Oklahoma Rural Health Transformation Program

Rural Health HIE & EHR Assistance Application

Through the Rural Health Transformation Program (RHTP), the Oklahoma Health Care Authority (OHCA) is providing assistance to eligible rural healthcare providers seeking to participate in Oklahoma's statewide Health Information Exchange (HIE) and/or implement, replace, optimize, or expand certified Electronic Health Record (EHR) systems.

This application notifies the Office of the State Coordinator for Health Information Exchange (OSC) of your organization's interest in **HIE assistance, EHR assistance, or both**.

Submission of this application does not guarantee funding or approval for assistance. Applications will be reviewed based on program eligibility, funding availability, provider need, implementation readiness, and program priorities.

> **Participation Requirement:** Providers receiving assistance through this program must participate in Oklahoma's state-designated HIE, operated by MyHealth Access Network.

*** Which assistance are you requesting?**

- ◯ HIE Assistance ⓘ
- ◯ EHR Assistance ⓘ
- ◯ Both (HIE & EHR Assistance) ⓘ

PLEASE NOTE: Not all questions shown below will appear for every assistance option. Questions displayed in the application may vary based on the assistance type selected and responses to previous questions.

APPLICATION PREVIEW ONLY

* **Organization Name:**

* **Organization Type:**

Select one

- Ancillary Group (OT/PT/SP/Dieticians/etc)
- Behavioral Health Group/Facility
- Certified Community Behavioral Health Clinic (CCBHC)
- Chiropractic Group
- Clinic - Primary Care
- Clinic - Specialty
- Dental Group
- EMS Group
- FQHC
- Health System
- Hospice
- Hospital
- Lab
- Long-Term Care
- Optometry
- Pharmacy
- Rural Health Center
- Urgent Care Facility
- Other

ORGANIZATION TYPE METRIC REQUIREMENT:
Based on the Organization Type selected

Ancillary Group → Count of Licensed Providers
Behavioral Health → Annual Count of Unique Patients Served
CCBHC → Annual Count of Unique Patients Served
Chiropractic Group → Count of Licensed Providers
Clinic - Primary Care → Count of Prescribing Providers
Clinic - Specialty → Count of Prescribing Providers
Dental Group → Count of Prescribing Providers
EMS Group → Annual Count of Calls/Pickups
FQHC → Count of Prescribing Providers
Hospice → Average Patients Per Day
Lab → **Count of Annual Accession Numbers**
Long-Term Care → Average Patients Per Day
Optometry → Count of Licensed Optometrists
Pharmacy → Count of Licensed Pharmacists
Rural Health Center → Count of Prescribing Providers
Urgent Care Facility → Count of Prescribing Providers

APPLICATION PREVIEW ONLY

* **NPI Type 2 (Organization Level):**

As listed in the NPPES NPI Registry ⓘ

0/10

* **Tax ID:**

0/9

* **Total Staff Count:**

* **Number of Service Locations:**

1-3 SERVICE LOCATIONS
A service location section will automatically display for each location reported.

* **Please provide the location details of each service location:**

Only service locations in Oklahoma should be included.

	*Street Address	Suite	*City	State	*ZIP	*County
Location 1				OK		Select County
Location 2				OK		Select County
Location 3				OK		Select County

4 + SERVICE LOCATIONS
A PDF containing the complete address information for all service locations is required.

* **Upload a PDF containing the address, city, ZIP code, and county for all Oklahoma service locations.**

Only one file may be uploaded.

Select a file or drag here

APPLICATION PREVIEW ONLY

* **Current EHR system:**

- [x] Existing EHR
- [ ] Paper-based or partially electronic process
- [ ] Unsure

EHR VENDOR DETAILS
Required only when **Existing EHR** is selected.

* **Please provide the EHR vendor details below:**

Vendor Name and Product are required; include the Version, if known.

	*EHR Vendor Name	*Product	Version
EHR Vendor Details:			

* **How long have you used your current system?** *(Select one)*:

- [ ] Less than one year
- [ ] 1 - 3 years
- [ ] 4 - 6 years
- [ ] 7 - 10 years
- [ ] 11 - 15 years
- [ ] More than 15 years
- [ ] Unsure

SYSTEM USE DURATION
Required only when **Existing EHR** is selected.

