Health Network

A Care Coordination Program for Patients Who Move During Treatment

MIGRANT CLINICIANS NETWORK

MIGRANT CLINICIANS NETWORK

MCN

A force for health justice

Somos una fuerza dedicada a la justicia en salud

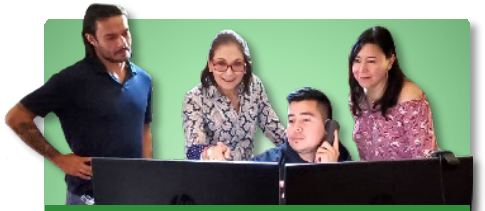
Our mission is to create practical solutions at the intersection of vulnerability, migration, and health.

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

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

MCN

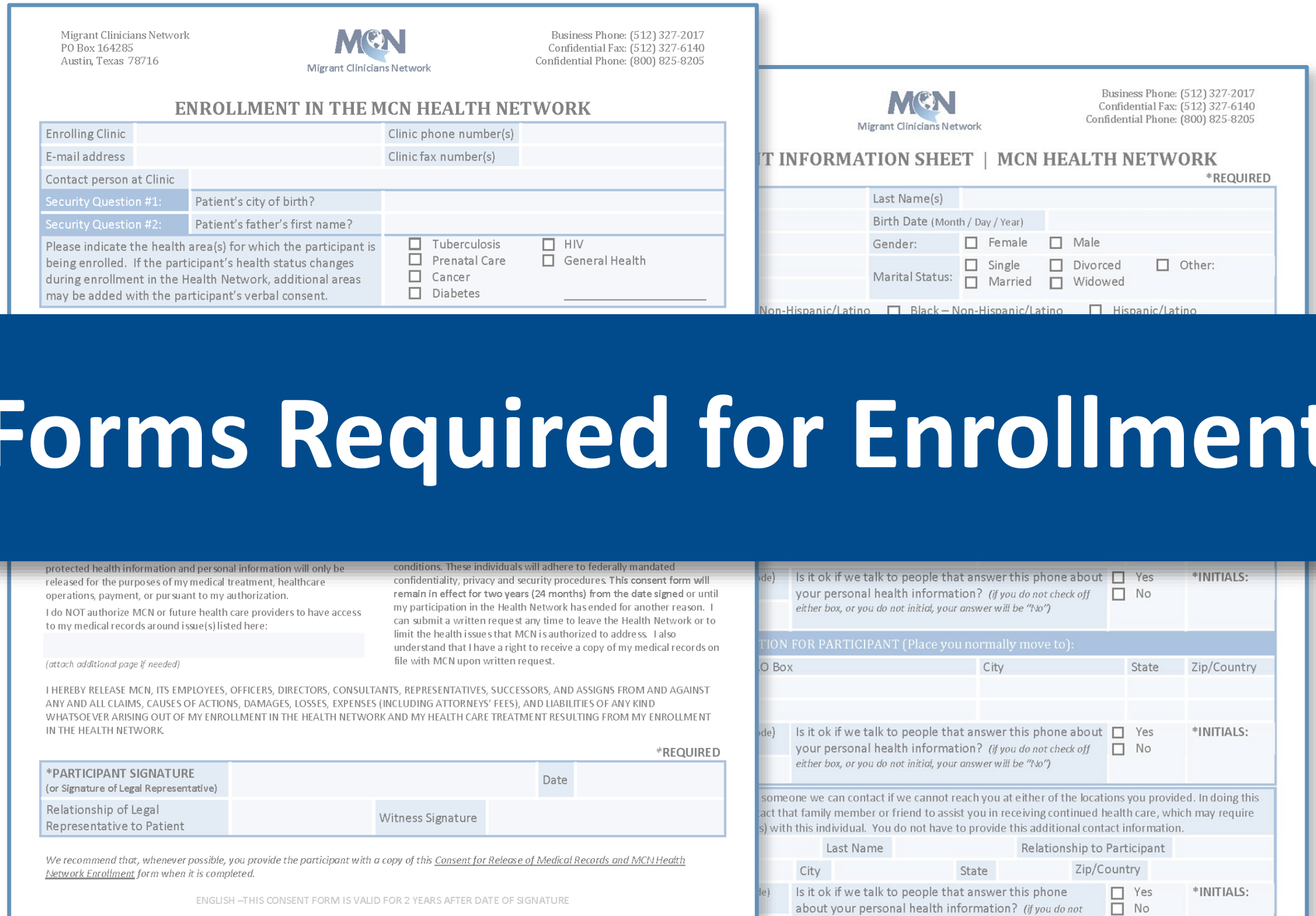
Health Network

Eliminate health disparities due to patient mobility


Health Network
28 Years of Innovation
Photo by 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.

