



Health Network

A Care Coordination Program for
Patients Who Move During Treatment

MIGRANT CLINICIANS NETWORK



*A force for health justice for
the mobile poor*

MIGRANT CLINICIANS NETWORK



“To be a force for health justice
for the mobile poor”



**Training &
Technical
Assistance Services**



**Continuity
of Care**



**Environmental
and Occupational
Health**



**Health Justice
Advocacy**



**Violence
Prevention**

MIGRANT CLINICIANS NETWORK



Office Locations



10,000 +
constituents



Photo by Earl Dotter



MCN's Primary Constituents

- Health educators
- Nurses
- Primary care providers
- Dentists
- Social workers
- CHWs
- Outreach workers
- Medical assistants



Migrant
Mobile poor
Immigrants

Clinicians

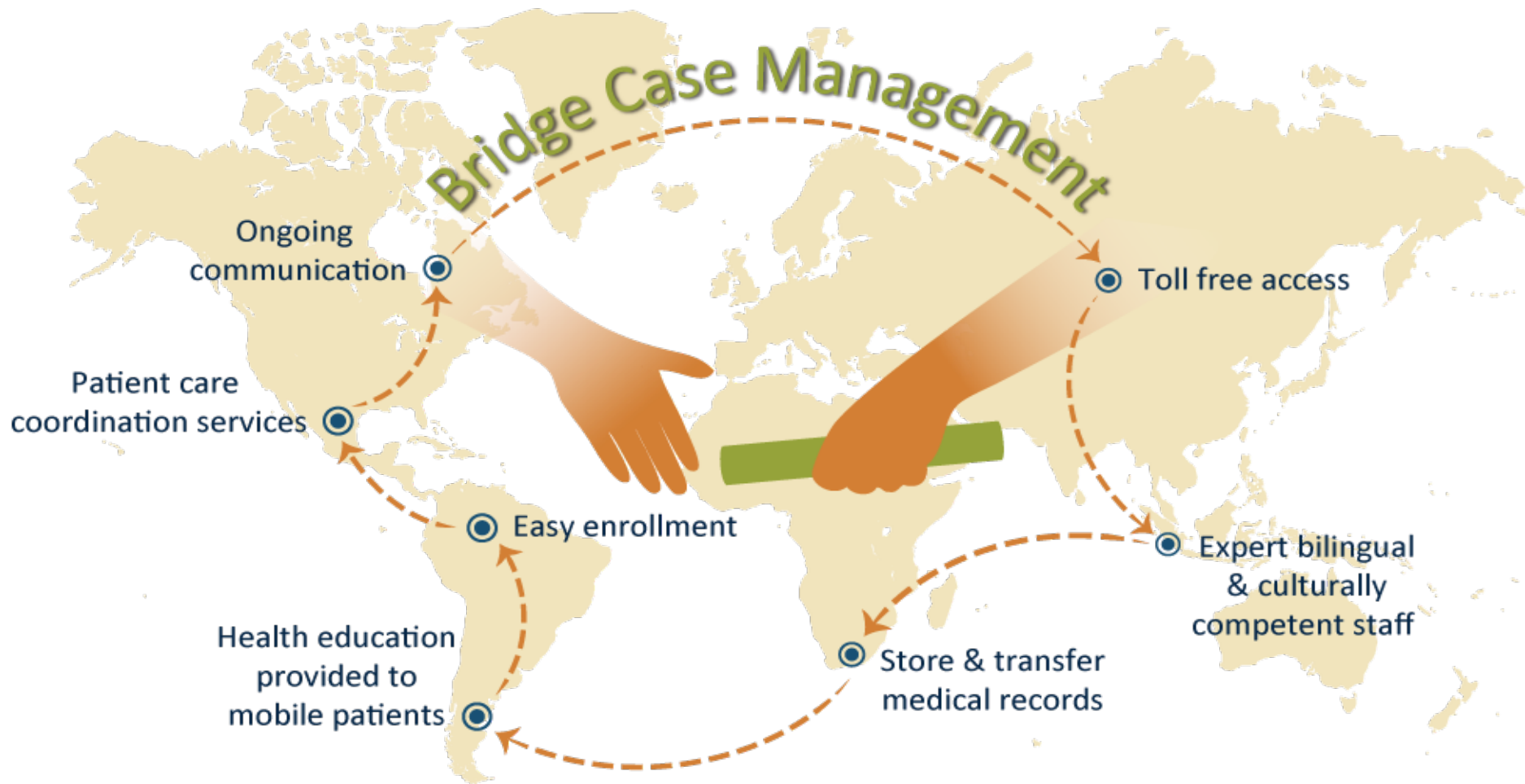
Federally
funded
Migrant &
Community
Health Centers

