COVID-19 Telemedicine Implementation ECHO

Session Date: _____

Submission Date: _____

ECHO ID: _____

1) Clinic size: _____

2) Clinic location (zip code): _____

3) Clinic type:
☐ Hospital-based
☐ Community-based

4) Telemedicine launch timeline:

[   ]

5) Patient population:
☐ Primarily uninsured
☐ Primarily insured
☐ Evenly split insurance statuses

6) Are any telemedicine tools integrated into the EMR?
☐ Yes   ☐ No
Please describe:

[   ]

7) What type of services do you plan to offer through telemedicine? *(please select all that apply)*
☐ Direct to patient non-urgent primary care
☐ Behavioral health
☐ Follow-up with patients in my own practice
☐ Specialist services (i.e. non-behavioral health) - *please describe:*

[   ]

8) Do you plan to maintain telemedicine services past the COVID-19 emergency?
☐ Yes
☐ No
☐ Unsure