- ✓ **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

Migrant Clinicians Network

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.

☐ Tuberculosis ☐ HIV
☐ Prenatal Care ☐ General Health
☐ Cancer
☐ Diabetes

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T INFORMATION SHEET | MCN HEALTH NETWORK

*REQUIRED

Last Name(s)
Birth Date (Month / Day / Year)
Gender: ☐ Female ☐ Male
Marital Status: ☐ Single ☐ Divorced ☐ Other: ☐ Married ☐ Widowed

Non-Hispanic/Latino ☐ Black – Non-Hispanic/Latino ☐ Hispanic/Latino

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)

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.

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.

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

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:

TION FOR PARTICIPANT (Place you normally move to):

O Box | City | State | Zip/Country

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:

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? *(if you do not* ☐ Yes ☐ No *INITIALS:

Forms Required for Enrollment

Must have the participant's signature

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

Authorized individuals from MCN may contact me by phone, 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 rea can submit a written request any time to leave the Health Networ 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 re file with MCN upon written request.

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*I

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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.

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

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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:	☐ Female ☐ Male
Place of birth: State		Marital Status:	☐ Single ☐ Divorced ☐ Other: ☐ Married ☐ Widowed
Place of birth: Country			
Race/Ethnicity:	☐ White – Non-Hispanic/Latino ☐ Black – Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Asian – Non-Hispanic/Latino ☐ Indigenous ☐ Other:		
Language(s) Spoken:	☐ English ☐ Creole ☐ Spanish ☐ Other:	Language you prefer to be contacted in:	
Occupation(s) (from past two years):	☐ Farmworker ☐ Construction ☐ Retired ☐ Homemaker ☐ Factory ☐ Unemployed ☐ Student ☐ Child care ☐ Other:		
Current Residence:	☐ Farmworker Camp Housing ☐ Jail ☐ Homeless ☐ Home ☐ ICE Detention Center ☐ 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

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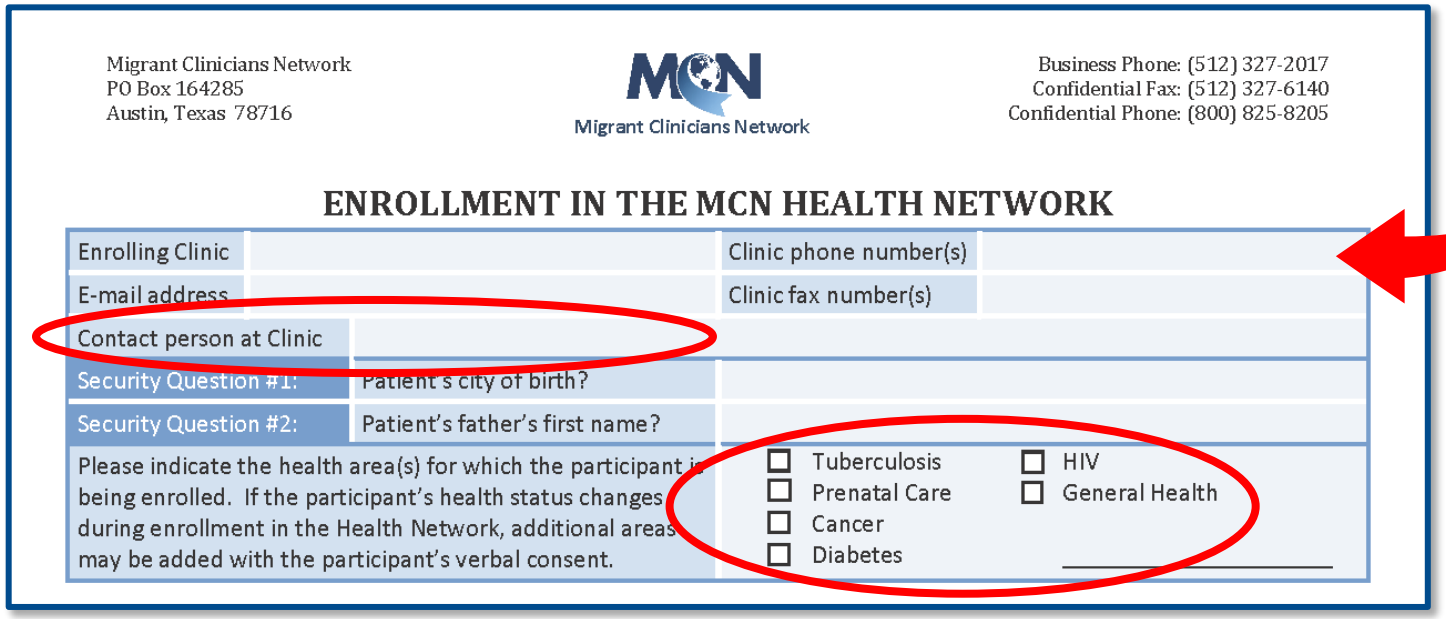
Single Point of Contact at the Health Center



