



# Health Network



A Care Coordination Program  
for Patients Who Move  
During Treatment



MIGRANT CLINICIANS NETWORK



**A force for health justice**

**Somos una fuerza dedicada a  
la justicia en salud**

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

**We envision** a world based on health justice and equity, where migration is never an impediment to well-being.

## Conflict of Interest Disclosure

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We have no real or perceived vested interests that relate to this presentation, nor do we have any relationships with pharmaceutical companies, biomedical device manufacturers and/or other corporations whose products or services are related to pertinent therapeutic areas.

### **Migrant Clinicians Network (MCN) is accredited as an approved provider of continuing nursing education by the American nurses credentialing center's commission on accreditation**

- To receive contact hours for this continuing education activity participants must complete a post-activity evaluation.
- Once successful completion has been verified, each participant will receive an electronic copy of his/her certificate that details the number of contact hours awarded.
- The planning committee members, presenters, faculty, authors, and content reviews of this CNE activity have disclosed no relevant professional, personal, or financial relationships related to the planning or implementation of this CNE activity.
- This CNE activity received no sponsorship or commercial support.
- This CNE activity does not endorse any products.
- For questions or additional information please contact: Jillian Hopewell at [jhopewell@migrantclinician.org](mailto:jhopewell@migrantclinician.org)

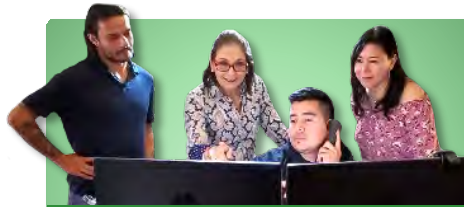
# Our Work



**Resource  
Development**



**Education**



**Technical  
Assistance**



**Research**



**Bridge Case  
Management**



**Worker Health  
and Safety**



**Psychosocial Support  
for Providers**



**Evaluation**



**Advocacy**



**Peer  
Networking**

MIGRANT CLINICIANS NETWORK

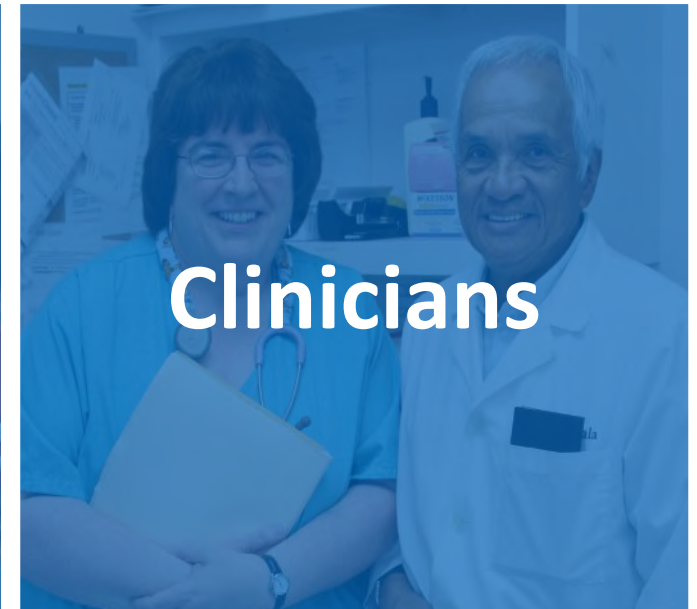


# Where We Are



# MCN's Primary Constituents

- Primary Care Providers
- Community Health Workers
- Nurses
- Dentists
- Social Workers
- Outreach Workers
- Public Health Professionals
- Health Educators
- Medical Assistants



MIGRANT CLINICIANS NETWORK



# Health Network

-----  
Eliminate health  
disparities due  
to patient mobility



©Earl Dotter



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



# 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

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



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### PERSONAL INFORMATION SHEET | MCN HEALTH NETWORK

\*REQUIRED

Last Name(s)	
Birth Date (Month / Day / Year)	
Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other: <input type="checkbox"/> Married <input type="checkbox"/> Widowed
<input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Black – Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino	

# Forms Required for Enrollment

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

*We recommend that, whenever possible, you provide the participant with a copy of this Consent for Release of Medical Records and MCN Health Network Enrollment form when it is completed.*

Is it ok if we talk to people that answer this phone about your personal health information? <i>(if you do not check off either box, or you do not initial, your answer will be "No")</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	*INITIALS:
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LOCATION FOR PARTICIPANT (Place you normally move to):

PO Box	City	State	Zip/Country
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Is it ok if we talk to people that answer this phone about your personal health information? <i>(if you do not check off either box, or you do not initial, your answer will be "No")</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	*INITIALS:
---	---	------------

someone we can contact if we cannot reach you at either of the locations you provided. In doing this act that family member or friend to assist you in receiving continued health care, which may require s) with this individual. You do not have to provide this additional contact information.

