



MIGRANT CLINICIANS NETWORK



Health Network: A Care Coordination Program for Patients Who Move During Treatment

MIGRANT CLINICIANS NETWORK



Our mission is to create practical solutions at the intersection of vulnerability, migration, and health.



**Cutting Edge
Programming**



**Resources and
Dissemination**



**Advocacy
and Policy**



**Research and
Knowledge
Mobilization**



**Clinical Support
and Capacity
Building**

MIGRANT CLINICIANS NETWORK



Office Locations



10,000 + constituents

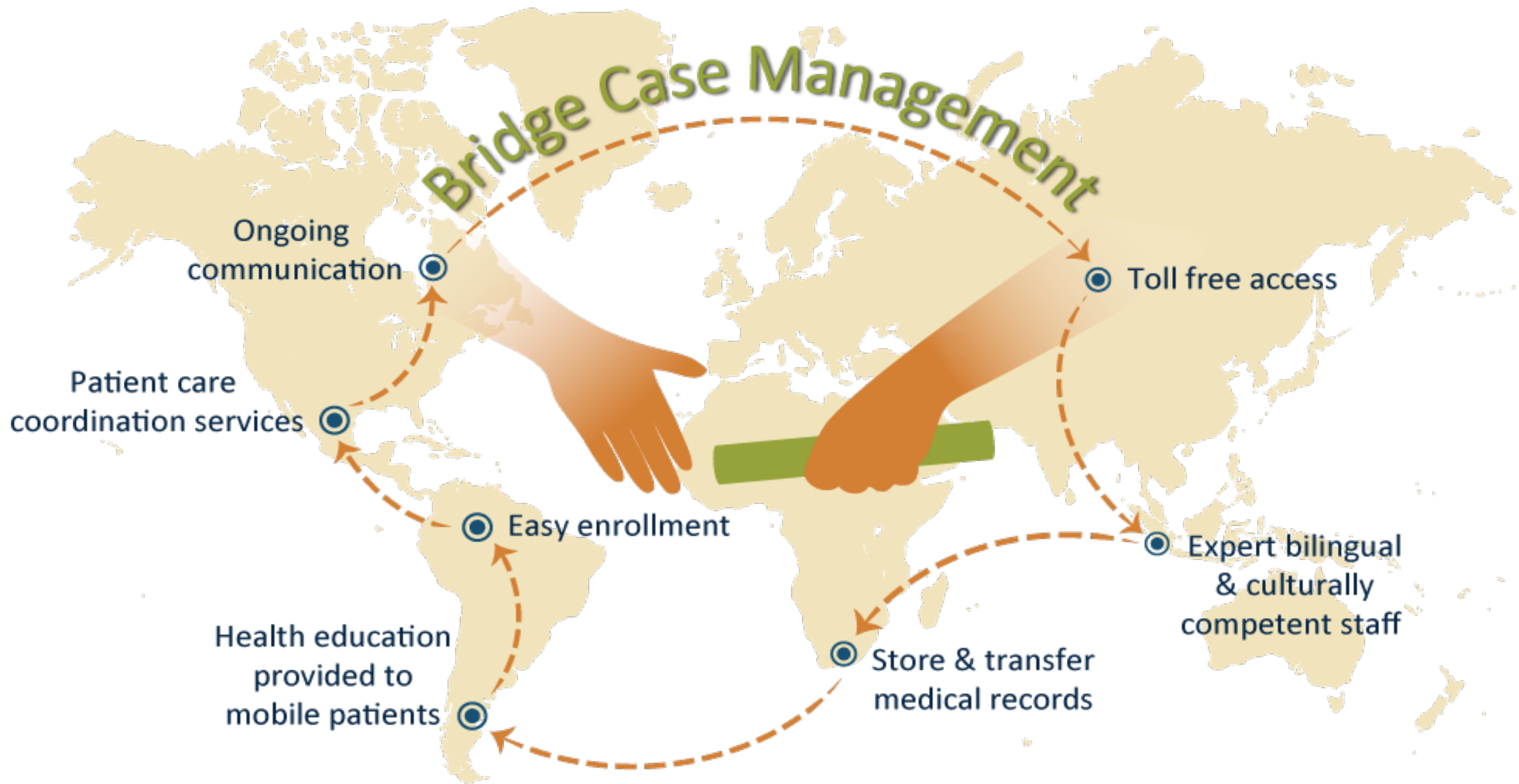
- Health educators
- Nurses
- Primary care providers
- Dentists
- Social workers
- CHWs
- Outreach workers
- Medical assistants
- Others





