



TidalHealth Peninsula  
Regional – Population  
Health Management

# REACH Program Data Collection and Reporting Process

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MA

July 13, 2022



# Agenda

1. Coalition Organization – Definitions and Services
2. TidalHealth – Internal Data Collection Process
3. CBOs (Rebirth and Mosaic) Process
4. AGH, LHDs Process
5. Centralized Processing and Upload to CRISP

# Coalition Definitions and Services

Project Designated Areas & Zip Codes	
Salisbury	21801
Salisbury	21804
Eden	21822
Pocomoke	21851
Princess Anne	21853
Snow Hill	21863

Project Participants Being Served
<b>Unduplicated Participants</b>
<ul style="list-style-type: none"> <li>• Black Adult (18+)</li> <li>• Reside within Designated Zip Code</li> </ul>
<b>Health Conditions</b>
<ul style="list-style-type: none"> <li>• Diagnosed with Pre-Diabetes</li> <li>• Diagnosed with Diabetes</li> <li>• Diagnosed with Hypertension</li> </ul>

Project Clinical Health Services and/or SDOH Services <i>(Not all Inclusive)</i>
<b>Addressing</b>
<ul style="list-style-type: none"> <li>• Chronic Disease</li> <li>• Food Insecurity</li> <li>• Economic / Income Needs</li> </ul>
<b>Accessing</b>
<ul style="list-style-type: none"> <li>• Affordable, Stable Housing</li> <li>• Health Care / PCP</li> <li>• Health Education</li> <li>• Health Insurance</li> <li>• Transportation</li> </ul>

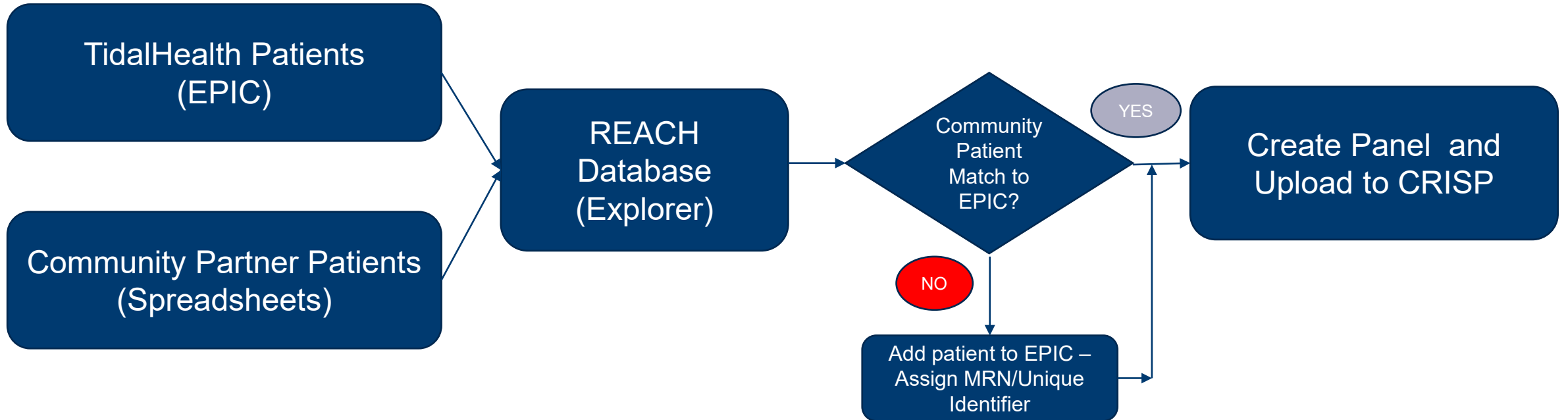
**Key Project Notes:**

1. Establish an ongoing relationship with program participants.
2. Ensure participants receive services to be “counted”.
3. If the participant receives health education and/or screenings, the individual must be referred to clinical health services or Social Determinants of Health (SDOH) service partners for ongoing case management / ongoing services to be “counted” as participant served.
4. Providing health education and/or screenings, but not establishing an ongoing relationship with the participant which results in care coordination and the receipt of actual services, will not be considered as receiving services based on CHRC requirements.
5. If a participant is “counted” as receiving services, the grantee must be able to collect the demographic information in the standard patient intake form and ensure that the individual is not “double counted” in the total number of unique participants served.