Last Name	Relationship to Participant	
City	State	Zip/Country

Is it ok if we talk to people that answer this phone about your personal health information? <i>(if you do not check off either box, or you do not initial, your answer will be "No")</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	*INITIALS:
---	---	------------

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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	

Gives MCN staff legal permission to transfer participants' medical records and contact participants

### 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 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 of my medical history containing sensitive health information (example: 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.

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.

Authorized individuals from MCN may contact me by phone, email, 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 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 file with MCN upon written request.

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 WAIVES 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.

*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 Records and MCN Health Network Enrollment form when it is completed.*

Must have the participant's signature



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


## 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	<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:		Language you prefer to be contacted in:	
<input type="checkbox"/> English <input type="checkbox"/> Creole <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"/> Homemaker		<input type="checkbox"/> Factory
	<input type="checkbox"/> Student		<input type="checkbox"/> Child care
Current Residence:	<input type="checkbox"/> Farmworker Camp Housing		<input type="checkbox"/> Jail
	<input type="checkbox"/> Home		<input type="checkbox"/> ICE Detention Center
			<input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Other:
		<input type="checkbox"/> Homeless <input type="checkbox"/> Other:	
<b>CURRENT CONTACT INFORMATION FOR PARTICIPANT:</b>			
Street / P.O Box		City	State
Zip/Country			
<b>*PHYSICAL ADDRESS:</b>			
<b>*MAILING ADDRESS:</b>			
<b>*PHONE NUMBER</b> (with Area Code) HOME / CELL / WORK:		Is it ok if we talk to people that answer this phone about your personal health information? <i>(if you do not check off either box, or you do not initial, your answer will be "No")</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<b>*INITIALS:</b>	
<b>OTHER CONTACT INFORMATION FOR PARTICIPANT (Place you normally move to):</b>			
Street / P.O Box		City	State
Zip/Country			
Physical Address:			
Mailing Address:			
<b>*PHONE NUMBER</b> (with Area Code) HOME / CELL / WORK:		Is it ok if we talk to people that answer this phone about your personal health information? <i>(if you do not check off either box, or you do not initial, your answer will be "No")</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<b>*INITIALS:</b>	
<p><b>Additional Contact:</b> 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.</p>			
First Name		Last Name	
Relationship to Participant			
Street / P.O Box		City	State
Zip/Country			
<b>*PHONE NUMBER</b> (with Area Code) HOME / CELL / WORK:		Is it ok if we talk to people that answer this phone about your personal health information? <i>(if you do not check off either box, or you do not initial, your answer will be "No")</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<b>*INITIALS:</b>	

# Single Point of Contact at the Health Center

Migrant Clinicians Network  
PO Box 164285  
Austin, Texas 78716




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We recommend that, whenever possible, you provide the participant with a copy of this Consent for Release of Medical Records and MCN Health Network Enrollment 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 MCN Health Network.

02-07

Page 1 of 2

# These enrollment resources are available:

[www.migrantclinician.org/health-network/enrollment](http://www.migrantclinician.org/health-network/enrollment)



La Red de Salud es un sistema de administración de casos para pacientes móviles creado por Migrant Clinicians Network.



Cualquier proveedor de salud que trabaja con migrantes que tienen la intención de marcharse y se encuentran bajo tratamiento



La Red de Salud también puede proveer al paciente con educación necesaria acerca de temas clínicos.

Informational  
Videos about  
Health Network

Download Enrollment  
Packets in English,  
Haitian Creole,  
Portuguese and  
Spanish

## HIPAA BUSINESS ASSOCIATE AGREEMENT

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT (the "Agreement") is entered into effective [date] (the "Effective Date"), by and between Migrant Clinicians Network ("MCN", "Business Associate", or "Party") and <<organization>> (the "Covered Entity" or "Party") (collectively referred to as the "Parties").

Business associate and covered entity have a business relationship (the "Relationship" or the "Agreement") in which business associate may perform functions or activities on behalf of covered entity involving the use and/or disclosure of protected health information received from, or created or received by, business associate on behalf of covered entity. Therefore, if business associate is functioning as a business associate to covered entity, business associate agrees to the following terms and conditions set forth in this HIPAA Business Associate Agreement.