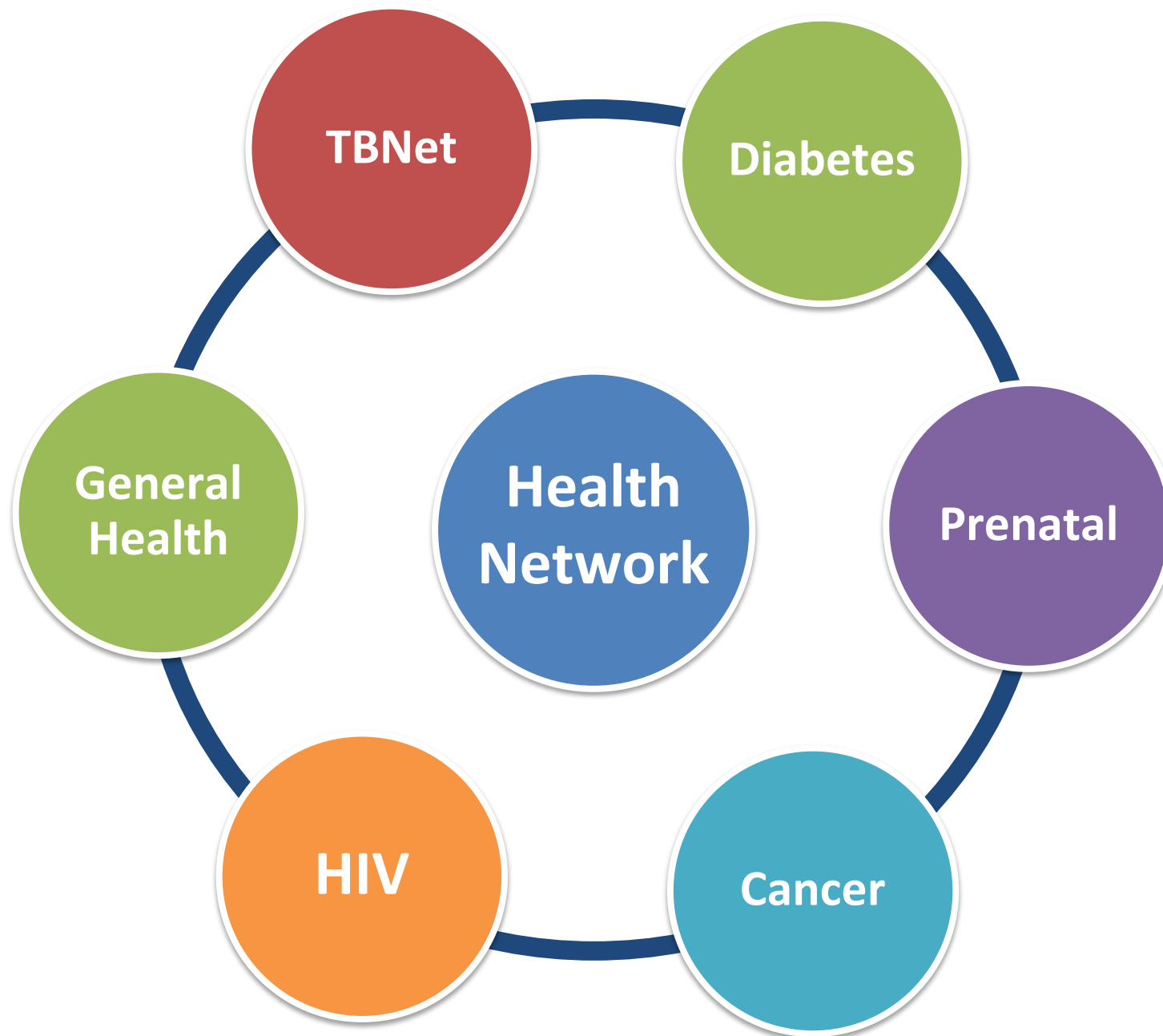


24 Years of Innovation

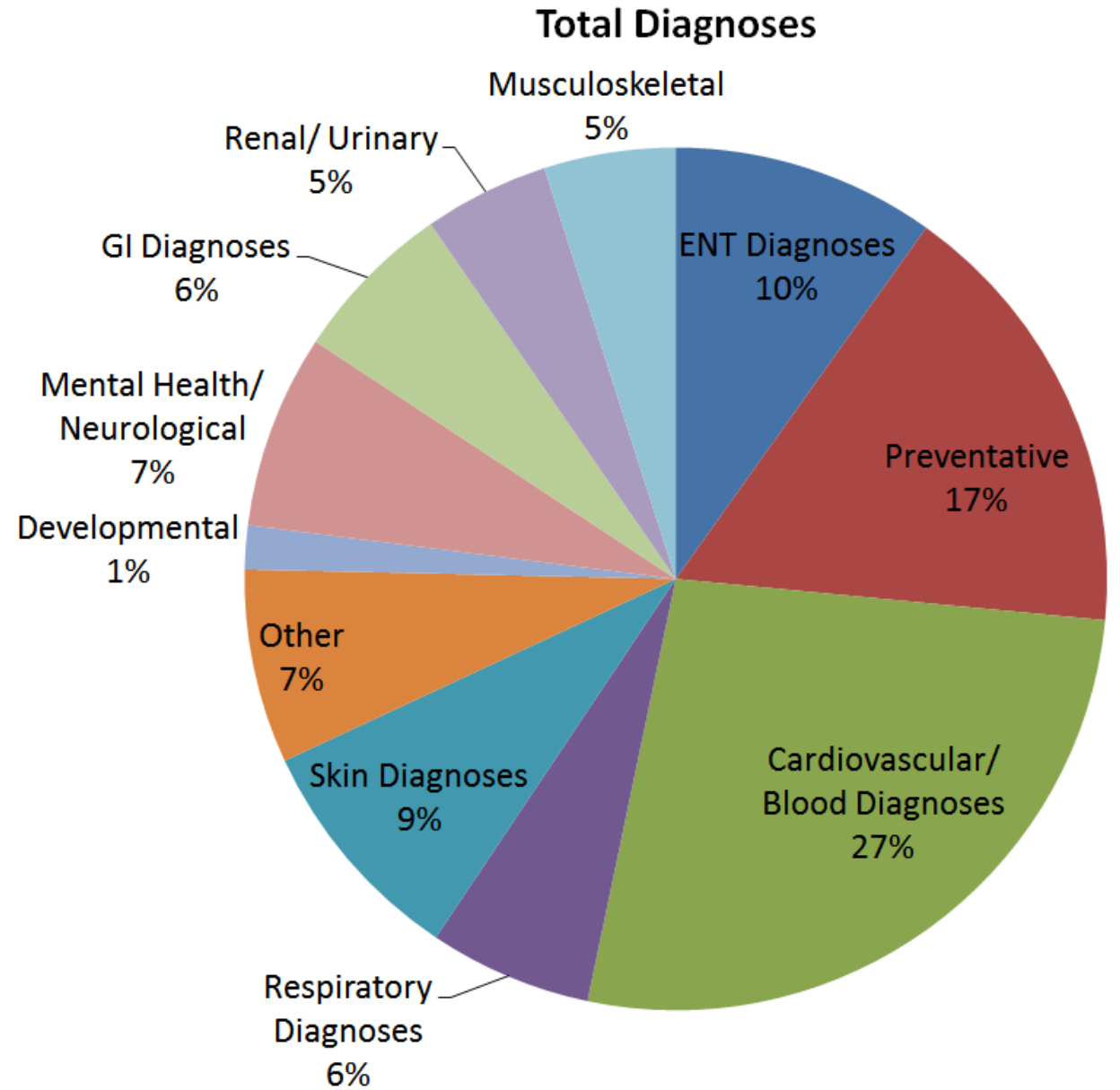




MCN's Health Network does not discriminate on the basis of immigration status and will not share personal patient information without patient permission.