State and local
health
departments



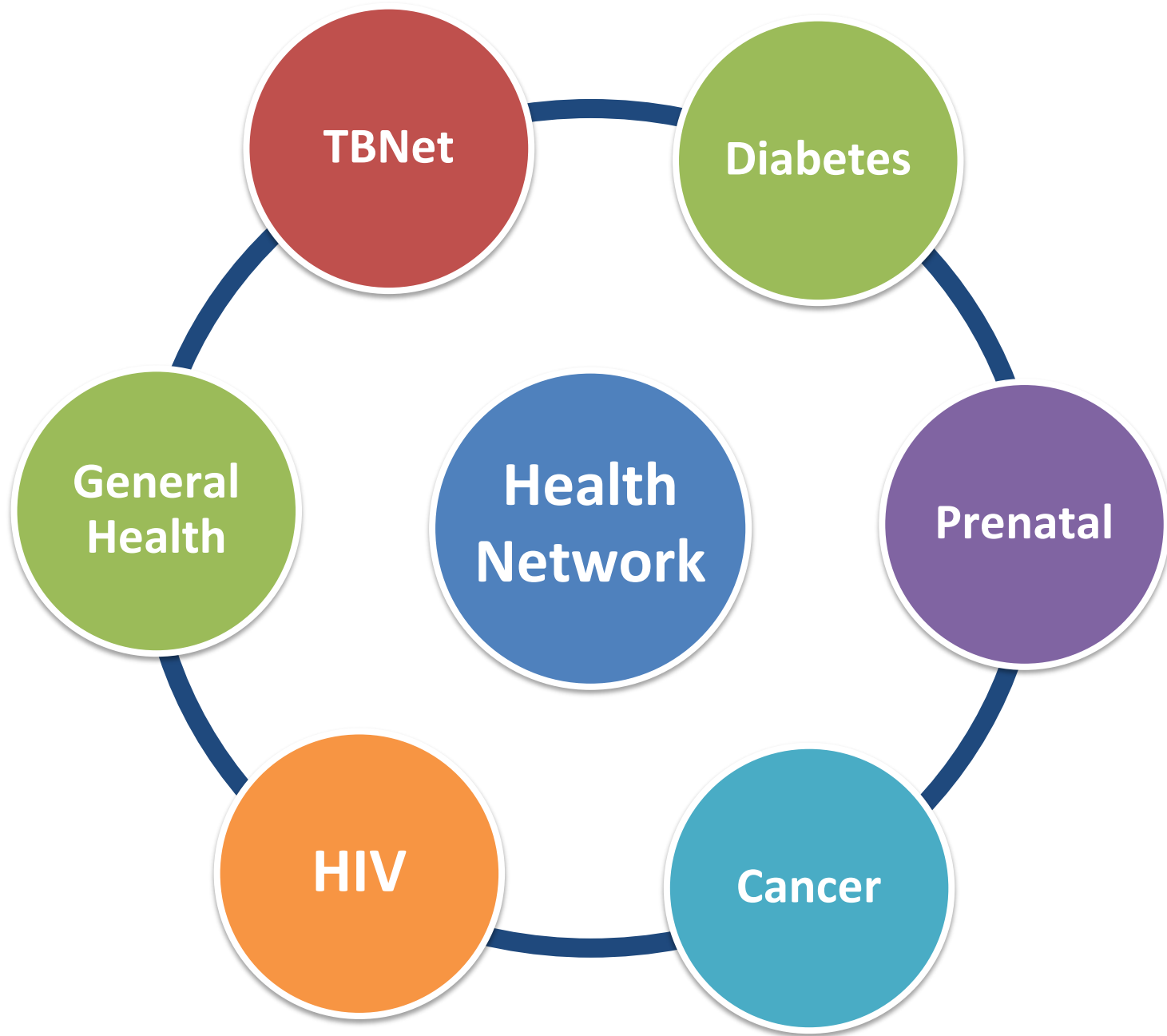
24 Years of
Innovation

Care Management AND Referral Tracking and Follow-up Health Network





MCN's Health Network does not discriminate on the basis of immigration status and will not share personal patient information without patient permission.