### Definitions

#### Catch-all definition:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

#### Specific definitions:

(a) Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean *MCN*.

(b) Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean *[insert Name of Covered Entity]*.

(c) HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

### Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

# Business Associates Agreements

---

# Required to be compliant with HIPAA

# Recap of 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





# Steps to Maintaining a Patient in Care

# MCN's Health Network Associate:



✓ Contacts patients on a scheduled basis



✓ Contacts clinics monthly, other healthcare clinics receive updates as requested, and when treatment has completed.



✓ Assists patients in locating clinics for services and resources



✓ Reports back to the enrolling clinic and notifies them of final outcomes



# The Patient's Role...

As many  
phone numbers  
as possible

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

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

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



**Inform Health Network (HN)  
Associates of any phone or  
address changes and  
contact HN staff after  
arriving in a new area**





**Continue  
treatment as  
long as  
indicated by  
their physician**



**Over 15,100 total  
HN enrollments**



Over 3,000 total clinics in U.S. and over 114 countries engaged to eliminate mobility as an obstacle to continuity of care





MCN's Health Network program began  
initially as TB NET

**2,125**

**Treatment Recommended**

(26 MDR; 65 resistant to at least one drug)

*37 deceased*

A faint, light blue world map is visible in the background of the slide, centered behind the text.

