Oklahoma State Health Information Network & Exchange (OKSHINE) Intake Assessment Tool

The information requested in this document will enable the OKSHINE team to better understand your organization in preparation for connection to OKSHINE.

General Information

Respondent Name: _____

Organization: _____

Email: _____

Phone: _____

Organization Type

Ambulatory Surgery Center	Hospital
Clinic	Pharmacy
Corrections	PT/OT/ST
EMS	Nursing Facility
Home Health & Hospice	Other

Organization National Provider Identifier (NPI)

Physical Address

Billing Address

Contact Information

Role	Name	Title	Email	Telephone
Main Point of Contact				
Privacy Officer				
Master Patient Index Coordinator				
Training/Education Resource				

Participation Organization Information

What services does your organization provide:

Behavioral Health   Primary Care

Dental   Post Acute Care

Laboratory   Radiology

Pediatrics   Other [   ]

Pharmacy

Please list the organization names that you most frequently share patient data (this will help prioritize further outreach).

[   ]

Does your organization accept Medicaid patients?

○ Yes

○ No

Are any of the organization's providers 42 CFR Part 2 (Substance Abuse) Program participants?

○ Yes

○ No

Electronic Health Record (EHR) Technology

Please select your EHR Vendor:

○ Allscripts   ○ eMDs   ○ Nextgen

○ Athena   ○ Epic   ○ Point Click Care

○ Cerner   ○ GE Centricity ○ Practice Fusion

○ CPSI   ○ Greenway   ○ RPMS - Indian Health Services System

○ eClinical Works ○ Meditech   ○ Success EHR

○ N/A   ○ Other [   ]

What EHR product do you use?

[   ]

Do you use or share your EHR instance with any other organization?

○ Yes

○ No

If Yes, what organization?

[   ]

Is your organization using Direct Secure Messaging (DSM)?

○ Yes

○ No

If Yes, what vendor or Health Information Service Provider (HISP) are you using?

[ ]

Approximately how many users will have OKSHINE access?

○ 0-49

○ 50-99

○ 100+

Quality Program Reporting

Are you participating in the Medicaid Promoting Interoperability Program?

○ Yes

○ No

Do you report to any of the following Quality Programs?

Accountable Care Organization (ACO)   Primary Care First (PCF)

Comprehensive Primary Care Plus (CPC+)   Patient Centered Medical Home (PCMH)

Merit-Based Incentive Payment System (MIPS) Other [ ]

What public health data are you reporting electronically?

Behavior Health Risk Tracking   Laboratory

Chronic Disease (Cancer, Cardiovascular, Diabetes)   Syndromic Surveillance

End of Life Registry/Advance Health Care Directives Trauma Care

Immunizations   Other [ ]

Organization Owned Sites

Does your organization own any additional clinics or hospitals? *

○ Yes

○ No

Please provide a list of additional sites associated with your organization with: (Name, Address, Phone, and Point of Contact)

Facility Name	Address	Phone Number	Point of Contact	EHR