient contacted by TM Nurse, date of scheduled appointment, comment field to track messages, unable to reach or other pertinent information.
4. Each specialist has an assigned date book of schedules. The referral information is then logged in the appropriate specialist’s schedule book.

II. Scheduling a Clinic

1. Determining Date of clinic:
   - Contact the specialist or his office secretary or the Outreach nurse and confirm date, time and consultant’s availability.
2. After the date and time are established, contact the Technical Coordinator, Marshall Hoff, to advise him of the clinic.

III. Preparing for the Clinic

1. Call the patient to remind him/her of the appointment time and location of the consultation (usually occurs 1 week prior to scheduled clinic).
2. Using the specialist’s schedule book, compile a list of all patients scheduled for that particular telemedicine session included In this list: patients name, patient’s condition, symptoms, problems, referring provider, patient’s date of birth, patient’s home & work phone numbers, patient’s date of injury, date of service, assigned TM Identification #.
3. Assign each patient an identification number, different from the medical record number or hospital identification number. This number will be used exclusively for the telemedicine office and each patient will be assigned only one number. A repeat patient uses the originally assigned number, regardless of the specialist or specialty. The number is used on the telemedicine evaluation forms.

IV. Patient Contact
1. Call the patient at number given to schedule an appointment.
2. Identify yourself and the department.
3. Obtain medication information from the patient. If the patient is unsure of the name of the prescription, have the patient bring all medications with him/her to the telemedicine session.
4. Obtain as much information as possible from patient regarding the problem for the visit including the location of the problem and how long it’s been present. Also, if there has been any biopsies or treatments previously.
5. Obtain all medications/over-the-counter drugs, lotions, creams used recently to treat the presenting problem.
6. Explain the telemedicine procedures and answer any questions the patient may have.
7. Schedule the patient for a date and time when the appropriate specialist is available.
8. Inform patient of directions to the clinic/hospital.
9. Give the patient thorough instructions as to when the patient arrives for the appointment and where he/she needs to register.

V. Record Preparation

1. Use the Dermatology Consult Form for documenting the visit, one for each patient.
2. Clinic or hospital charts are obtained and record preparations begin.
3. Obtain history from patient’s medical record.
4. Utilizing the patient’s medical record:
   a. Obtain information about the patient’s presenting problem(s) and history of problems i.e. using dictations, consults, lab reports, MRI, CT, etc. Copy all pertinent information.
   b. Obtain the provider’s referral letter, if any, and copy.
   c. Obtain a copy of the most recent consult dictation with previous specialist or primary care provider. **FUMC does not have access to the patient’s charts. It’s important to include a copy of all necessary information.
5. All data collected is written on the specialty specific telemedicine consult sheets.
6. Records and consults forms are faxed to the designated location for the telemedicine session. The FUMC staff or technical coordinator secures the information. In some cases, the information is faxed directly to the specialist.
7. If the patient has been injured on the job and identified as a worker’s compensation case, the work ability report must be faxed to the specialist, completed by the specialist and faxed back to the originating location.

VI. Patient Registration

Telemedicine Clinic Protocols

The information provided is that of Minnesota Telehealth Network and does not constitute legal or business advice. Any person who takes or uses the information from this document must tailor the information to coincide with the user’s own organizational needs. Minnesota Telehealth Network disclaims any and all liability of any kind that results from user’s copying information from this document.
1. Telemedicine patient list is generated on the computer. The list includes specialty, specialist, date and time of the clinic.
2. The telemedicine clinic patient list is then distributed to:
   a. the clinic - enables telemedicine staff to obtain each patient’s medical record
   b. front desk - registration check-in point
3. The patient enters the clinic and registers at the front desk (site-specific). Patient demographics are verified. The patient is then brought to the telemedicine office where the consent forms; evaluation form and triage are completed.