# 2,088 Followed for Active TB

211 lost to follow up  
106 refused treatment

**1,771 Complete Treatment**

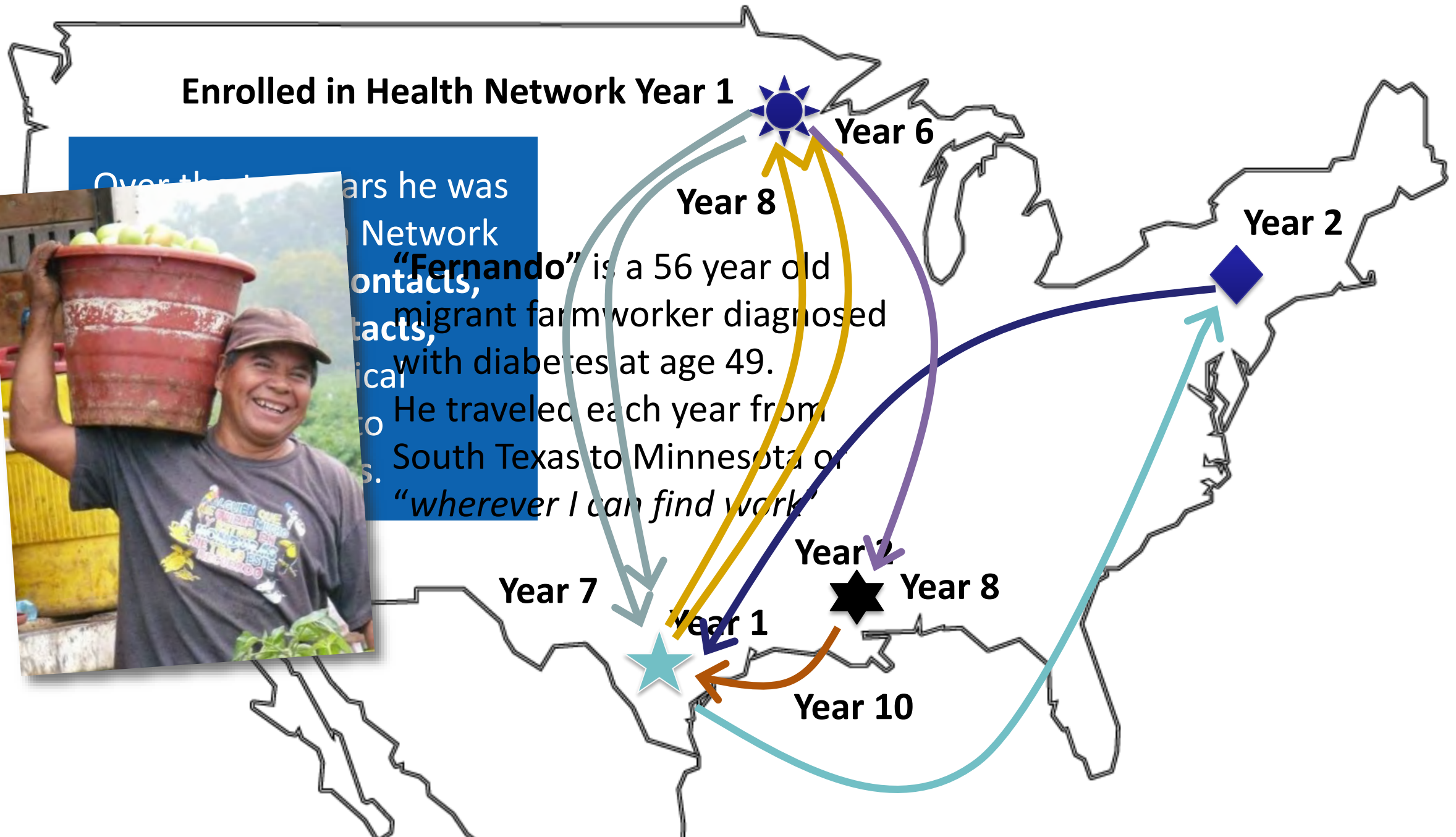


**84.8%**

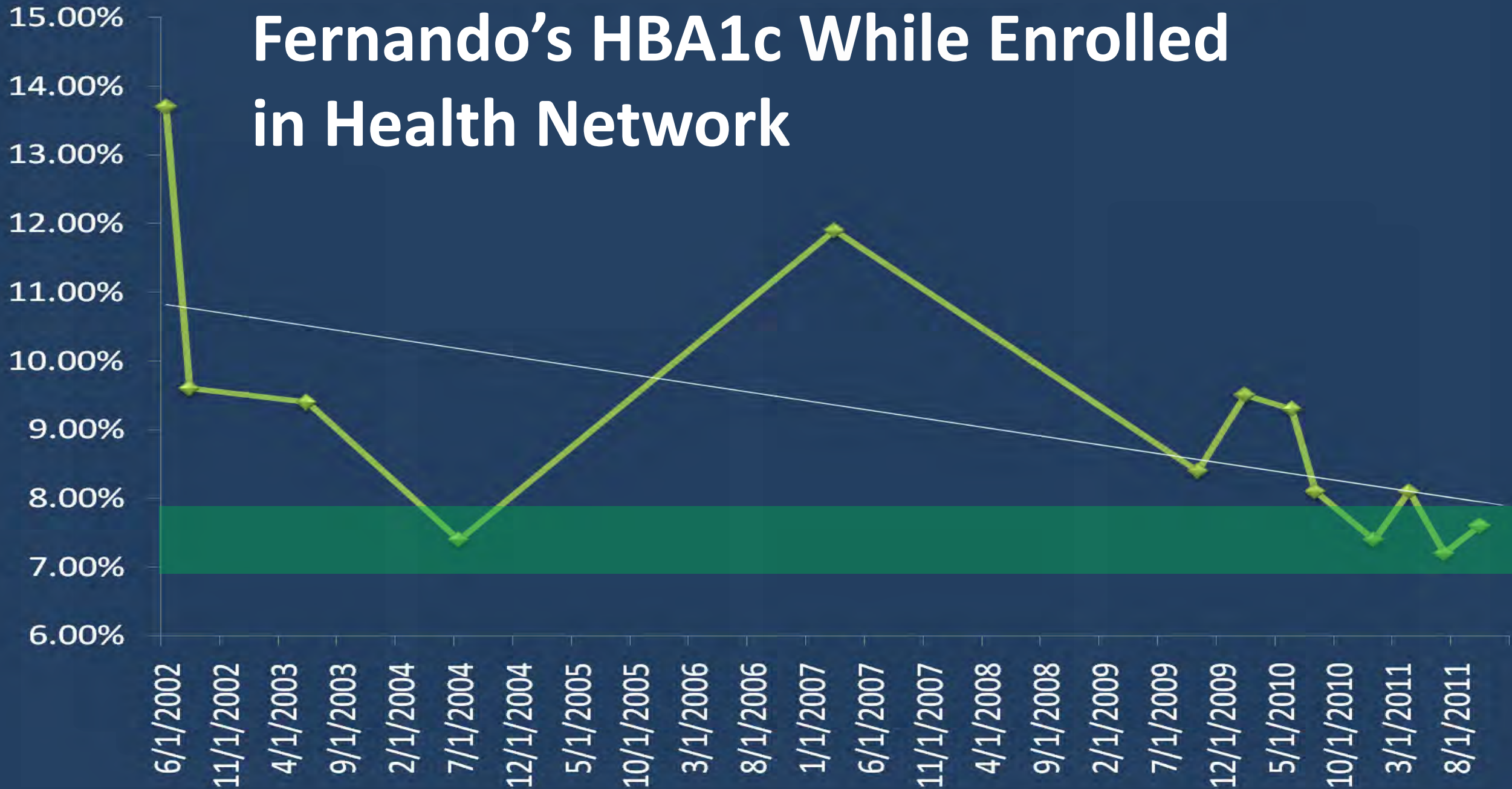
Enrolled in Health Network Year 1



Over the next 10 years he was  
Network  
contacts,  
contacts,  
ical  
to  
s.  
“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”



