Implementation Readiness Assessment:

Hospital Name:

Assessment completed by the following person(s):

Date Completed:

Technology Assessment:

1. Who is the IT contact for your facility:
   a. Contact information
   b. Preferred method of contact

2. Do you want to connect to the central site for telepharmacy services through the A/V telepharmacy equipment only or do you also want the central site to access through your pharmacy computer system?
   - [ ] A/V telepharmacy equipment only
   - [ ] A/V telepharmacy equipment and pharmacy computer system
     a. If you want the central site to access your pharmacy computer system what software and software version are you currently using?
     b. Do you want to provide order entry
        - [ ] Yes
        - [ ] No
     c. If yes how would we get access
     d. Do you have two access points available (1) for pharmacy and (1) for A/V
        - [ ] Yes
        - [ ] No

3. What level of IT support staff do you currently have available
   a. Hours of Coverage
   b. Onsite or outsourced
   c. If outsourced who is your provider
   d. Help Desk support
      - [ ] Yes
      - [ ] No
         i. If yes who is the provider
   e. What is the IT staff’s comfort level of working with telepharmacy equipment:
      - [ ] Very comfortable
      - [ ] Somewhat comfortable
      - [ ] Somewhat uncomfortable
      - [ ] Not comfortable at all
   f. Does your hospital currently have BTWAN connection:
      - [ ] Yes
      - [ ] No
      - [ ] I don’t know
What is the current data management infrastructure
- Remote access
- Offsite data storage
- In-house server (data storage)

Cabling from BTWAN to pharmacy and alternate location (e.g. nursing station)
  i. Is it on a separate router
     - Yes
     - No

What is the distance between the pharmacy and the BTWAN router?

Will there be connection points other than the pharmacy and the BTWAN router?
- Yes
- No
  i. If yes, where will the additional connection points be located?

Do you currently have wireless system
- Yes
- No
  i. If yes is it secured or open wireless
  ii. If yes what band does it run on
      - 802.11a
      - 802.11b
      - 802.11g
      - Other
  iii. If yes do you currently have any dead zones
      - Yes
      - No
  iv. Where are the dead zones located
  v. If no which location(s) would need to be installed

Security

Is VPN access to Pharmacy available
- Yes
- No
  i. If yes please describe:

Personnel Readiness –

CEO/CFO/CIO engagement
- Yes
- No

Has the consulting pharmacists been engaged
- Yes
- No
- Not applicable
7. Has the CMO and/or Physician leader been engaged in the project
   - Yes
   - No

8. Has the CNO been engaged in the project
   - Yes
   - No

9. Has the IT staff been informed about this project
   - Yes
   - No

10. Have entry points (admitting, ED) been engaged in the project
    - Yes
    - No

11. Has clinical staff (Pharmacists, nurses, and physicians etc.) been identified as point for the project
    - Yes
    - No
    If Yes what is their comfort level of working with technology
      - Very comfortable
      - Somewhat comfortable
      - Somewhat uncomfortable
      - Not comfortable at all

    a. Has clinical staff worked with Telepharmacy equipment previously
       - Yes
       - No

    b. Has clinical staff been included in the communication regarding the project
       - Yes
       - No

    c. What level of Pharmacy Technician Support do you currently have:
       - One year of pharmacy technician experience
       - Nurse crossed trained as a pharmacy technician
       - Exception from your State Board of Pharmacy
       - None of the above

**Document Readiness**

12. Business agreement signed with CHI
    - Yes
    - No

13. Subaward agreement with NDSU
    - Yes
    - No

14. Subclass K license with ND Board of Pharmacy
    - Yes
    - No
    - Not applicable

15. Service agreement in place for A/V equipment (circle one)
    - Yes
Physical Site Readiness
16. Physical Space available for mobile cart
   a. Telepharmacy equipment preference (circle one)
      ☐ Mobile Cart
      ☐ Stationary equipment
   b. Main location of telepharmacy equipment preference
   c. Alternative site locations of the telepharmacy equipment
   d. Other