VII. Post Visit

1. Orders are taken verbally for medications, lab tests, X-rays, diagnostic tests and ordered accordingly.
2. The presenting nurse arranges for tests to be done locally or nearest facility that performs the required testing.
3. Medications are phoned verbally to the pharmacy from the presenting nurse. The dermatology patients will receive handouts and some education on medications given, appointments scheduled for biopsies,
4. If surgery is required (a) the presenting nurse calls the secretary of the specialist and schedules an appointment. The demographic and orders are faxed to the specialist’s office for their file. (b) The presenting nurse schedules with the patient an appointment for pre-op physical and education.
5. Patient education on the diagnostic findings and tests are done.
6. Rechecks: If the patient required a recheck it is determined at the end of the telemedicine clinic by the specialist at which time the patient is scheduled for a follow-up appointment. If a specialty clinic is not yet scheduled for this future period of time, the nurse then logs the information in the follow-up file by month by specialty. Included in the log is the name of the patient, date of birth, phone numbers, identification number assigned by the TM staff, and reason for another appointment. The appointment scheduler will call the patient to confirm the date once a specific date is determined.

VIII. Medical Records

1. Every medical record generated from a telemedicine consult is kept alphabetically in the telemedicine office.
2. 3 books for each provider are kept in the telemedicine office.
   a. Schedules book – includes past, present and future schedules, blank report of workability forms, OT & PT referral sheets, lists all rechecks and follow-up patients.
   b. Current book – includes the past 3 months consultations including client list of patients
c. Old Telemedicine Book – patients that have been seen in the past 12 months by the specialist and will not be returning unless new problem develops.

3. The following receive records of the telemedicine patient:
   a. Hospital or clinic where TM services were performed - receives the original signed dictation consent form, and registration.
   b. Referring provider’s medical records – receives a copy of the signed dictation
   c. Telemedicine office – copies of demographics, consent, evaluation, workability report,
      Nurse’s notes, telemedicine consult form.
   d. Workman’s Compensation – copies of the workability report.

IX. Billing

1. The specialist providing consultative or follow-up care will bill the patient’s insurance carrier or the service through UMP Billing Office. If the insurance carrier denies payment, the Office of Advancement for Telehealth Grant will supplement the physicians at a predetermined rate for a maximum of 3 years. This would include all patients without insurance. If the insurance carrier makes payment, no payment will be made by the grant funds. The hub and spoke site will continue to negotiate coverage for these services with payers in the area of service sites.
2. The dictation must be submitted with the patient's charge master.
Cardiology Protocols

I. Identifying the Patient

1. Patient requires a referral from a primary physician to initiate a consult with a specialist via telemedicine.
2. Referrals for telemedicine may be accepted as orders, written or verbal, from physician, nurse practitioner and/or physician assistant.
3. Referrals are logged in a Telemedicine Referral Log (See Attachment Log 1) Date of referral, patient’s name, home & work numbers, patient’s condition, symptoms, problems, referring provider, specialist assigned, date patient contacted by TM Nurse, date of scheduled appointment, comment field to track messages, unable to reach or other pertinent information.
4. Each specialist has an assigned date book of schedules. The referral information is then logged in the appropriate specialist’s schedule book.

II. Scheduling a Clinic

1. Determining Date of clinic: Contact the specialist or his office secretary or the Outreach nurse and confirm date, time and consultant’s availability.
2. After the date and time are established, contact the Technical Coordinator, Marshall Hoff, to advise him of the clinic.

III. Preparing for the Clinic

1. Call the patient to remind him/her of the appointment time and location of the consultation (usually occurs 1 week prior to scheduled clinic).
2. Using the specialist’s schedule book, compile a list of all patients scheduled for that particular telemedicine session included In this list: patients name, patient’s condition, symptoms, problems, referring provider, patient’s date of birth, patient’s home & work phone numbers, patient’s date of injury, date of service, assigned TM Identification #.
3. Assign each patient an identification number, different from the medical record number or hospital identification number. This number will be used exclusively for the telemedicine office and each patient will be assigned only one number. A repeat patient uses the originally assigned number, regardless of the specialist or specialty. The number is used on the telemedicine evaluation forms.

IV. Patient Contact

1. Call the patient at number given to schedule an appointment.
2. Identify yourself and the department.
3. Obtain medication information from the patient. If the patient is unsure of the name of the prescription, have the patient bring all medications with him/her to the telemedicine session.