**REACH Project Services**  
*(Outreach, Interventions, Activities)*

Coalition / Partner	Grant Funded Services	Designated Area / Zip Code
TidalHealth	<ul style="list-style-type: none"> <li>Community Wellness / Care Coordination</li> <li>Mobile Integrated Health Screenings (Diabetes Risk Assessments, Blood Pressure Checks, Healthcare Access)</li> <li>Grant Administration and Management</li> <li>Grant Reporting</li> </ul>	21801 – Salisbury 21804 – Salisbury 21822 – Eden 21853 – Princess Anne
{Partner Name}	<ul style="list-style-type: none"> <li>Diabetes Self-Management Education (DSME)</li> <li>Diabetes Support Groups</li> <li>Pre-Diabetes Risk Screenings</li> <li>HbA1c Screenings</li> <li>Bone Density Screenings</li> <li>BMI Screenings</li> <li>COVID/Flu Testing and Vaccinations</li> <li>Mobile Van Outreach (Telemedicine Linked to Urgent Care and Behavioral Health Providers)</li> </ul>	21851 - Pocomoke 21863 - Snow Hill
{Partner Name}	<ul style="list-style-type: none"> <li>CHW Case Management</li> <li>Healthy Lifestyle Programming</li> <li>Health Screenings</li> <li>Diabetes Self-Management Education</li> </ul>	21851 – Pocomoke 21863 – Snow Hill
{Partner Name}	<ul style="list-style-type: none"> <li><b>Referral Source</b> (Transportation, Case and Care Management, Insurance Eligibility, Enrollment)</li> </ul>	All Areas

# Workflow for CRISP REACH Participant Panel



# TidalHealth Assessment and Enrollment Process

- RN review report of discharged patients who meet preliminary eligibility for grant services (zip code, condition, readmission risk score, ED visits)
- RN outreach and triage
- RN/CHW home visit – consent and enrollment into REACH services
- Flagged in Epic as REACH patient with an enrollment date
- CHW Assessment for SDOH factors (view CHW assessment)
- All data captured in Epic

Downtime, DoNotUse A...

Chart Review
History
Allergies
P

### Demographics

Contact Information
Clinical Infor

**DOWNTIME, DONOTUSE A "Teresa"**  
 Female, 25 y.o., 5/17/1997  
 MRN: 960177568  
 Code: **Not on file**  
 COVID-19: Last tested 7/29/2021  
 Infection: None  
 Wt: 91.6 kg >7 days, BP: 120/80 >1 day

**COVID-19 Vaccine: Overdue for booster dose**

COVID-19: Last tested 7/29/2021  
 Infection: None

**Research Participant**

**DOWNTIME, DONOTUSE A "Teresa"**  
 DOWNTIME, DONOTUSE A (Legal Name)

25 y.o., 5/17/1997  
 Legal sex: Female  
 Marital status: Single  
 Race: American Indian or Alaska Native  
 Ethnicity: Other Hispanic, Latino/a, or Spanish origin

Preferred language: English

100 E Carroll Street  
 Unit 2  
 SALISBURY MD 21801

MRN: 960177568

## Data Collected at Intake:

Participant First Name

Participant Last Name

DOB

Address

Gender

Race

Ethnicity

Enrollment Date

## Mosaic Community Health Worker Intake Form

### Patient Information

Date of Enrollment (MM/DD/YYYY) \*

First Name \*

Last Name \*

Date of Birth (MM/DD/YYYY) \*

Street Address

City/Town

State

Zip Code \*

Gender \*

Other - Gender

Race \*

Other - Race

Ethnicity \*





# AGH, LHDs, YMCA Process

## Manual Processes

- Intake forms with all required demographic and enrollment date information.
- Converted to Excel spreadsheets
- Submitted securely (SDI process for LHDs; FTP site for AGH) to TidalHealth

# Explorer Analysis in Epic with Tableau Dashboard Reporting

- Files ingested by Epic through Explorer Analysis.
- Participants without EMR record – Epic generates a shell record with the demographic information.
- Exported as an Excel spreadsheet.
- Validated by data analyst; duplicate records removed.
- Spreadsheet prepared and upload to CRISP panel monthly.



**Thank you.**

**Questions?**