APPLICATION PREVIEW ONLY

*** What is your organization's current EHR system cost?**

- ◯ Monthly: **$** _____
- ◯ Annual: **$** _____
- ◯ No EHR cost
- ◯ Unknown

EHR SYSTEM COST
Required when **Existing EHR** is selected

INTEGRATION SUPPORT
Required when **Existing EHR** is selected

*** Do you have third-party IT or integration support?**

- ◯ Yes (please provide the name of the third-party IT or integration support vendor): _____
- ◯ No

*** Current Tools in Use** *(Select all that apply)*:

- ☐ E-prescribing
- ☐ Patient Portal
- ☐ Population Health Management Tools
- ☐ Quality Reporting Tools
- ☐ Secure Messaging
- ☐ Support for Patient Survey
- ☐ Telehealth
- ☐ Unsure
- ☐ None

APPLICATION PREVIEW ONLY

EHR WORKFLOW CHALLENGES Required when **Existing EHR** is selected.



*** What are the primary workflow challenges or pain points with your current EHR system?**
(Select all that apply):

- [ ] Excessive documentation requirements
- [ ] Too many clicks/screens to complete tasks
- [ ] Slow system performance or downtime
- [ ] Difficulty exchanging data with other providers or HIEs
- [ ] Limited interoperability with external systems
- [ ] Duplicate data entry across systems
- [ ] Challenges with referral management and care coordination
- [ ] Difficulty accessing patient information at the point of care
- [ ] Limited reporting, analytics, or population health capabilities
- [ ] Revenue cycle, billing, or claims workflow issues
- [ ] User interface is difficult to navigate
- [ ] Limited mobile or remote access capabilities
- [ ] Vendor support or training challenges
- [ ] Regulatory or quality reporting challenges
- [ ] High maintenance or licensing costs
- [ ] Other (please specify):

APPLICATION PREVIEW ONLY

* **Support Requested** *(Select all that apply)*:

- [ ] New EHR
- [ ] EHR Replacement
- [ ] EHR Upgrade/Optimization
- [ ] Training
- [ ] Workflow Redesign
- [ ] Data Migration
- [ ] HIE Connectivity/Interoperability
- [ ] Compliance Preparation
- [ ] Quality or Public Health Reporting
- [ ] Reporting Setup
- [ ] Network/Internet Bandwidth, Hardware, Cybersecurity, or Other IT Infrastructure Support
- [ ] Other (please specify):

* **What is your anticipated timeframe to go live with your new, replacement, or upgraded EHR?**

- ◯ 1 - 3 months
- ◯ 3 - 6 months
- ◯ 6 - 9 months
- ◯ 9 - 12 months
- ◯ 12 - 18 months

APPLICATION PREVIEW ONLY

* **Are you currently connected to MyHealth or another HIE?**

- [x] Yes
- [ ] No
- [ ] Unsure

CURRENT HIE STATUS
Required when **Yes** is selected for the question above.

* **Please describe your organization's current HIE status:**

* **As a representative for the organization named in this form:**

- [ ] I acknowledge that by receiving this assistance my organization is expected to transmit health care data to the State Designated Entity on a regular basis and will be responsible for all ongoing maintenance, licensing, subscription, and support costs following the conclusion of funding availability.

- [ ] I acknowledge that receiving approved assistance is contingent upon available funding, and understand that approval for this program does not guarantee funding in future years.

APPLICATION PREVIEW ONLY

Attestation

By typing my name below, I attest that the foregoing information is true, accurate and complete.

* Submitter Information:

Please provide the information below (All fields are required)

* First Name:

* Last Name:

* Job Title:

Email:

Phone Number:

*** Are you the organization's primary point of contact for this application?**

- ◯ Yes
- ◯ No

APPLICATION PREVIEW ONLY

PRIMARY POINT OF CONTACT
Required when **No** is selected for the question above.

*** Primary Point of Contact Information:**

Please provide the information below (All fields are required)

* First Name:

* Last Name:

* Job Title:

Email:

Phone Number:

APPLICATION PREVIEW ONLY

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