4. Obtain as much information as possible from patient regarding the problem for the visit including the location of the problem and how long it’s been present. Also, if there has been treatments previously.

5. Obtain all medications/over-the-counter drugs used recently to treat the presenting problem.

6. Explain the telemedicine procedures and answer any questions the patient may have.

7. Schedule the patient for a date and time when the appropriate specialist is available.

8. Inform patient of directions to the clinic/hospital.

9. Give the patient thorough instructions as to when the patient arrives for the appointment and where he/she needs to register.

V. Record Preparation

1. Use the consult form for documenting the visit, one for each patient.

2. Clinic or hospital charts are obtained and record preparations begin.

3. Obtain history from patient’s medical record.

4. Utilizing the patient’s medical record:
   a. Obtain information about the patient’s presenting problem(s) and history of problems i.e. using dictations, consults, lab reports, MRI, CT, etc. Copy all pertinent information.
   b. Obtain the provider’s referral letter, if any, and copy.
   c. Obtain a copy of the most recent consult dictation with previous specialist or primary care provider. **FUMC does not have access to the patient’s charts. It’s important to include a copy of all necessary information.

5. All data collected is written on the specialty specific telemedicine consult sheets.

6. Records and consults forms are faxed to the designated location for the telemedicine session. The FUMC staff or technical coordinator secures the information. In some cases, the information is faxed directly to the specialist.

7. If the patient has been injured on the job and identified as a worker’s compensation case, the work ability report must be faxed to the specialist, completed by the specialist and faxed back to the originating location.

VI. Patient Registration

1. Telemedicine patient list is generated on the computer. The list includes specialty, specialist, date and time of the clinic.

2. The telemedicine clinic patient list is then distributed to:
   a. the clinic - enables telemedicine staff to obtain each patient’s medical record
b. front desk - registration check-in point
3. The patient enters the clinic and registers at the front desk (site-specific). Patient demographics are verified. The patient is then brought to the telemedicine office where the consent forms; evaluation form and triage are completed.

VII. Post Visit

1. Orders are taken verbally for medications, lab tests, EKG, diagnostic tests and ordered accordingly.
2. The presenting nurse arranges for tests to be done locally or nearest facility that performs the required testing.
3. Medications are phoned verbally to the pharmacy from the presenting nurse.
4. Dermatology patients receive more teaching on medications, handouts given, appointments scheduled for biopsies,
5. Workman’s Compensation approvals are obtained for patients that need additional diagnostic tests visits surgeries, etc.
6. If surgery is required (a) the presenting nurse calls the secretary of the specialist and schedules an appointment. The demographic and orders are faxed to the specialist’s office for their file. (b) The presenting nurse schedules with the patient an appointment for pre-op physical and education.
7. Patient education on the diagnostic findings and tests are done.
8. If the patient required a recheck it is determined at the end of the telemedicine clinic by the specialist at which time the patient is scheduled for a follow-up appointment. If a specialty clinic is not yet scheduled for this future period of time, the nurse than logs the information in the follow-up file by month by specialty. Included in the log is the name of the patient, date of birth, phone numbers, identification number assigned by the TM staff, and reason for another appointment. The appointment scheduler will call the patient to confirm the date once a specific date is determined.

VIII. Medical Records

1. Every medical record generated from a telemedicine consult is kept alphabetically in the telemedicine office.
2. 3 books for each provider are kept in the telemedicine office.
   a. Schedules book – includes past, present and future schedules, blank report of workability forms, OT & PT referral sheets, lists all rechecks and follow-up patients.
   b. Current book – includes the past 3 months consultations including client list of patients
c. Old Telemedicine Book - patients that have been seen in the past 12 months by the specialist and will not be returning unless new problem develops.