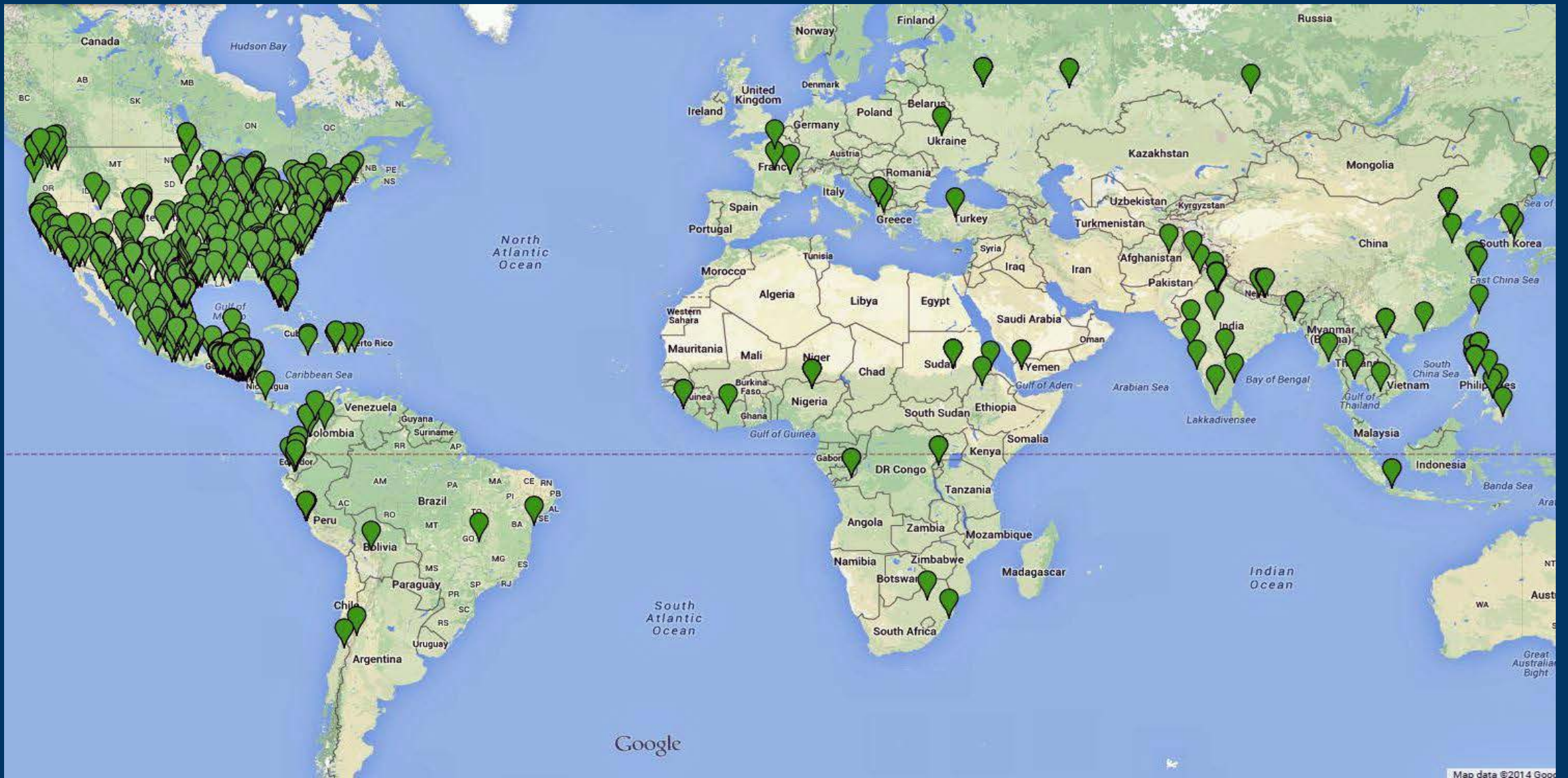


General Health





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"/> HIV
		<input type="checkbox"/> Prenatal Care	<input type="checkbox"/> General Health
		<input type="checkbox"/> Cancer	
		<input type="checkbox"/> Diabetes	

CONSENT FOR RELEASE OF MEDICAL INFORMATION

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

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 a 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, person regarding follow up and referral for my treatment for conditions. These individuals will adhere to federally mandated confidentiality, privacy and security procedures. **This consent remain in effect for two years (24 months) from the date of my participation in the Health Network has ended for another person can submit a written request any time to leave the Health Network to 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 ALL CLAIMS, CAUSES OF ACTIONS, DAMAGES, LOSSES, EXPENSES (INCLUDING ATTORNEYS' FEES), AND LIABILITY 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

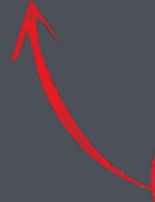
Please contact us at 512-327-2017 or www.migrantclinician.org/network for more information on the network.