TBNet

Diabetes

**Health
Network**

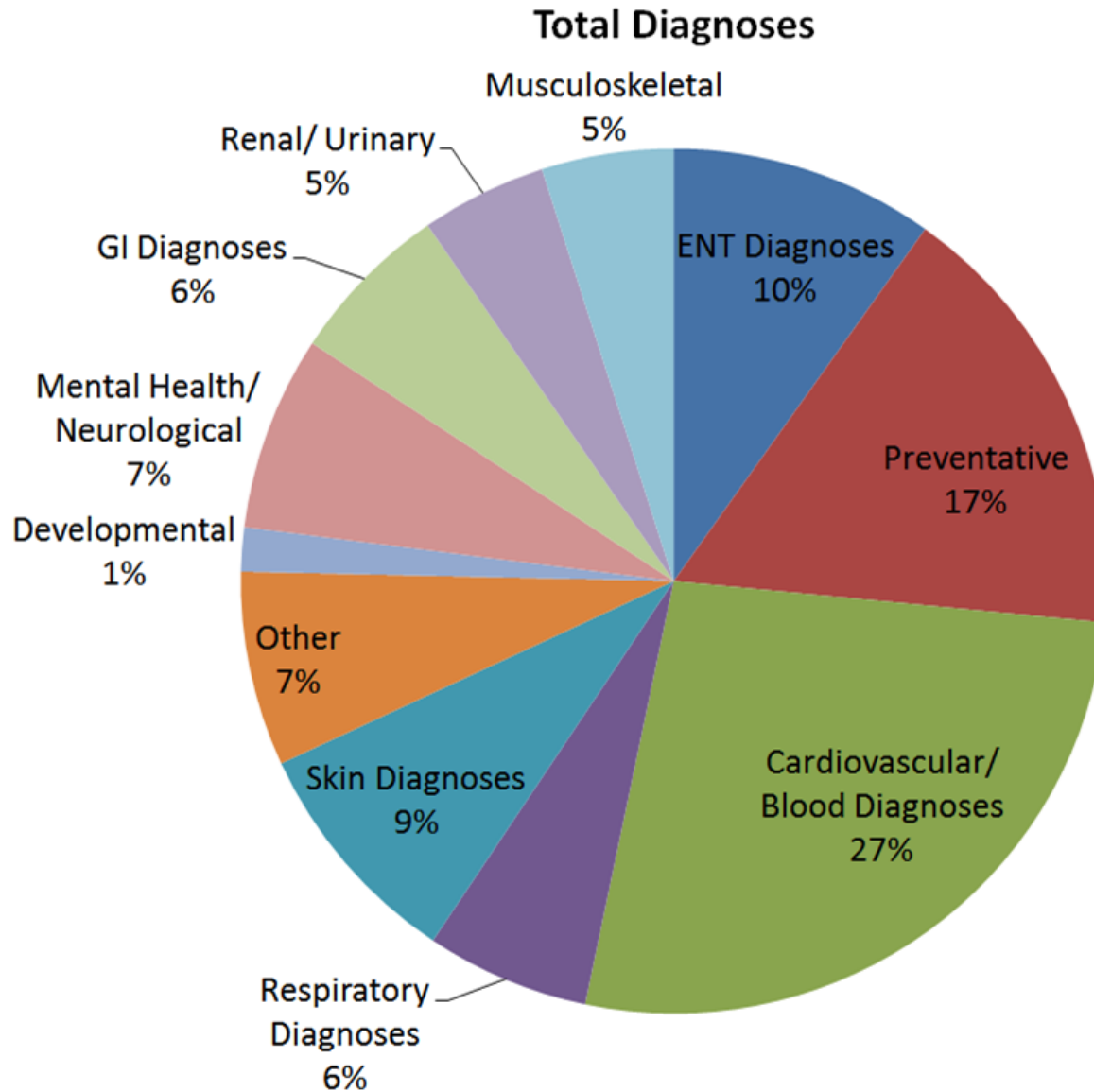
Prenatal

**General
Health**

HIV

Cancer

General Health





Over 12,000
total HN
enrollments



2,951 total clinics in U.S.
and over **114** countries

Health Network Enrollment Criteria

1

Patient is:

- Mobile / Migrant
- Thinking of leaving area of care

2

Patient has:

- Need for clinical follow-up
- Working phone number or family member with phone number
- Signed MCN consent form
- Clinical base or enrolling clinic

CONFIDENTIAL

- Confidentiality is critical to all MCN staff and all Health Network procedures conform to HIPPA standards
- All patients are asked to sign (or have a witness sign) a consent form before enrollment in Health Network

Participant Benefits

- A clinic / doctor / nurse is waiting
- Updated records are forwarded to clinic / patient
- Toll free number in the U.S. and Mexico
- Better understanding and diagnosis of condition
- Completion results stored in patient file



Forms Required for Enrollment



ENROLLMENT IN THE MCN HEALTH NETWORK

Enrolling Clinic	Clinic phone number(s)	
E-mail address	Clinic fax number(s)	
Contact person at Clinic		
Security Question #1:	Patient's city of birth?	
Security Question #2:	Patient's father's first name?	
Please indicate the health area(s) for which the participant is being enrolled. If the participant's health status changes during enrollment in the Health Network, additional areas may be added with the participant's verbal consent.		
<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Prenatal Care		
<input type="checkbox"/> Cancer		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> HIV		
<input type="checkbox"/> General Health		

CONSENT FOR RELEASE OF MEDICAL INFORMATION

First Name	Last Name(s)
Nicknames, Etc	Birth Date (Month / Day / Year)

The Health Network currently helps with continuity of care for people with chronic illnesses or other healthcare concerns. (i) MCN is the company coordinating my enrollment in the Health Network; (ii) MCN may not be able to obtain health care services that are available to care for my condition at no cost to me; (iii) health care providers who will be providing my treatment are not and not employees of MCN; and (iv) MCN does not provide, and is not responsible for, any health care treatment, or the outcomes of that treatment, in connection with any or all of the Health Network services.

I agree to notify my future health care providers of my enrollment in the MCN Health Network to help facilitate the transfer of my medical records. I understand and consent to MCN maintaining records containing sensitive health information (examples: HIV status and information about mental health issues) if my health care provider believes this information is needed for my treatment. I authorize and future health care providers to have access to those medical records that my health care providers feel are necessary for my medical treatment and/or continued screening.

Authorized individuals from MCN may contact me by phone, email, or in person regarding follow up and referral for my treatment for my conditions. These individuals will adhere to federally mandated confidentiality, privacy and security procedures. **This consent remains in effect for two years (24 months) from the date of my participation in the Health Network.** I can submit a written request any time to leave the Health Network and limit the health issues that MCN is authorized to address. I also understand that I have a right to receive a copy of my medical records on file with MCN upon written request.

I HEREBY RELEASE MCN, ITS EMPLOYEES, OFFICERS, DIRECTORS, CONSULTANTS, REPRESENTATIVES, SUCCESSORS, AND AGENTS FROM ANY AND ALL CLAIMS, CAUSES OF ACTIONS, DAMAGES, LOSSES, EXPENSES (INCLUDING ATTORNEYS' FEES), AND LIABILITIES WHATSOEVER ARISING OUT OF MY ENROLLMENT IN THE HEALTH NETWORK AND MY HEALTH CARE TREATMENT RESULTS IN THE HEALTH NETWORK.

*PARTICIPANT SIGNATURE (or Signature of Legal Representative)	Date
Relationship of Legal Representative to Patient	Witness Signature

We recommend that, whenever possible, you provide the participant with a copy of this Consent for Release of Medical Information form when it is completed.

ENGLISH - THIS CONSENT FORM IS VALID FOR 2 YEARS AFTER DATE OF SIGNATURE

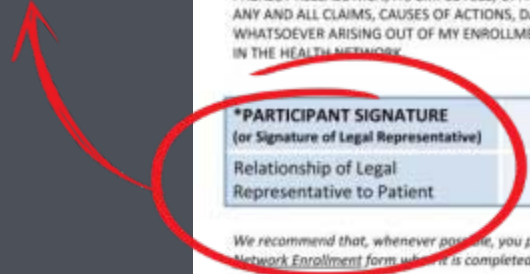
Please contact us at 512-327-2017 or www.migrantclinician.org/network for more information on the network.