3. The following receive records of the telemedicine patient:
   a. Hospital or clinic where TM services were performed - receives the original signed dictation consent form, and registration.
   b. Referring provider’s medical records - receives a copy of the signed dictation
   c. Telemedicine office - copies of demographics, consent, evaluation, workability report, nurse’s notes, telemedicine consult form.
Pulmonology Protocols

I. Identifying the Patient

1. Patient requires a referral from a primary physician to initiate a consult with a specialist via telemedicine.
2. Referrals for telemedicine may be accepted as orders, written or verbal, from physician, nurse practitioner and/or physician assistant.
3. Referrals are logged in a Telemedicine Referral Log (See Attachment Log 1) Date of referral, patient’s name, home & work numbers, patient’s condition, symptoms, problems, referring provider, specialist assigned, date patient contacted by TM Nurse, date of scheduled appointment, comment field to track messages, unable to reach or other pertinent information.
4. Each specialist has an assigned date book of schedules. The referral information is then logged in the appropriate specialist’s schedule book

II. Scheduling a Clinic

1. Determining Date of clinic:
   Contact the specialist or his office secretary or the Outreach nurse and confirm date, time and consultant’s availability.
2. After the date and time are established, contact the Technical Coordinator, Marshall Hoff, to advise him of the clinic.
3. Contact the Respiratory Therapist and notify him/her of the date and time of the clinic and the number of patients scheduled. Arrange to have pulmonary function tests done before clinic if patient has not had any or if it has been more than a year prior to having one or being seen by a physician.

III. Preparing for the Clinic

1. Call the patient to remind him/her of the appointment time and location of the consultation (usually occurs 1 week prior to scheduled clinic).
2. Using the specialist’s schedule book, compile a list of all patients scheduled for that particular telemedicine session included In this list: patients name, patient’s condition, symptoms, problems, referring provider, patient’s date of birth, patient’s home & work phone numbers, patient’s date of injury, date of service, assigned TM Identification #.
3. Assign each patient an identification number, different from the medical record number or hospital identification number. This number will be used exclusively for the telemedicine office and each patient will be assigned only one number. A repeat patient
uses the originally assigned number, regardless of the specialist or specialty. The number is used on the telemedicine evaluation forms.

IV. Patient Contact

1. Call the patient at number given to schedule an appointment.
2. Identify yourself and the department.
3. Obtain medication information from the patient. If the patient is unsure of the name of the prescription, have the patient bring all medications with him/her to the telemedicine session.
4. Obtain as much information as possible from patient regarding the problem for the visit including the location of the problem and how long it’s been present. Also, if there has been any biopsies or treatments previously.
5. Obtain all medications/over-the-counter drugs, lotions, creams used recently to treat the presenting problem.
6. Explain the telemedicine procedures and answer any questions the patient may have.
7. Schedule the patient for a date and time when the appropriate specialist is available.
8. Inform patient of directions to the clinic/hospital.
9. Give the patient thorough instructions as to when the patient arrives for the appointment and where he/she needs to register.

V. Record Preparation

1. Use the consult form for documenting the visit, one for each patient.
2. Clinic or hospital charts are obtained and record preparations begin.
3. Obtain history from patient’s medical record.
4. Obtain a letter from the primary care physician or physician’s assistant identifying the presenting problems and all history they have on the patient.
5. Obtain the chest x-ray from the clinic, primary care physician or the radiology department and have it available for the consultant.
6. Utilizing the patient’s medical record:
   a. Obtain information about the patient’s presenting problem(s) and history of problems i.e. using dictations, consults, lab reports, MRI, CT, etc. Copy all pertinent information.
   b. Obtain the provider’s referral letter, if any, and copy.
   c. Obtain a copy of the most recent consult dictation with previous specialist or primary care provider. **FUMC does not have access to the patient’s charts. It’s important to include a copy of all necessary information.
7. All data collected is written on the specialty specific telemedicine consult sheets.
8. Records and consults forms are faxed to the designated location for the telemedicine session. The FUMC staff or technical coordinator secures the information. In some cases, the information is faxed directly to the specialist.