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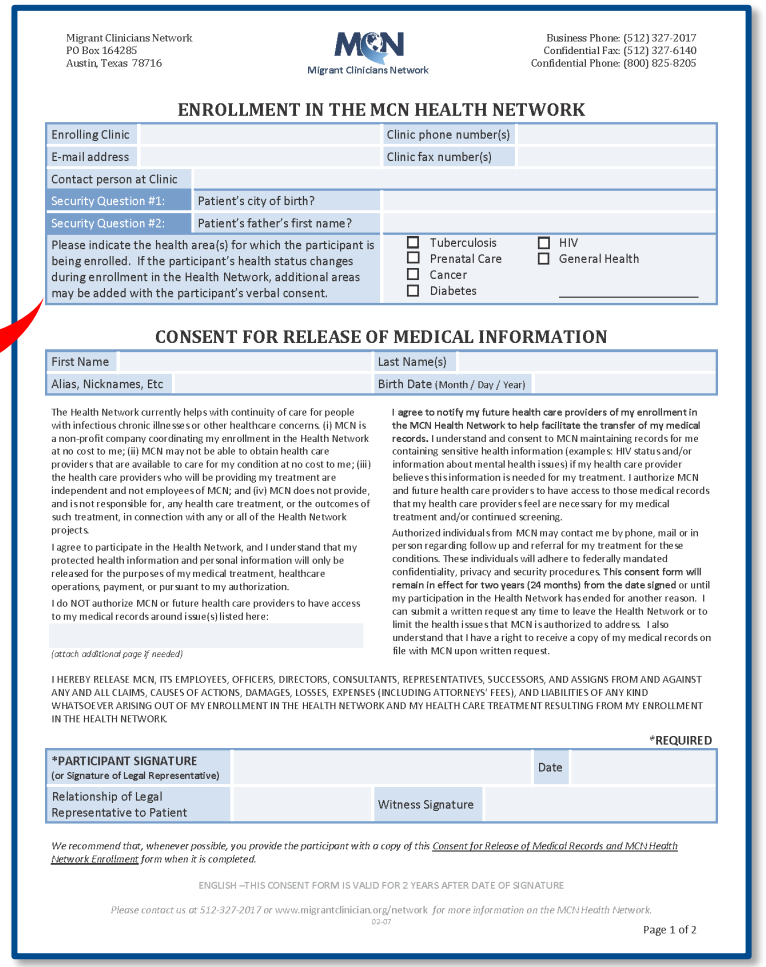