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

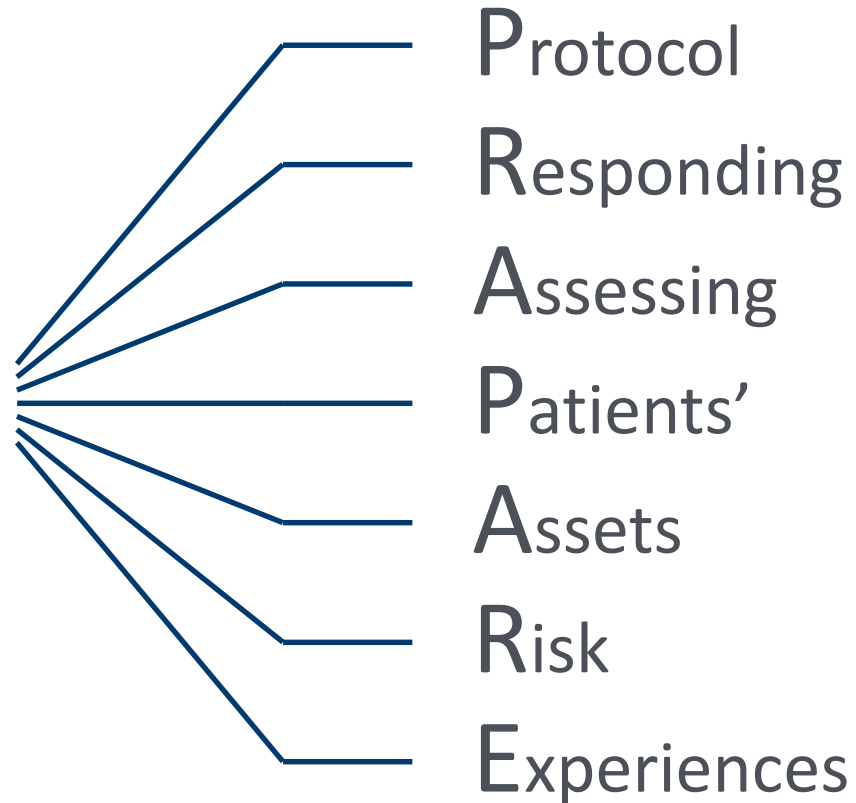
*REQUIRED

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

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")					<input type="checkbox"/> Yes	<input type="checkbox"/> 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")					<input type="checkbox"/> Yes	<input type="checkbox"/> 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")					<input type="checkbox"/> Yes	<input type="checkbox"/> No	*INITIALS:

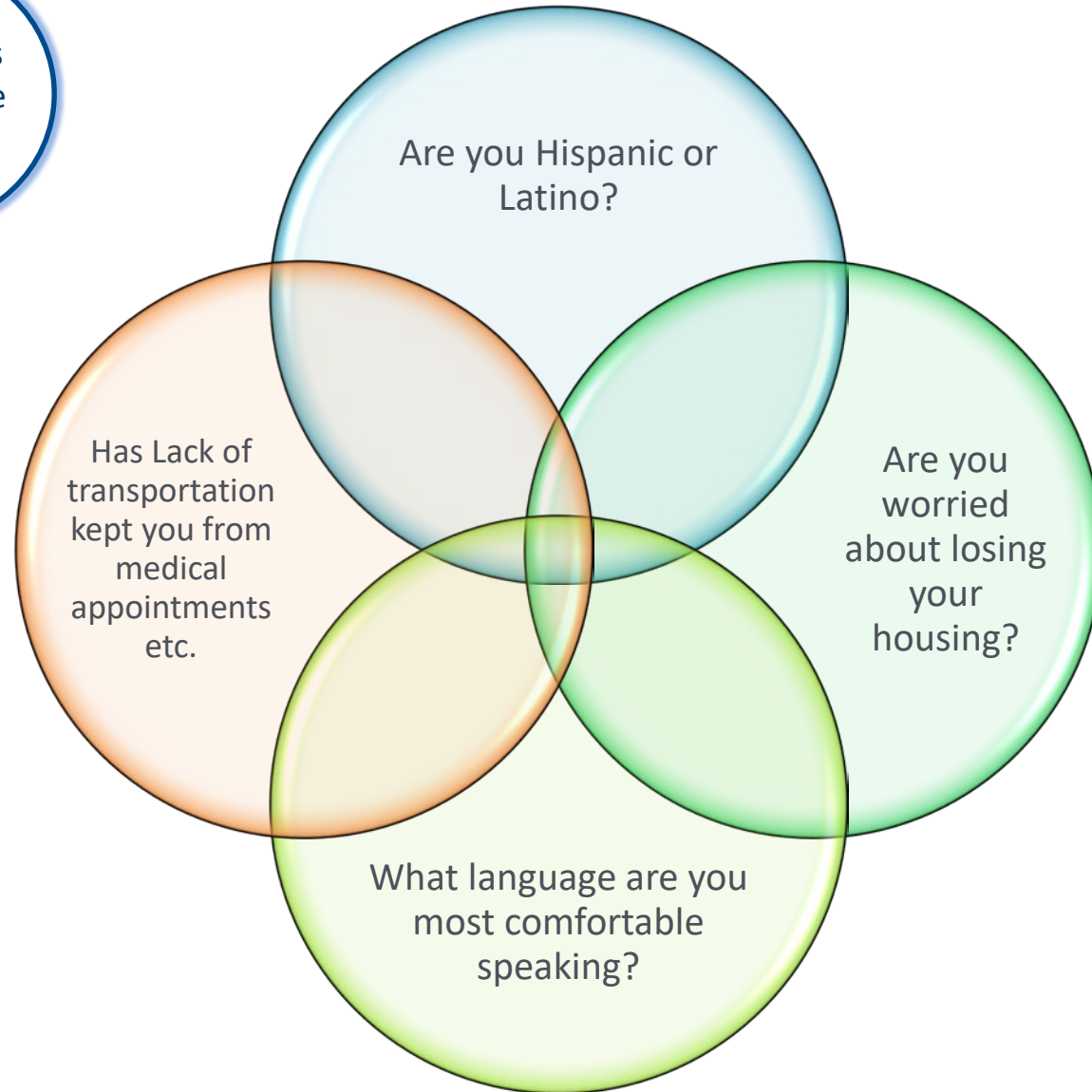
Optional Information for Enrollment

PRAPARE



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			
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)	
Alias, Nicknames, Etc		Birth Date (Month / Day / Year)	

Migrant Clinicians Network
PO Box 164285
Austin, Texas 78716



Business Phone: (512) 327-2017
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ENROLLMENT IN THE MCN HEALTH NETWORK

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

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

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

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.

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 for me containing sensitive health information (examples: HIV status and/or information about mental health issues) if my health care provider believes this information is needed for my treatment. I authorize MCN 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, mail or in person regarding follow up and referral for my treatment for these conditions. These individuals will adhere to federally mandated confidentiality, privacy and security procedures. **This consent form will remain in effect for two years (24 months) from the date signed or until my participation in the Health Network has ended for another reason.** I can submit a written request any time to leave the Health Network or to 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.

***REQUIRED**

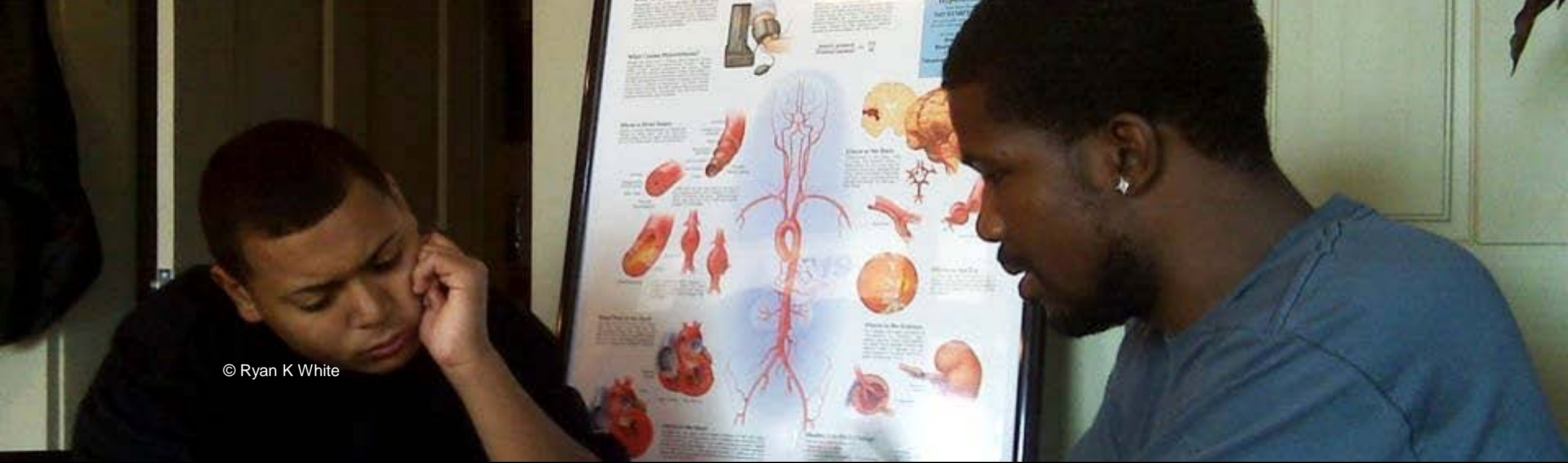
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10/11