# Fernando's HBA1c While Enrolled in Health Network



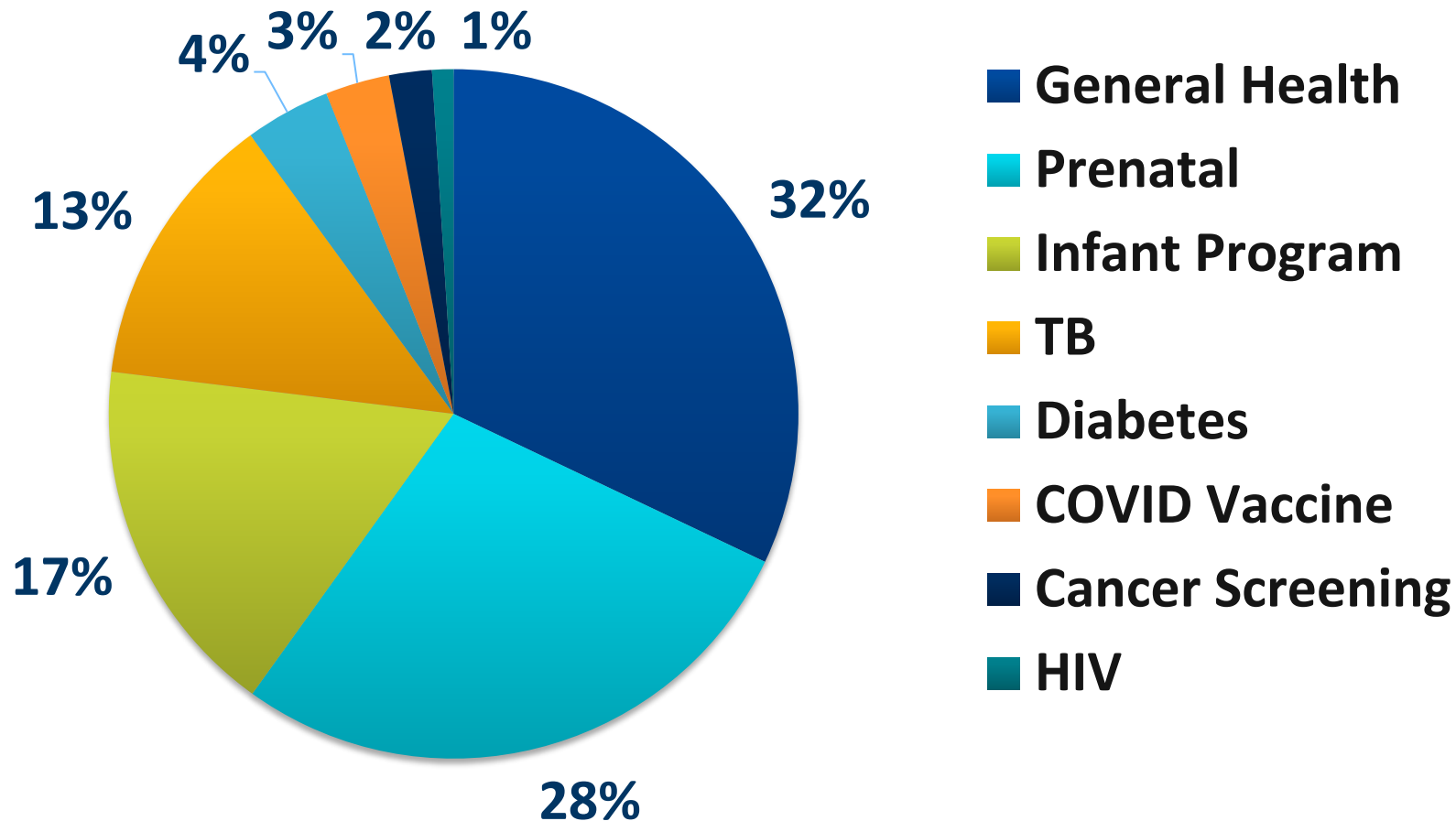


## How Can MCN's Health Network Have such a high completion rate to 114 countries??

- Multilingual/multicultural case managers who use multiple communication techniques.
- MCNs' Case managers speak multiple languages (English, Spanish, Haitian Creole, French and Portuguese and use Language Line for all others)