Needs Assessment
17. After Hours Drug Distribution system
   ☐ Automated Dispensing Cabinets
   ☐ Pharmacy Box or Closet
   ☐ Have access into Inpatient Pharmacy
18. Do you have an electronic drug information system i.e.: Micromedex, Lexi-Comp
   ☐ Yes
   ☐ No
   i. If no would you like to explore options to gain access
      ☐ Yes
      ☐ No
19. Expected use of the Central Pharmacy Service
   i. Days of week and hours of service desired:
      ☐ Sunday ☐ AM ☐ PM
      ☐ Monday ☐ AM ☐ PM
      ☐ Tuesday ☐ AM ☐ PM
      ☐ Wednesday ☐ AM ☐ PM
      ☐ Thursday ☐ AM ☐ PM
      ☐ Friday ☐ AM ☐ PM
      ☐ Saturday ☐ AM ☐ PM
   ii. Estimated number of orders to review
      New Orders
      Change Orders
      Discontinued Orders
      Clarification of Orders
      Verification of Orders
      Daily average of number of admissions on evening and night shift:
      Weekdays:
      Weekends:
   iii. Are you interested in additional pharmacy services such as?
      (Medication Reconciliation, Formulary reviews, P&T, Consulting services)
      ☐ Yes ☐ No
20. Are you currently exploring any of the following grant/support monies to support Telepharmacy or other clinical technology?
- USAC
- ASHP
- Center for Rural Health
- Other

If yes please describe:

21. Clinical Assessment
   a. Have you developed standard concentrations on the following items
      i. Potassium [ ] Yes [ ] No
      ii. Heparin [ ] Yes [ ] No
      iii. Dopamine [ ] Yes [ ] No
      iv. Dobutamine [ ] Yes [ ] No
      v. Epidurals [ ] Yes [ ] No
      vi. Others (please list)
   b. If no on any of the above are you willing to develop standard concentrations on the following items? [ ] Yes [ ] No
      i. Potassium [ ] Yes [ ] No
      ii. Heparin [ ] Yes [ ] No
      iii. Dopamine [ ] Yes [ ] No
      iv. Dobutamine [ ] Yes [ ] No
      v. Epidurals [ ] Yes [ ] No
   c. Have you developed protocols for:
      i. Aminoglycoside monitoring [ ] Yes [ ] No
      ii. Vanco monitoring [ ] Yes [ ] No
      iii. Others (please list)
   d. Are you willing to developed protocols for:
      i. Aminoglycoside monitoring [ ] Yes [ ] No
      ii. Vanco monitoring [ ] Yes [ ] No
      iii. Others (please list)
   e. Do you document complete medication histories on admission? [ ] Yes [ ] No
      i. If yes, who is responsible for doing this?
   f. Do you document complete medication history on discharge? [ ] Yes [ ] No
      i. If yes, who is responsible for doing this?
      ii. If yes, is this shared with a local pharmacy? [ ] Yes [ ] No
      iii. If yes, is this shared with a physician’s office? [ ] Yes [ ] No
      iv. If yes, is this shared with referring facility (i.e. long-term care facility)? [ ] Yes [ ] No
      v. If yes, is this shared with the patient or responsible family member? [ ] Yes [ ] No
   g. Do you currently have a face sheet for patient demographics or a nursing admission assessment form that you transfer to other facilities? [ ] Yes [ ] No
22. Purchasing Assessment
   a. Do you belong to a group purchasing organization (contract buying group)?
      □ Yes □ No
   i. If yes which one?
   b. What is your average drug expense per month?
   c. Who is your supplier and or drug wholesaler?
   d. Do you have a Pharmacy & Therapeutics Committee? □ Yes □ No
   g. How would you describe the functionality of your P&T committee?.
      □ High Functioning
      □ Active Meeting Regulatory Requirements
      □ Meets But Needs Significant Improvement
      □ Poorly Functioning

1. Has budget funding for telepharmacy services been allocated? □ Yes □ No
   a. If yes, what is the time frame? (i.e. give dates)

2. What is your preferred start-up time for a go live date for telepharmacy service?

Please return completed form to: (by e-mail or fax)
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Fax 1-701-237-8195.
If you have questions please contact Shelley at 701-412-5668