GIVES MCN STAFF LEGAL PERMISSION TO TRANSFER PARTICIPANTS' MEDICAL RECORDS AND CONTACT PARTICIPANTS

VALID IF SENT WITHIN 5 BUSINESS DAYS OF BEING SIGNED BY PATIENT, REMAINS VALID FOR 24 MONTHS FROM THE DATE SIGNED

PARTICIPANTS MAY RENEW THEIR CONSENT AFTER IT EXPIRES IF THEY STILL NEED ASSISTANCE

MUST HAVE THE PARTICIPANT'S SIGNATURE OR THE SIGNATURE OF A WITNESS TO CONSENT



PARTICIPANT INFORMATION SHEET | MCN HEALTH NETWORK

*REQUIRED

First Name			Last Name(s)			
Mother's Maiden Name			Birth Date (Month / Day / Year)			
Place of birth:	City	Gender:		<input type="checkbox"/> Female	<input type="checkbox"/> Male	
	State	Marital Status:		<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Other:
	Country			<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	
Race/Ethnicity:	<input type="checkbox"/> White – Non-Hispanic/Latino		<input type="checkbox"/> Black – Non-Hispanic/Latino		<input type="checkbox"/> Hispanic/Latino	
	<input type="checkbox"/> Asian – Non-Hispanic/Latino		<input type="checkbox"/> Indigenous		<input type="checkbox"/> Other:	
Language(s) Spoken:	<input type="checkbox"/> English		<input type="checkbox"/> Creole		Language you prefer to be contacted in:	
	<input type="checkbox"/> Spanish		<input type="checkbox"/> Other:			
Occupation(s) (from past two years):	<input type="checkbox"/> Farmworker		<input type="checkbox"/> Construction		<input type="checkbox"/> Retired	
	<input type="checkbox"/> Homemaker		<input type="checkbox"/> Factory		<input type="checkbox"/> Unemployed	
	<input type="checkbox"/> Student		<input type="checkbox"/> Child care		<input type="checkbox"/> Other:	
Current Residence:	<input type="checkbox"/> Farmworker Camp Housing		<input type="checkbox"/> Jail		<input type="checkbox"/> Homeless	
	<input type="checkbox"/> Home		<input type="checkbox"/> ICE Detention Center		<input type="checkbox"/> Other:	

CURRENT CONTACT INFORMATION FOR PARTICIPANT:

Street / P.O. Box City State Zip/Country

*PHYSICAL ADDRESS:

*MAILING ADDRESS:

*PHONE NUMBER (with Area Code)
HOME / CELL / WORK:

Is it ok if we talk to people that answer this phone about your personal health information? (if you do not check off either box, or you do not initial, your answer will be "No")

Yes
 No

*INITIALS:

OTHER CONTACT INFORMATION FOR PARTICIPANT (Place you normally move to):

Street / P.O. Box City State Zip/Country

Physical Address:

Mailing Address:

*PHONE NUMBER (with Area Code)
HOME / CELL / WORK:

Is it ok if we talk to people that answer this phone about your personal health information? (if you do not check off either box, or you do not initial, your answer will be "No")

Yes
 No

*INITIALS:

Additional Contact: Please list someone we can contact if we cannot reach you at either of the locations you provided. In doing this you give MCN permission to contact that family member or friend to assist you in receiving continued health care, which may require discussing your health condition(s) with this individual. You do not have to provide this additional contact information.

First Name Last Name Relationship to Participant

Street / P.O. Box City State Zip/Country

*PHONE NUMBER (with Area Code)
HOME / CELL / WORK:

Is it ok if we talk to people that answer this phone about your personal health information? (if you do not check off either box, or you do not initial, your answer will be "No")

Yes
 No

*INITIALS:

**MUST HAVE
THE WORKING
PHONE NUMBERS
OR E-MAIL**

Optional Information for Enrollment

PRAPARE

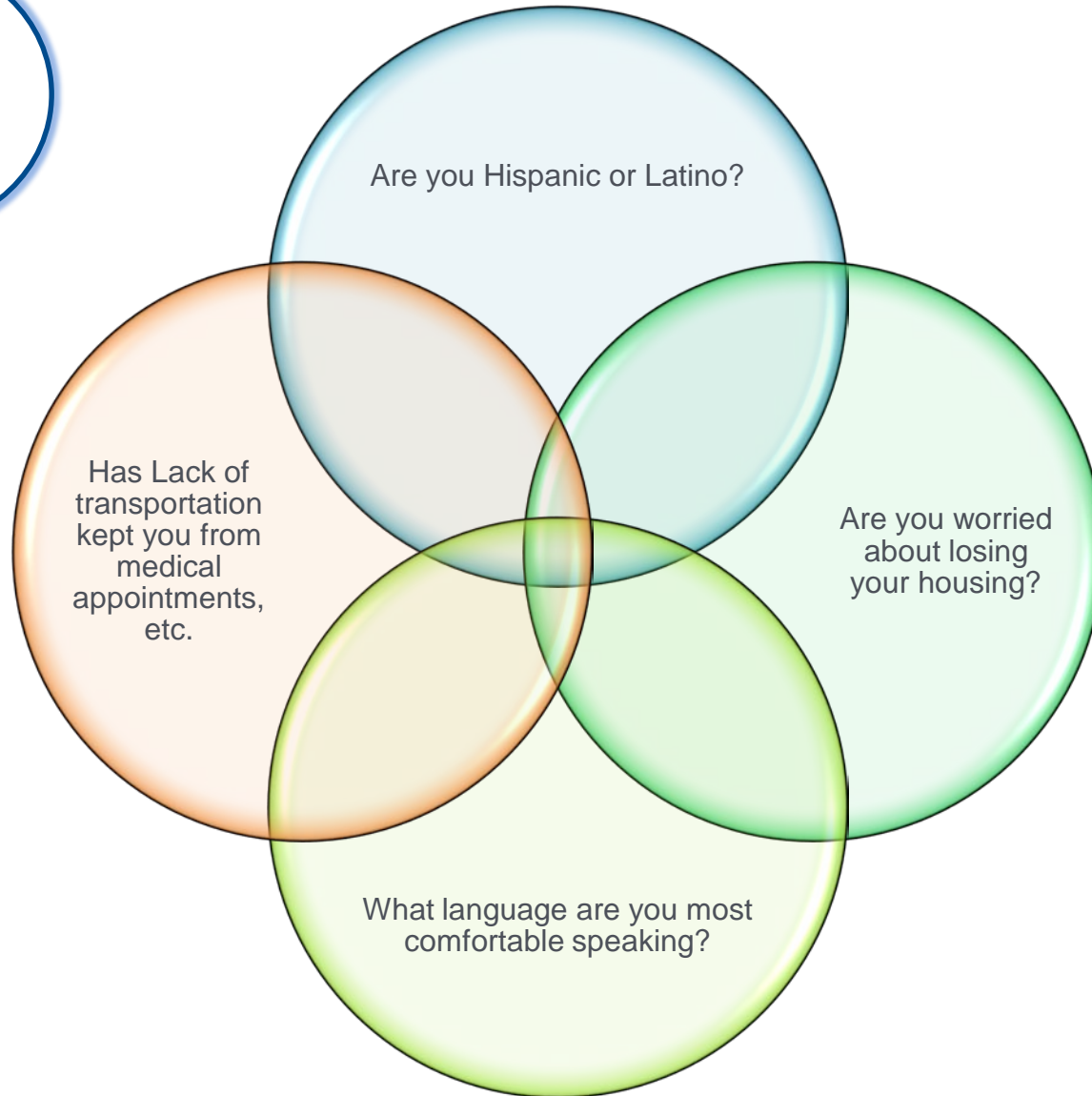


Stands for

- Protocol
- Responding
- Assessing
- Patients'
- Assets
- Risk
- Experiences

PRAPARE DATA

21 questions
to determine
SDOH
issues



2 Ways to Enroll

Option 1

We Interview:

1. Simply have us interview the patient, we explain the program, fill out the forms
2. We will then fax the forms to you to have the patient sign them*
3. Then fax us the signed forms along with the patient's medical records

**Please be ready to have the patient sign the faxed consent form immediately after an interview.*

Option 2

You Interview:

1. Fill out the information about the patient
2. Have the patient sign the consent form and provide all the contact information (must include phone numbers)
3. Fax the signed forms and medical records to Health Network staff

Regardless of which option you pick, we will need...

1. The signed consent form
2. The contact information
3. The medical record or summary

before we can provide the navigation for the patient.

Challenges to Success

- Staff turnover at clinics
(#1 Challenge)
- **No single health center point
of contact**
(Close 2nd)
- Patient Cooperation
- Identifying mobile patients
- Incorrect patient information
- Delay in enrollment



Single Point of Contact

Migrant Clinicians Network
PO Box 164285
Austin, Texas 78716



Business Phone: (512) 327-2017
Confidential Fax: (512) 327-6140
Confidential Phone: (800) 825-8205

ENROLLMENT IN THE MCN HEALTH NETWORK

Enrolling Clinic	Clinic phone number(s)	
E-mail address	Clinic fax number(s)	
Contact person at Clinic		
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Security Question #2:	Patient's father's first name?	
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CONSENT FOR RELEASE OF MEDICAL INFORMATION

First Name	Last Name(s)
Alias, Nicknames, Etc	Birth Date (Month / Day / Year)

Migrant Clinicians Network
PO Box 164285
Austin, Texas 78716



Business Phone: (512) 327-2017
Confidential Fax: (512) 327-6140
Confidential Phone: (800) 825-8205

ENROLLMENT IN THE MCN HEALTH NETWORK

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I agree to participate in the Health Network, and I understand that my protected health information and personal information will only be released for the purposes of my medical treatment, healthcare operations, payment, or pursuant to my authorization.

I do NOT authorize MCN or future health care providers to have access to my medical records around issue(s) listed here:

(attach additional page if needed)

I HEREBY RELEASE MCN, ITS EMPLOYEES, OFFICERS, DIRECTORS, CONSULTANTS, REPRESENTATIVES, SUCCESSORS, AND ASSIGNS FROM AND AGAINST ANY AND ALL CLAIMS, CAUSES OF ACTIONS, DAMAGES, LOSSES, EXPENSES (INCLUDING ATTORNEYS' FEES), AND LIABILITIES OF ANY KIND WHATSOEVER ARISING OUT OF MY ENROLLMENT IN THE HEALTH NETWORK AND MY HEALTH CARE TREATMENT RESULTING FROM MY ENROLLMENT IN THE HEALTH NETWORK.

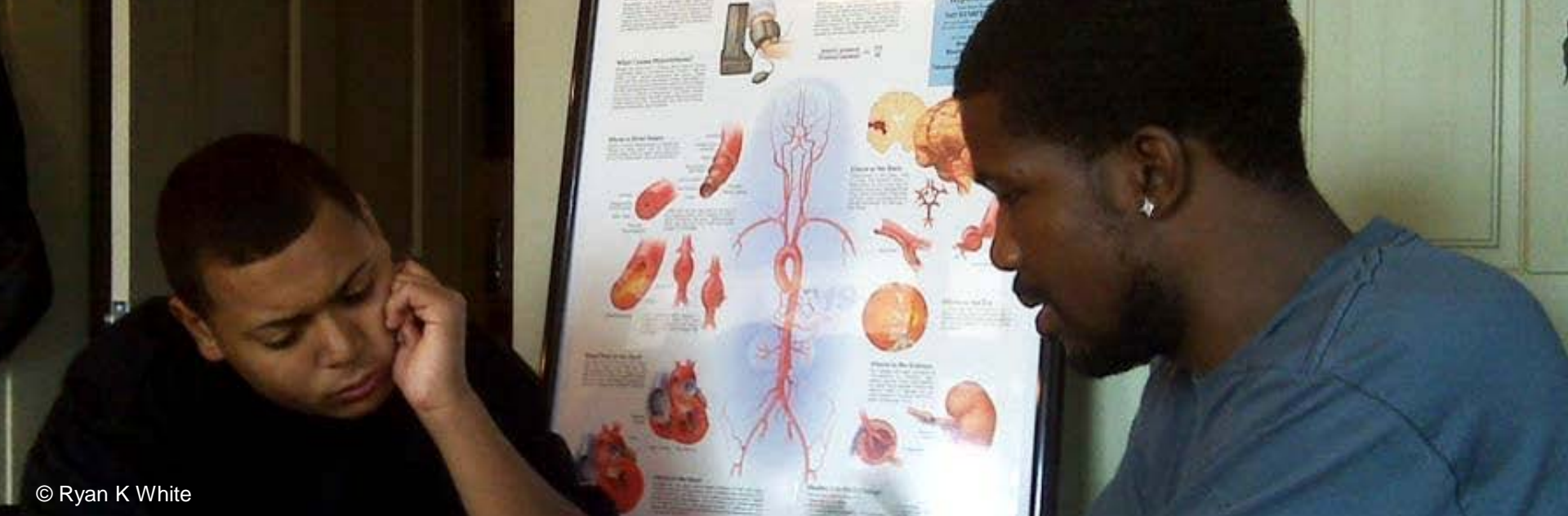
***REQUIRED**

*PARTICIPANT SIGNATURE (or Signature of Legal Representative)	Date
Relationship of Legal Representative to Patient	Witness Signature