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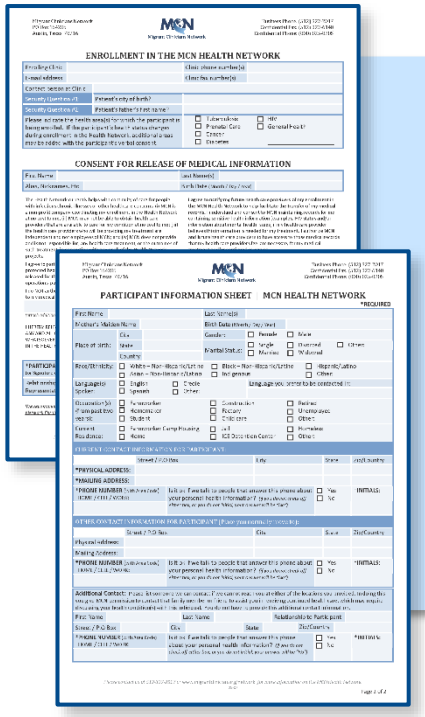
Please contact us at 512-327-2017 or www.migrantclinician.org/network for more information on the MCN Health Network.

02-07

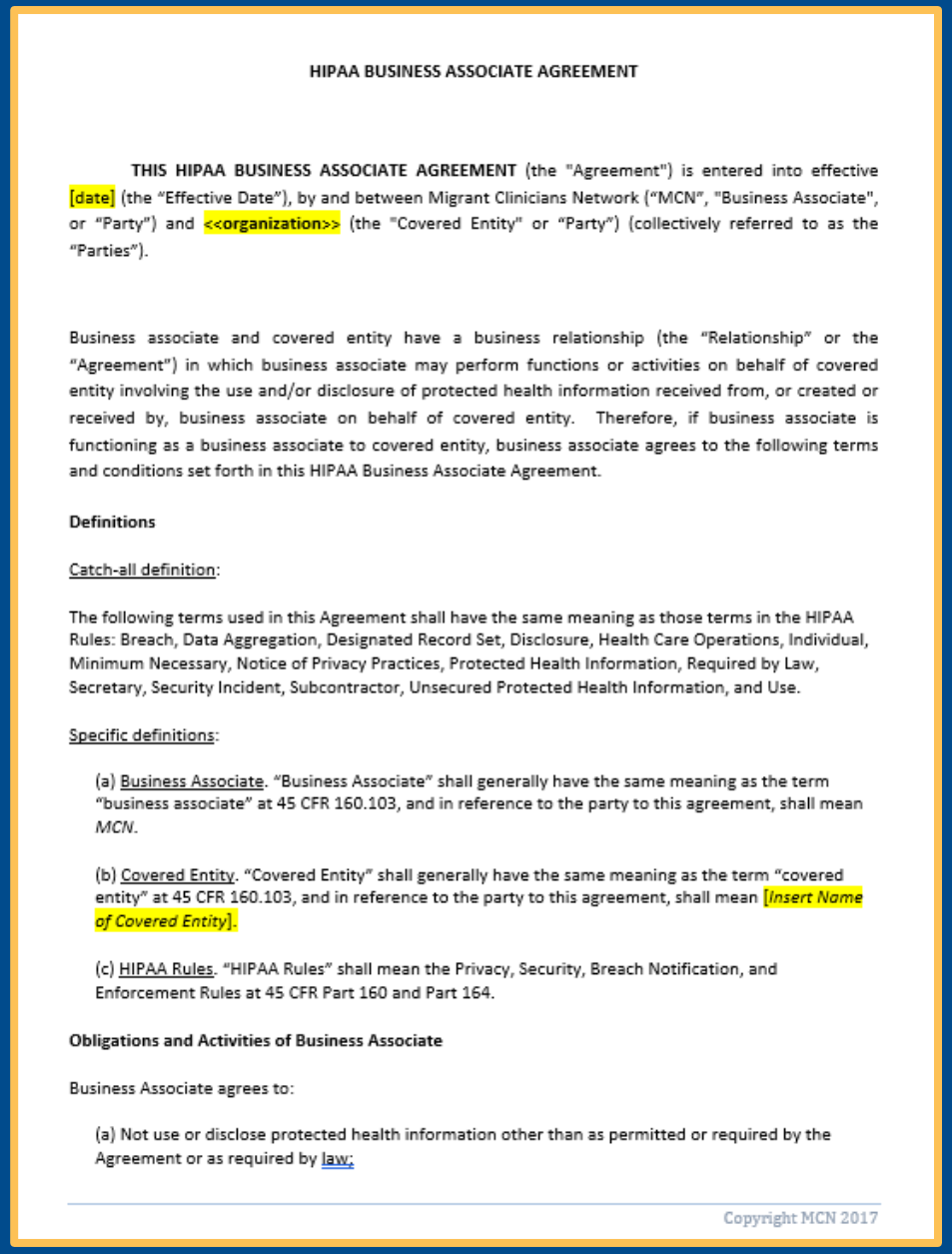
These enrollment resources are available:

www.migrantclinician.org/health-network/enrollment

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)