VI. Patient Registration

1. Telemedicine patient list is generated on the computer. The list includes specialty, specialist, date and time of the clinic.
2. The telemedicine clinic patient list is then distributed to:
   a. the clinic – enables telemedicine staff to obtain each patient’s medical record
   b. front desk – registration check-in point
   c. Occupational therapy, physical therapy & respiratory therapy– a representative from each department is present during specific telemedicine clinics.
   d. X-ray – identifies clinic times in the event patient will need x-ray per specialist request.
3. The patient enters the clinic and registers at the front desk (site-specific). Patient demographics are verified. The patient is then brought to the telemedicine office where the consent forms; evaluation form and triage are completed.

VII. Post Visit

1. Orders are taken verbally for medications, lab tests, X-rays, diagnostic tests and ordered accordingly.
2. The presenting nurse arranges for tests to be done locally or nearest facility that performs the required testing.
3. Medications are phoned verbally to the pharmacy from the presenting nurse.
4. Dermatology patients receive more teaching on medications, handouts given, appointments scheduled for biopsies,
5. Workman’s Compensation approvals are obtained for patients that need additional diagnostic tests visits surgeries, etc.
6. If surgery is required (a) the presenting nurse calls the secretary of the specialist and schedules an appointment. The demographic and orders are faxed to the specialist’s office for their file. (b) The presenting nurse schedules with the patient an appointment for pre-op physical and education.
7. Patient education on the diagnostic findings and tests are done.
8. The patient completes post-visit evaluation section of the evaluation form.
9. If the patient required a recheck it is determined at the end of the telemedicine clinic by the specialist at which time the patient is scheduled for a follow-up appointment. If a
specialty clinic is not yet scheduled for this future period of time, the nurse then logs the information in the follow-up file by month by specialty. Included in the log is the name of the patient, date of birth, phone numbers, identification number assigned by the TM staff, and reason for another appointment. The appointment scheduler will call the patient to confirm the date once a specific date is determined.

VIII. Medical Records

1. Every medical record generated from a telemedicine consult is kept alphabetically in the telemedicine office.

2. 3 books for each provider are kept in the telemedicine office.
   a. Schedules book – includes past, present and future schedules, blank report of workability forms, OT & PT referral sheets, lists all rechecks and follow-up patients.
   b. Current book – includes the past 3 months consultations including client list of patients
   c. Old Telemedicine Book – patients that have been seen in the past 12 months by the specialist and will not be returning unless new problem develops.

3. The following receive records of the telemedicine patient:
   a. Hospital or clinic where TM services were performed - receives the original signed dictation consent form, and registration.
   b. Referring provider’s medical records – receives a copy of the signed dictation
   c. Telemedicine office – copies of demographics, consent, evaluation, workability report,
      Nurse’s notes telemedicine consult form, and workability report.
Child Psychiatry &/ or Adolescent Counseling by the Pediatrician

I. Identifying the Patient

1. Patient requires a referral from a primary physician to initiate a consult with a specialist via telemedicine.
2. Referrals for telemedicine may be accepted as orders, written or verbal, from physician, nurse practitioner and/or physician assistant.
3. Referrals are logged in a Telemedicine Referral Log (See Attachment Log 1) date of referral, patient’s name, home & work numbers, patient’s condition, symptoms, problems, referring provider, specialist assigned, date patient contacted by TM Nurse, date of scheduled appointment, comment field to track messages, unable to reach or other pertinent information.
4. Each specialist has an assigned date book of schedules. The referral information is then logged in the appropriate specialist’s schedule book.

II. Scheduling a Clinic

1. Determining Date of clinic: Contact the specialist or his office secretary or the Outreach nurse and confirm date, time and consultant’s availability.
2. After the date and time are established, contact the Technical Coordinator, Marshall Hoff, to advise him of the clinic.