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ENGLISH - THIS CONSENT FORM IS VALID FOR 2 YEARS AFTER DATE OF SIGNATURE

Please contact us at 512-327-2017 or www.migrantclinician.org/network for more information on the MCN Health Network.



© Ryan K White

Educating patients (using your trust relationship)

- How HN works and how they will benefit from participating (clinical support)
- How to use HN
- How HN keeps all patient information confidential
- The benefits, responsibilities and expectations



Maintaining a Patient in Care

The Patient's Role...

Provide as many phone numbers as possible

###-###-####

###-###-####

###-###-####



**Inform HN of any
phone or address
changes and
contact HN staff
after arriving in a
new area**



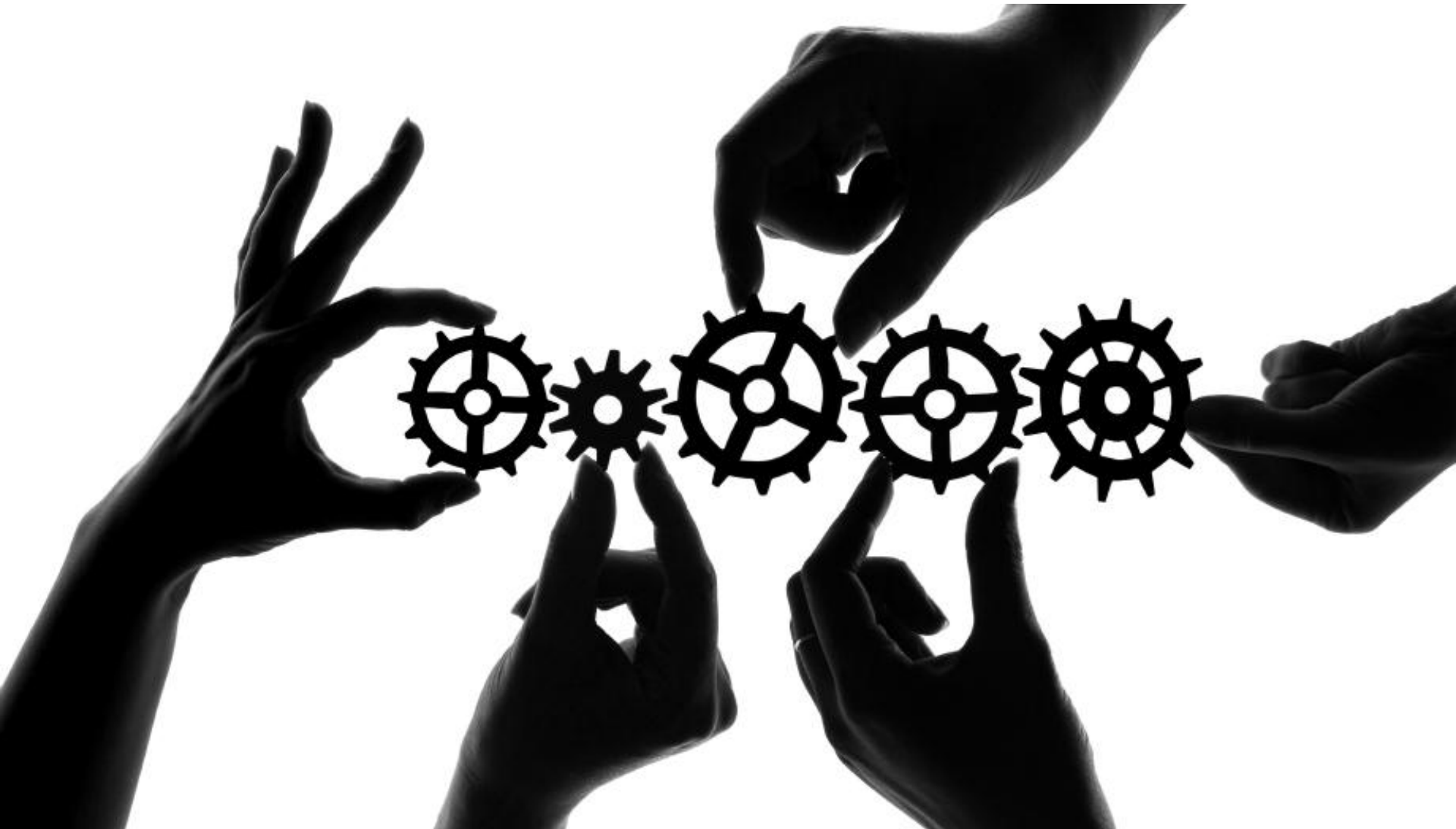
**Stay on
treatment as
long as indicated**



Notify new clinics of enrollment in HN



Team-Based Approach



Health Network Summary of Services



Contacts patients on a scheduled basis



Contacts clinics on a scheduled basis



Assists patients in locating clinics for services and resources. Transportation/Scheduling