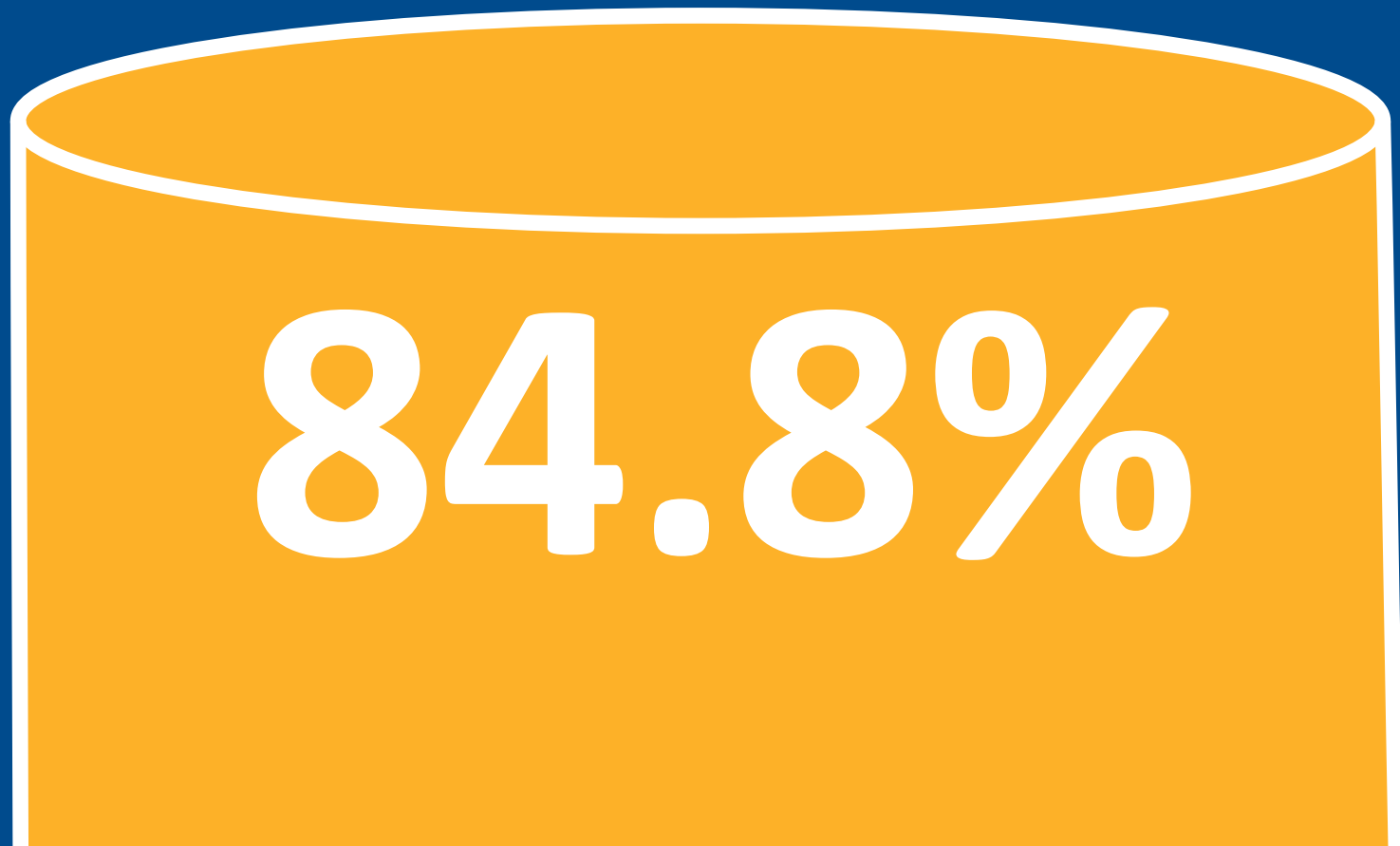
37 deceased

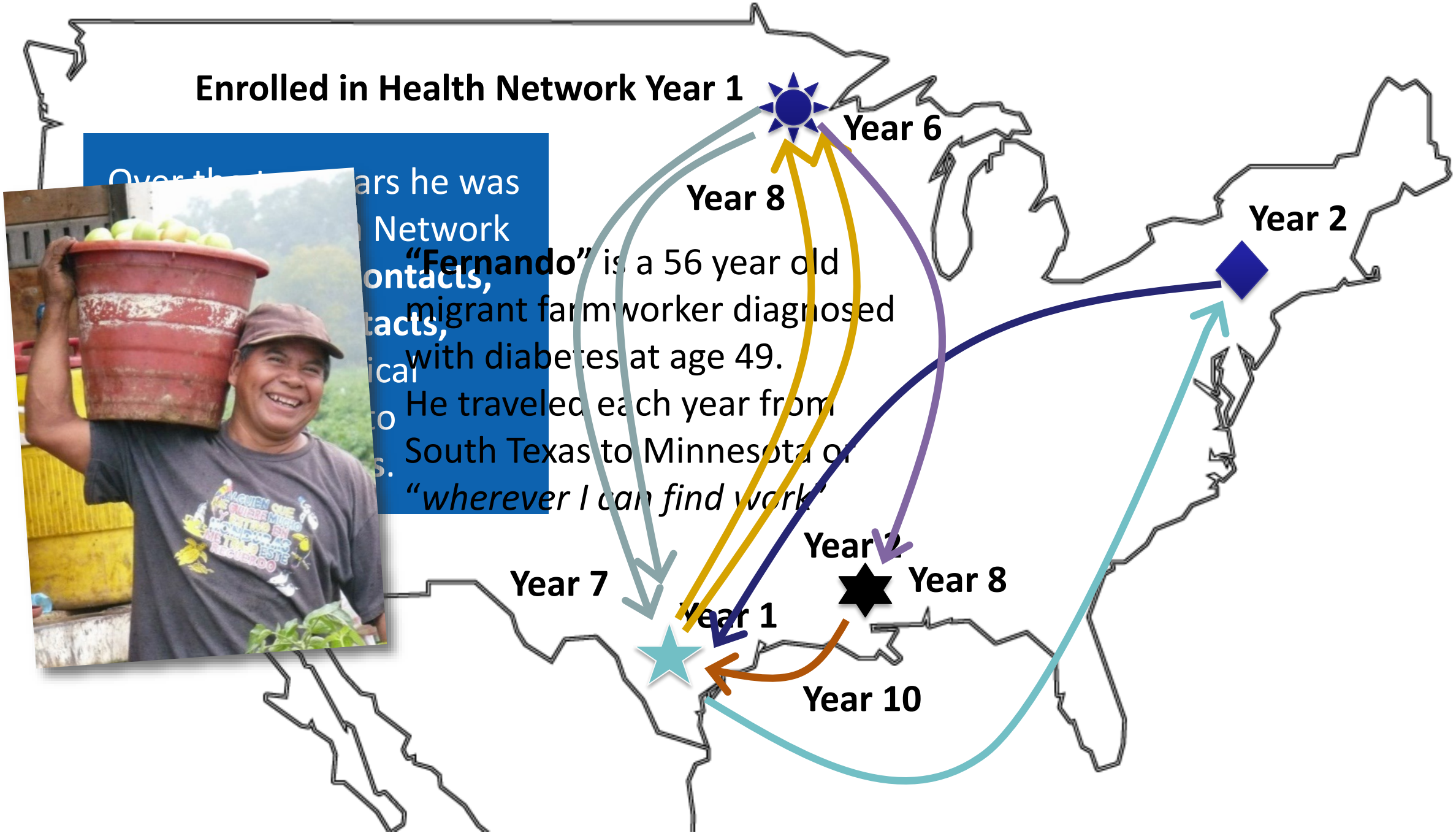
2,088 Followed for Active TB

211 lost to follow up

106 refused treatment

1,771 Complete Treatment