# MCN Health Network

## Percent of Health Network Enrollments by Primary Diagnosis





# What is the SCAN Program?

SCAN stands for the  
**Specialty Care Access Network**

SCAN's primary goal is to assist with the coordination of pediatric patients into sub-specialty care.



# Referral into the SCAN program

- ✓ A clinic, program, organization or SCAN member identifies a patient with sub-specialty need
- ✓ Health Network helps to guide and instruct on how to complete the enrollment packet.



# Referral into the SCAN program

SCAN's goal is to have the following information prepared to help with the continuation of care and coordination with the SCAN Team Member:

- Patient's information
- Signed consent form
- Patient Care Summary  
(if the patient has already been seen by a previous provider)
- Next Steps



# Referral into the SCAN program

- ✓ The SCAN Patient care coordinator will contact the family to introduce the program and complete patient enrollment if needed.
- ✓ Patient care coordinator will identify the appropriate SCAN Member to contact and send out a request for assistance with the patient's summary.



## Example of Patient Enrollment Summary

**ABCD is a 5-year-old girl born in Guatemala (DOB) with Developmental Delay to include Speech and Toileting.**

The child arrived at **Welcome Center** in Tucson on 01/01/2021.

Her mother speaks the Spanish language fluently and is literate. I talked with the mother about the referral and mom agreed: Mom also told me that in the past she was told that the child might have microcephaly, and was sent for tests, but mom never took her.

# Example of Patient Enrollment Summary

Mom says the child has had, essentially, no health care. Today I accomplished a complete EPSDT (Well Child Evaluation) on the child.

The physical exam is normal: height in 50%ile, weight in 25%ile: I will include the EPSDT form and growth chart when I send the records I have. The child has essentially no speech and uses diapers – does not toilet at all.

# Example of Patient Enrollment Summary

**The family is traveling to California later today.**

I have the address and telephone number of their sponsoring family. Mom signed the referral to the MCN. I will follow Luis' instructions and see if I can get the documents to you in a secure email. If not, we will use a secure fax to send them.

**The possible follow-up needs that I have identified are:**

- Pediatrician
- Peds Neurology
- Speech Therapy
- Occupational Therapy

# Who do you send the referral to for SCAN?

## **Patient care coordinator for SCAN – Camila Velasquez**

- Will complete the referral
- Identify the appropriate SCAN team member to contact
- Continue patient care coordination with SCAN Team member

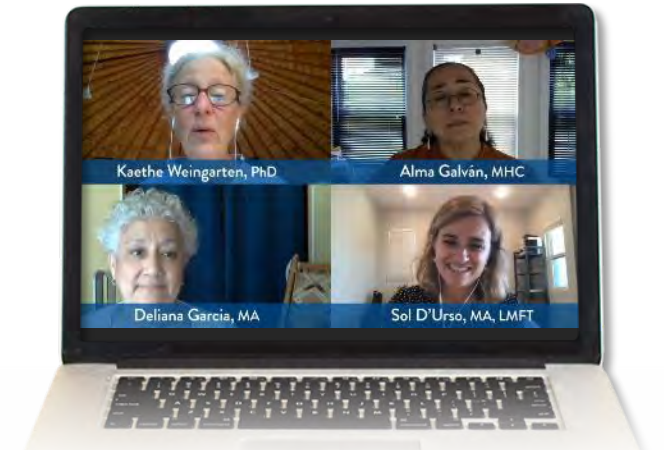
# Connect with MCN!



Access our  
latest resources



Get updates  
from the field



Attend our  
virtual trainings

*and a lot more at*

[www.migrantclinician.org](http://www.migrantclinician.org)





# Contact Us

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

If you have additional questions about the program or have additional training and technical assistance needs, you may also contact:

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



**Please remember to submit the evaluation.**  
Submission is required if you would like to receive a Certificate of Attendance or a Certificate of Continuing Nursing Education.

You can access the evaluation by scanning the QR code, clicking on the link provided in the chat, or wait until the session is closed and the evaluation will automatically open in a new window. **Thank you!**