III. Preparing for the Clinic

1. Call the patient to remind him/her of the appointment time and location of the consultation (usually occurs 1 week prior to scheduled clinic). The Outreach Nurse, scheduling personnel or site coordinator does this.
2. Using the specialist’s schedule book, compile a list of all patients scheduled for that particular telemedicine session included In this list: patients name, patient’s condition, symptoms, problems, referring provider, patient’s date of birth, patient’s home & work phone numbers, date of service, assigned TM Identification #.
3. Assign each patient an identification number, different from the medical record number or hospital identification number. This number will be used exclusively for the telemedicine office and each patient will be assigned only one number. A repeat patient uses the originally assigned number, regardless of the specialist or specialty. The number is used on the telemedicine evaluation forms.
IV. Patient Contact

1. Call the patient's parent or guardian at number given to schedule an appointment.
2. Identify yourself and the department.
3. Obtain medication information from the patient's parent or guardian. If the parent is unsure of the name of the prescription, have all medications brought the day of the telemedicine session.
4. Explain the telemedicine procedures and answer any questions the patient may have.
5. Schedule the patient for a date and time when the appropriate specialist is available.
6. Inform patient of directions to the clinic/hospital.
7. Give the patient thorough instructions as to when the patient arrives for the appointment and where he/she needs to register.

V. Record Preparation

1. Use the telemedicine consult sheets for each patient.
2. Clinic or hospital charts are obtained and record preparations begin (usually done by the nurse assigned to the clinic).
3. Obtain history from patient's medical record.
4. Utilizing the patient’s medical record:
   a. Obtain information about the patient’s presenting problem(s) and history of problems i.e. using dictations, consults, lab reports, testing done by the school or other professional, evaluations from primary care physician or counselors. Copy all pertinent information.
   b. Obtain the provider’s referral letter, if any, and copy.
   c. Obtain a copy of the most recent consult dictation with previous specialist or primary care provider. **FUMC does not have access to the patient’s charts. It’s important to include a copy of all necessary information.
5. All data collected is written on the specialty specific telemedicine consult sheets.
6. Records and consults forms are faxed to the designated location for the telemedicine session. The FUMC staff or technical coordinator secures the information.
7. Each psychiatrist has his/her individual preferences, however the assigned nurse will fax the patient’s collected information to the physician no later than 24 hours prior to the visit.
8. In the event a patient is presenting to the psychiatrist and it's a workman's compensation reported event, a work ability report must be faxed to the specialist, completed by the specialist and faxed back to the originating location.

VI. Patient Registration
1. Telemedicine patient list is generated on the computer. The list includes specialty, specialist, date and time of the clinic.

2. The telemedicine clinic patient list is then distributed to:
   a. the clinic – enables telemedicine staff to obtain each patient’s medical record
   b. front desk – registration check-in point

3. The patient enters the clinic and registers at the front desk (site-specific). Patient demographics are verified. The patient is then brought to the telemedicine office where the consent forms; evaluation form and triage are completed.

VII. **During the Consult**

1. Once the patient is registered, the patient is brought into the exam room. Once the psychiatrist is ready, the patient and parent/guardian or person accompanying them to the visit is introduced to the psychiatrist. When a child is the patient, it is necessary to do the introductions each visit.

2. Focus camera on patient only and leave the office once the equipment is set to the desired location. For confidentiality purposes, the nurse presenter leaves the office and gives the parent/guardian instructions once the session is completed. The nurse presenter is usually right outside the door.

3. If the exam rooms have 2 monitors, shut the power off of one of the monitors. "Near camera" which shows the activity at the spoke site.

VIII. **Post Visit**

1. Orders are taken verbally for medications, lab tests, and diagnostic tests and ordered accordingly. If the psychiatrist orders medications, the presenting nurse will call the patient’s primary care physician to confirm the order and management of the patient.

2. The presenting nurse arranges for tests to be done locally or nearest facility that performs the required testing.

3. Medications are phoned verbally to the pharmacy from the presenting nurse.

4. Workman’s Compensation approvals are obtained for patients that need additional diagnostic tests and/or further services.

5. The presenting nurse will perform patient education on the diagnostic findings and tests.

6. The patient completes post-visit evaluation section of the evaluation form.

7. If the patient requires additional services by the psychiatrist at the completion of the visit, a follow-up appointment is scheduled. If a specialty clinic is not yet scheduled for this future period of time, the nurse than logs the information in the follow-up file by month by specialty. Included in the log is the name of the patient, date of birth, phone numbers, identification number assigned by the TM staff, and reason for another appointment.
The appointment scheduler will call the patient to confirm the date once a specific date is determined.