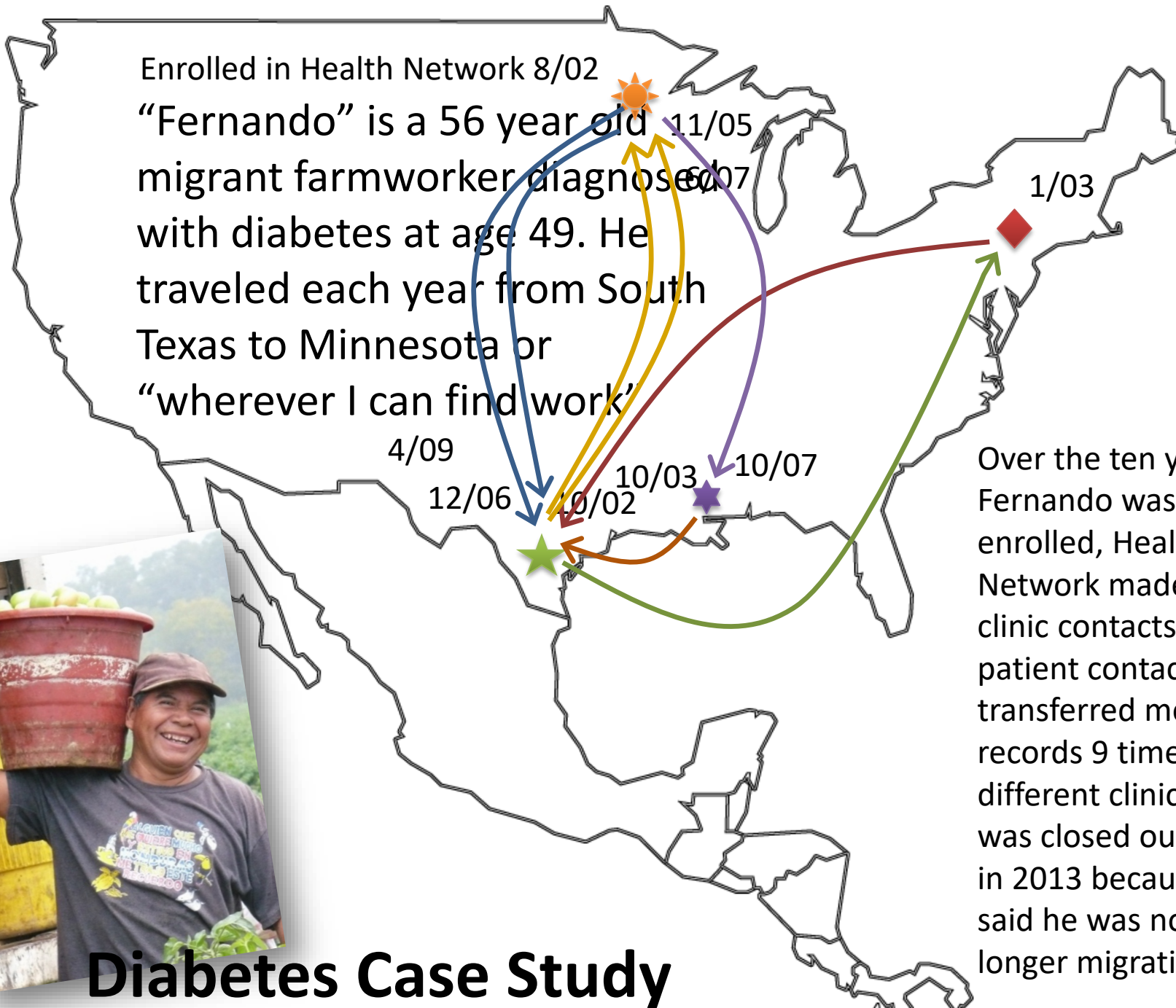
Reports outcome back to enrolling clinic

Enrolled in Health Network 8/02
“Fernando” is a 56 year old
migrant farmworker diagnosed
with diabetes at age 49. He
traveled each year from South
Texas to Minnesota or
“wherever I can find work”