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

A photograph showing two women in a clinical or hospital setting. The woman on the left is wearing glasses and a blue long-sleeved shirt, looking down at a computer monitor. The woman on the right is wearing a black top with a pink sash, also looking at the monitor. The background shows a computer workstation with a monitor and keyboard.

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

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 <u>NOT</u> 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

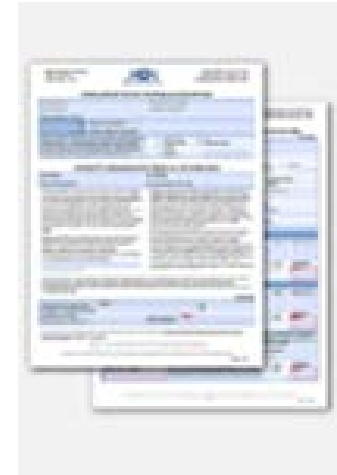
or

01-800-681-9508 if calling from Mexico

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

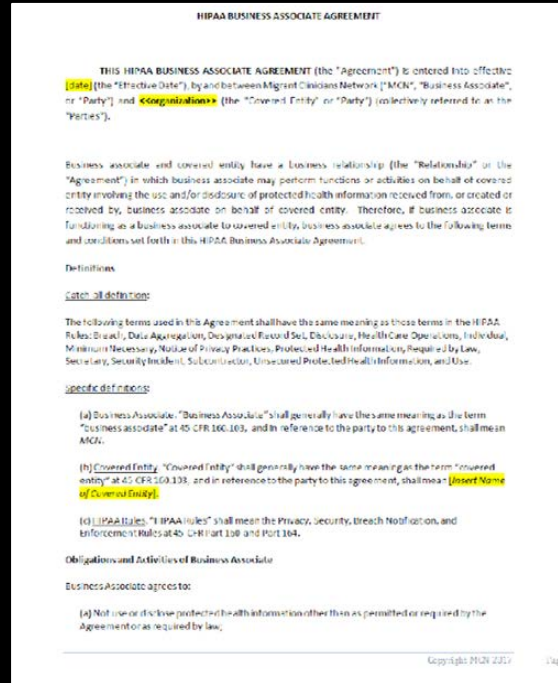


**Informational
Videos about
Health Network**



**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**

The Emergence of a Novel Coronavirus

8

BACKGROUND: FAMILY OF CORONAVIRUSES (CoV)

ANIMAL

- Numerous coronaviruses cause disease in animals

HUMAN

- Four types commonly circulate among humans, causing mild to moderate upper-respiratory-tract illnesses (229E, NL63, OC43, and HKU1)

ZOONOTIC

- Three animal coronaviruses have jumped to humans, then been transmitted from person to person:
 - SARS-CoV - emerged 2003, caused >8000 cases; no cases since 2004
 - MERS-CoV - emerged 2012, caused >2400 cases; continues to infect humans
 - SARS-CoV-2 - emerged 2019, outbreak ongoing