IX. Medical Records

1. Every medical record generated from a telemedicine consult is kept alphabetically in the telemedicine office.
2. 3 books for each provider are kept in the telemedicine office.
   a. Schedules book – includes past, present and future schedules, blank report of workability forms, OT & PT referral sheets, lists all rechecks and follow-up patients.
   b. Current book – includes the past 3 months consultations including client list of patients
   c. Old Telemedicine Book – patients that have been seen in the past 12 months by the specialist and will not be returning unless new problem develops.
3. The following receive records of the telemedicine patient:
   a. Hospital or clinic where TM services were performed – receives the original signed dictation consent form, and registration.
   b. Referring provider’s medical records – receives a copy of the signed dictation
   c. Telemedicine office – copies of demographics, consent, evaluation, workability report,
      Nurse’s notes, telemedicine consult form.
   d. Workman’s Compensation – copies of the workability report.

X. Billing

The specialist providing consultative or follow-up care will bill the patient’s insurance carrier for the service through UMP Billing Office. If the insurance carrier denies payment, the Office of Advancement for Telehealth Grant will supplement the physicians at market rate per patient. This would include all patients without insurance. If the insurance carrier makes payment, no payment will be made by the grant funds. The hub and spoke site will continue to negotiate coverage for these services with payers in the area of service sites.
Wound Care Protocols

I. Identifying the Patient

1. Patient requires a referral from a primary physician to initiate a consult with a specialist via telemedicine.
2. Referrals for telemedicine may be accepted as orders, written or verbal, from physician, nurse practitioner and/ or physician assistant.
3. Referrals are logged in a Telemedicine Referral Log (See Attachment Log 1)
   Date of referral, patient’s name, home & work numbers, patient’s condition, symptoms, problems, referring provider, specialist assigned, date patient contacted by TM Nurse, date of scheduled appointment, comment field to track messages, unable to reach or other pertinent information.
4. Each specialist has an assigned date book of schedules. The referral information is then logged in the appropriate specialist’s schedule book.

II. Scheduling a Clinic

1. Determining Date of clinic:
   Contact the specialist or his office secretary or the Outreach nurse and confirm date, time and consultant’s availability.
2. After the date and time are established, contact the Technical Coordinator, Marshall Hoff, to advise him of the clinic.

III. Preparing for the Clinic

1. Call the patient to remind him/ her of the appointment time and location of the consultation (usually occurs 1 week prior to scheduled clinic).
2. Using the specialist’s schedule book, compile a list of all patients scheduled for that particular telemedicine session included In this list: patients name, patient’s condition, symptoms, problems, referring provider, patient’s date of birth, patient’s home & work phone numbers, patient’s date of injury, date of service, assigned TM Identification #.
3. Assign each patient an identification number, different from the medical record number or hospital identification number. This number will be used exclusively for the telemedicine office and each patient will be assigned only one number. A repeat patient uses the originally assigned number, regardless of the specialist or specialty. The number is used on the telemedicine evaluation forms.

II. Patient Contact
1. Call the patient at number given to schedule an appointment.
2. Identify yourself and the department.
3. Obtain medication information from the patient. If the patient is unsure of the name of the prescription, have the patient bring all medications with him/her to the telemedicine session.
4. Explain the telemedicine procedures and answer any questions the patient may have.
5. Schedule the patient for a date and time when the appropriate specialist is available.
6. Inform patient of directions to the clinic/hospital.
7. Give the patient thorough instructions as to when the patient arrives for the appointment and where he/she needs to register.

III. During the Patient’s Visit
1. Collect the debriding instruments, dressings, and camera with grid film to take pictures of the wounds.