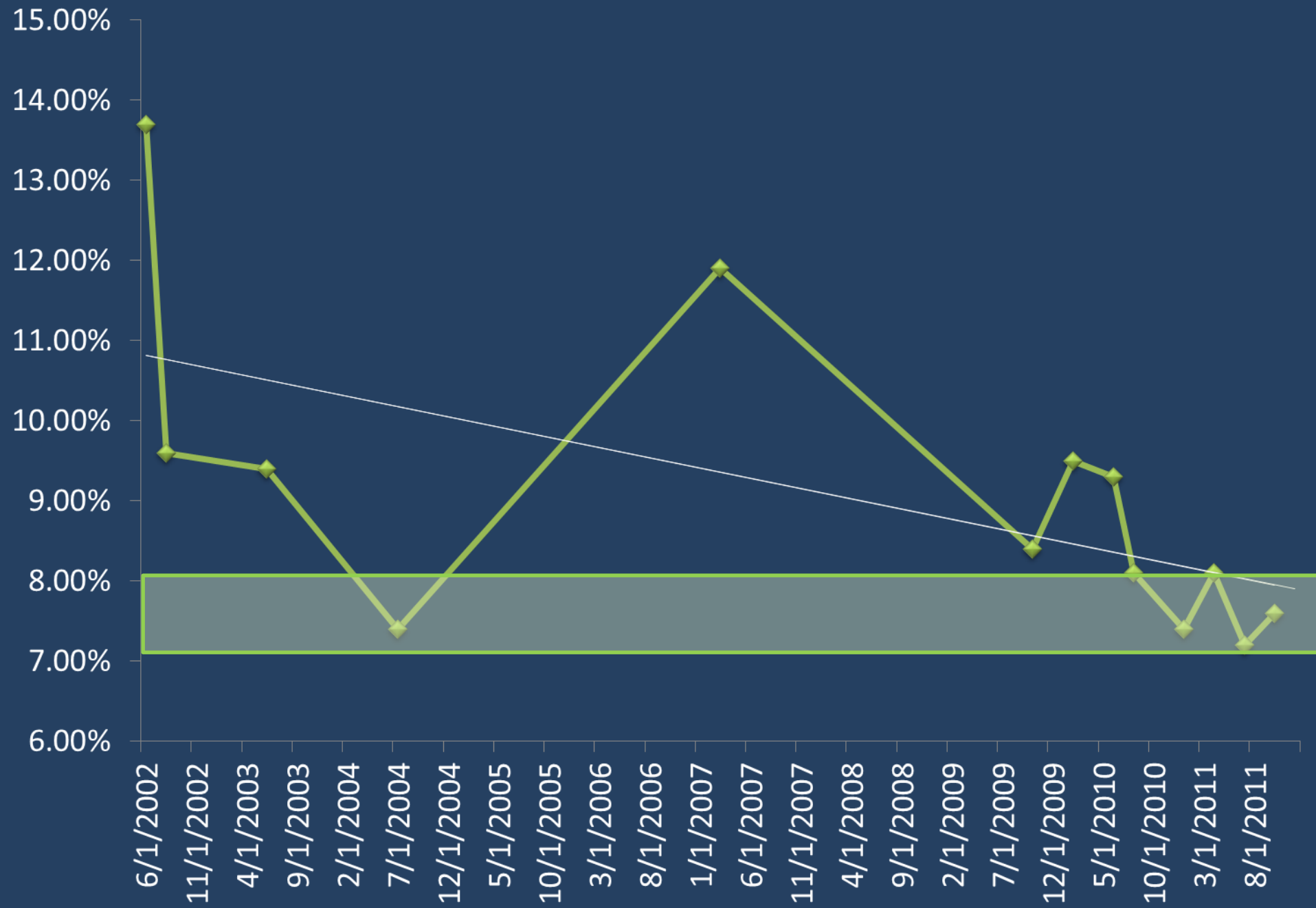


Diabetes Case Study

Over the ten years Fernando was enrolled, Health Network made 46 clinic contacts, 124 patient contacts, transferred medical records 9 times to 6 different clinics. He was closed out of HN in 2013 because he said he was no longer migrating.



Fernando's HBA1c While Enrolled in Health Network



Tools for Maintaining a Patient in Care

<p>ATTENTION PROVIDERS: This client is a user of the MCN Health Network. MCN can help you access:</p> <p>ATENCIÓN PROVEEDORES: Este paciente es usuario de la Red de Salud MCN. MCN les puede ayudar a encontrar:</p> <hr/> <p>This patient's medical record • <i>El expediente médico de este paciente</i> This patient's lab results • <i>Los resultados de laboratorio de este paciente</i> Financial assistance for his/her health care • <i>Ayuda económica para el cuidado de su salud</i></p> <p>This is a free service. • <i>El servicio es gratis.</i></p> <p>Call 1-800-825-8205 <i>De México 01-800-681-9508</i></p>	<p>MCN Health Network</p> <hr/> <p>Medical Records and Care Coordination Card <i>Tarjeta de Expedientes Médicos y Coordinación de Salud</i></p> <p>1-800-825-8205 <i>De México 01-800-681-9508</i> www.migrantclinician.org</p> <p>THIS IS NOT A MEDICAL INSURANCE CARD. <i>Esta no es una tarjeta de seguro médico.</i></p>
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Make sure patients have the HN toll free number:

800-825-8205

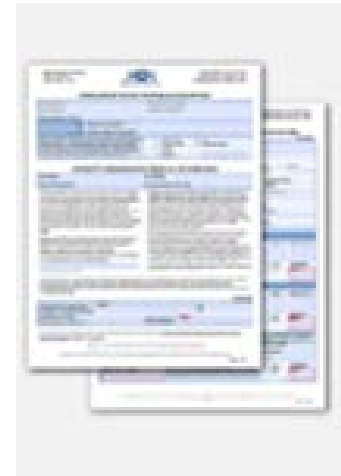
or

01-800-681-9508 if calling from Mexico

Enrollment resources at your fingertips: www.migrantclinician.org/services/network

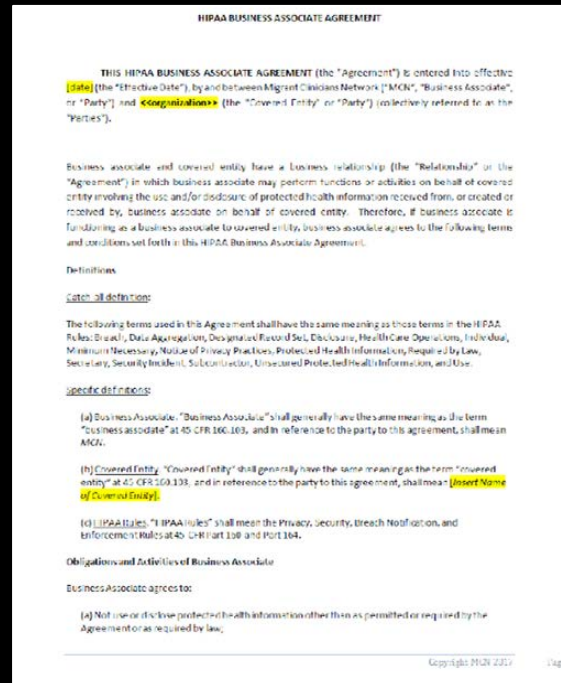


**Informational
Videos about
Health Network**



**Download Enrollment
Packets in English,
Kreyol, Portuguese
and Spanish**

Business Associates Agreements



Required to be compliant with HIPAA

Health Network **IMPACT**

- Bridge between patients and their providers
- Fewer patients lost to follow up
- Higher % of patients completing or continuing treatment
- Treatment completion reports
- Improved patient participation



Contact Us

- Health Network telephone:
800-825-8205 (U.S.)
01-800-681-9508 (from Mexico)
- Health Network fax: **512-327-6140**
- MCN website: <http://www.migrantclinician.org/>

If you have additional questions about the program,
you may also contact:

Theresa Lyons-Clampitt: **512-579-4511**
or **tlyons@migrantclinician.org**