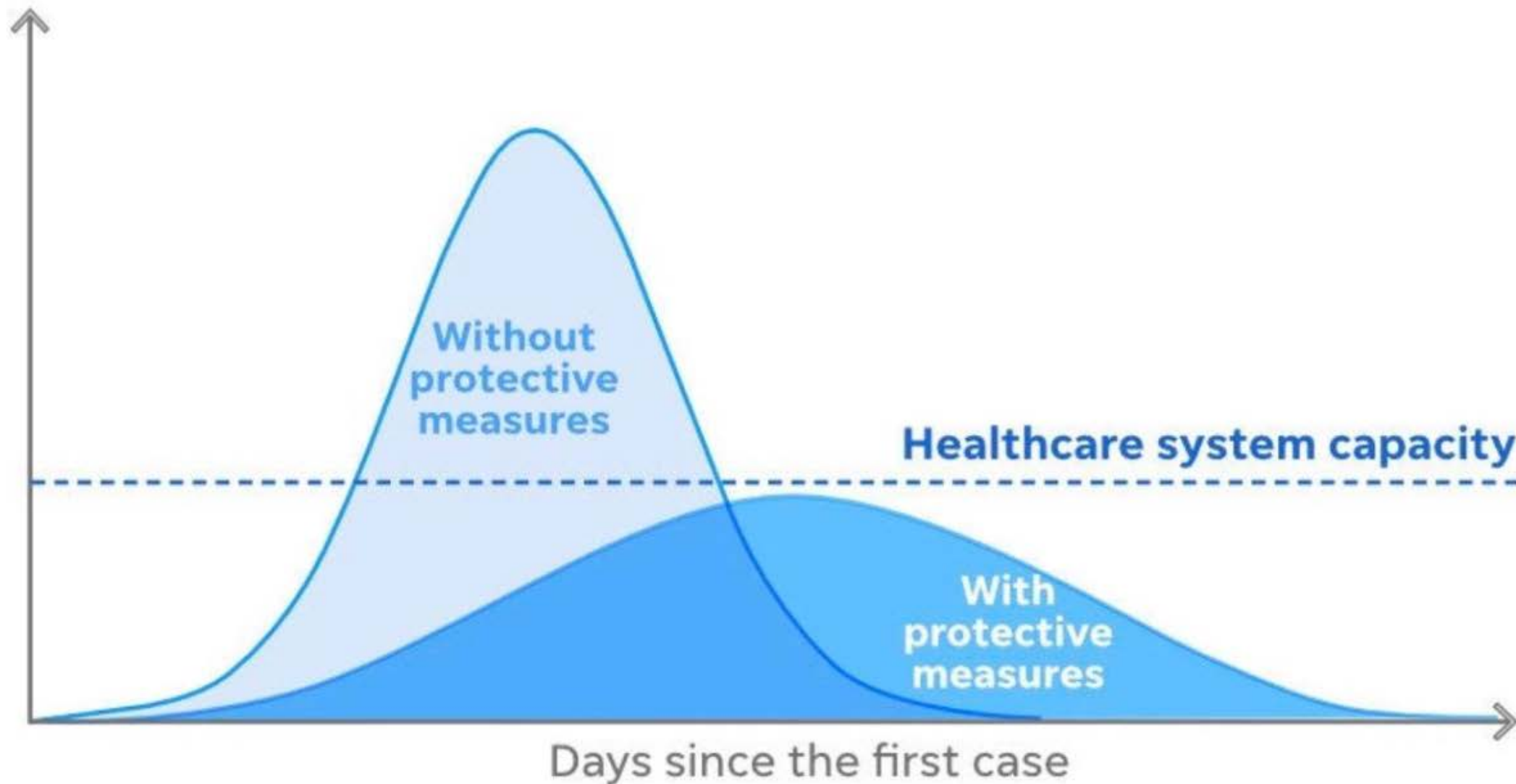
CHARACTERISTICS OF HOSPITALIZED CASES IN CHINA (N=138)

- 54% male
- Median age: 56 years (range 22-92)
- Hospital-associated transmission suspected:
 - 40 health care workers
 - 17 patients
- Chest computed tomographic (CT) scan
 - 100% bilateral ground glass opacities
- Among 36 transferred to ICU:
 - Acute respiratory distress syndrome (ARDS): 61%
 - Median age: 66 years
 - 72% had underlying comorbidities

Signs and symptoms	
Fever	99%
Dry cough	59%
Fatigue	70%

Laboratory findings	
Lymphopenia	70%
Prolonged prothrombin time	58%
Elevated lactate dehydrogenase	40%

Number of daily cases



SOURCE: CDC

COVID-19 Resources

<https://www.diabetes.org/diabetes/treatment-care/planning-sick-days/coronavirus>

<https://www.migrantclinician.org/blog/2020/mar/covid-19-widens-health-system-inequities-threatening-leave-migrants-and-immigrants-beh>

<https://es.hesperian.org/hhg/Coronavirus>

<https://www.scdhec.gov/infectious-diseases/viruses/coronavirus-disease-2019-covid-19/educational-outreach-materials-2019-ncov>