IV. Record Preparation
1. Use the telemedicine consult sheets for each patient.
2. Clinic or hospital charts are obtained and record preparations begin.
3. Obtain history from patient’s medical record.
4. Utilizing the patient’s medical record;
   a. Obtain information about the patient’s presenting problem(s) and history of problems i.e. using dictations, consults, lab reports, MRI, CT, etc. Copy all pertinent information.
   b. Obtain the provider’s referral letter, if any, and copy.
   c. Obtain a copy of the most recent consult dictation with previous specialist or primary care provider. ** FUMC does not have access to the patient’s charts. It’s important to include a copy of all necessary information.
5. All data collected is written on the specialty specific telemedicine consult sheets.
6. Records and consult forms are faxed to the designated location for the telemedicine session. The FUMC staff or technical coordinator secures the information. In some cases, the information is faxed directly to the specialist.
7. If the patient has been injured on the job and identified as a worker’s compensation case, the work ability report must be faxed to the specialist, completed by the specialist and faxed back to the originating location.

V. Patient Registration
1. Telemedicine patient list is generated on the computer. The list includes specialty, specialist, date and time of the clinic.
2. The telemedicine clinic patient list is then distributed to:
   a. the clinic – enables telemedicine staff to obtain each patient’s medical record
   b. front desk – registration check-in point
3. The patient enters the clinic and registers at the front desk (site-specific). Patient demographics are verified. The patient is then brought to the telemedicine office where the consent forms; evaluation form and triage are completed.

VI. Post Visit

1. Orders are taken verbally for medications, lab tests, X-rays, diagnostic tests and ordered accordingly.
2. The presenting nurse arranges for tests to be done locally or at the nearest facility to the patient that performs the required testing.
3. Medications are phoned verbally to the pharmacy from the presenting nurse.
4. If surgery is required (a) the presenting nurse calls the secretary of the specialist and schedules an appointment. The demographic and orders are faxed to the specialist’s office for their file. (b) The presenting nurse schedules with the patient an appointment for pre-op physical and education.
5. Patient education on the diagnostic findings and tests are done.
6. If the patient required a recheck it is determined at the end of the telemedicine clinic by the specialist at which time the patient is scheduled for a follow-up appointment. If a specialty clinic is not yet scheduled for this future period of time, the nurse than logs the information in the follow-up file by month by specialty. Included in the log is the name of the patient, date of birth, phone numbers, identification number assigned by the TM staff, and reason for another appointment. The appointment scheduler will call the patient to confirm the date once a specific date is determined.

VII. Medical Records

1. Gird pictures are kept on each patient evaluated and treated in the wound clinic.
2. The signed consent to photograph form.
3. Every medical record generated from a telemedicine consult is kept alphabetically in the telemedicine office.
4. 3 books for each provider are kept in the telemedicine office.
   a. Schedules book – includes past, present and future schedules, blank report of workability forms, OT & PT referral sheets, lists all rechecks and follow-up patients.
   b. Current book – includes the past 3 months consultations including client list of patients
c. Old Telemedicine Book – patients that have been seen in the past 12 months by the specialist and will not be returning unless new problem develops.

5. The following receive records of the telemedicine patient:
   a. Hospital or clinic where TM services were performed - receives the original signed dictation consent form, and registration.
   b. Referring provider’s medical records - receives a copy of the signed dictation
   c. Telemedicine office – copies of demographics, consent, evaluation, workability report, Nurse’s notes, telemedicine consult form.

VIII. Billing

The specialist providing consultative or follow-up care will bill the patient’s insurance carrier for the service through UMP Billing Office. If the insurance carrier denies payment, the Office of Advancement for Telehealth Grant will supplement the physicians at a predetermined rate per patient until August 30, 2003. This would include all patients without insurance. If the insurance carrier makes payment, no payment will be made by the grant funds. The hub and spoke site will continue to negotiate coverage for these services with payers in the area of service sites.
Medication Order Protocols

MO 1. When a physician orders a prescription medication for the patient during the Telemedicine Clinic, the presenting nurse will verbally accept the order and phone the medication to the pharmacy with the physician's DEA number.
## Telemedicine Referral Log

<table>
<thead>
<tr>
<th>Date of Referral</th>
<th>Patient’s Name</th>
<th>Date of Birth</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Patient’s Condition, Symptoms or Problems</th>
<th>Referring Provider</th>
<th>Specialist Assigned</th>
<th>Date Patient Contacted by TM Nurse</th>
<th>Scheduled Appt Date</th>
<th>Comments</th>
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</table>

### Telemedicine Clinic Protocols

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