Enrolled in Health Network Year 1
Year 6
Year 8
Year 2
Year 7
Year 1
Year 8
Year 10
ars he was
Network
ontacts,
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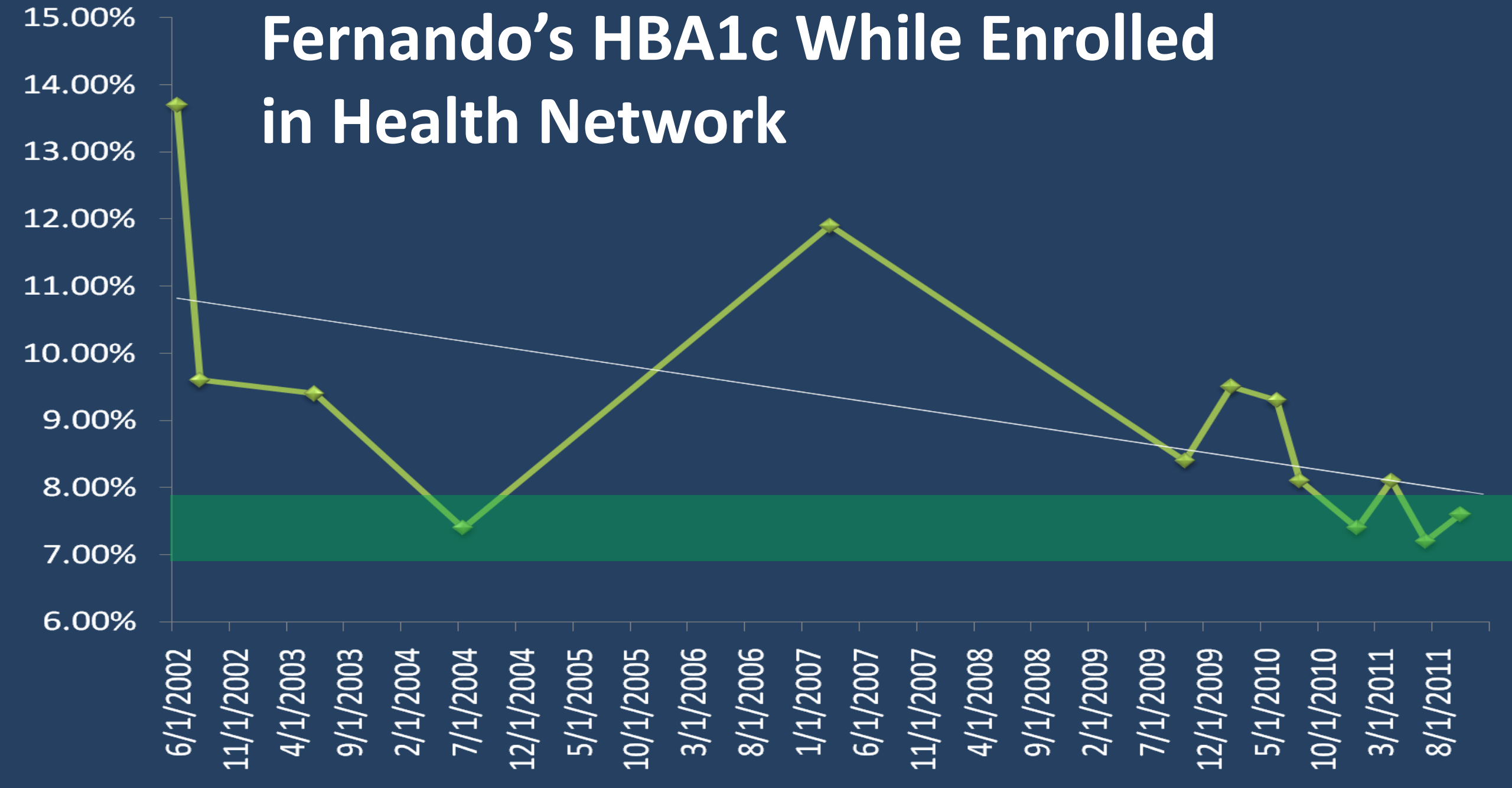
ical
o
s.
“Fernando” is a 56 year old migrant farmworker diagnosed with diabetes at age 49.
He traveled each year from South Texas to Minnesota or “wherever I can find work”

Fernando's HBA1c While Enrolled in Health Network

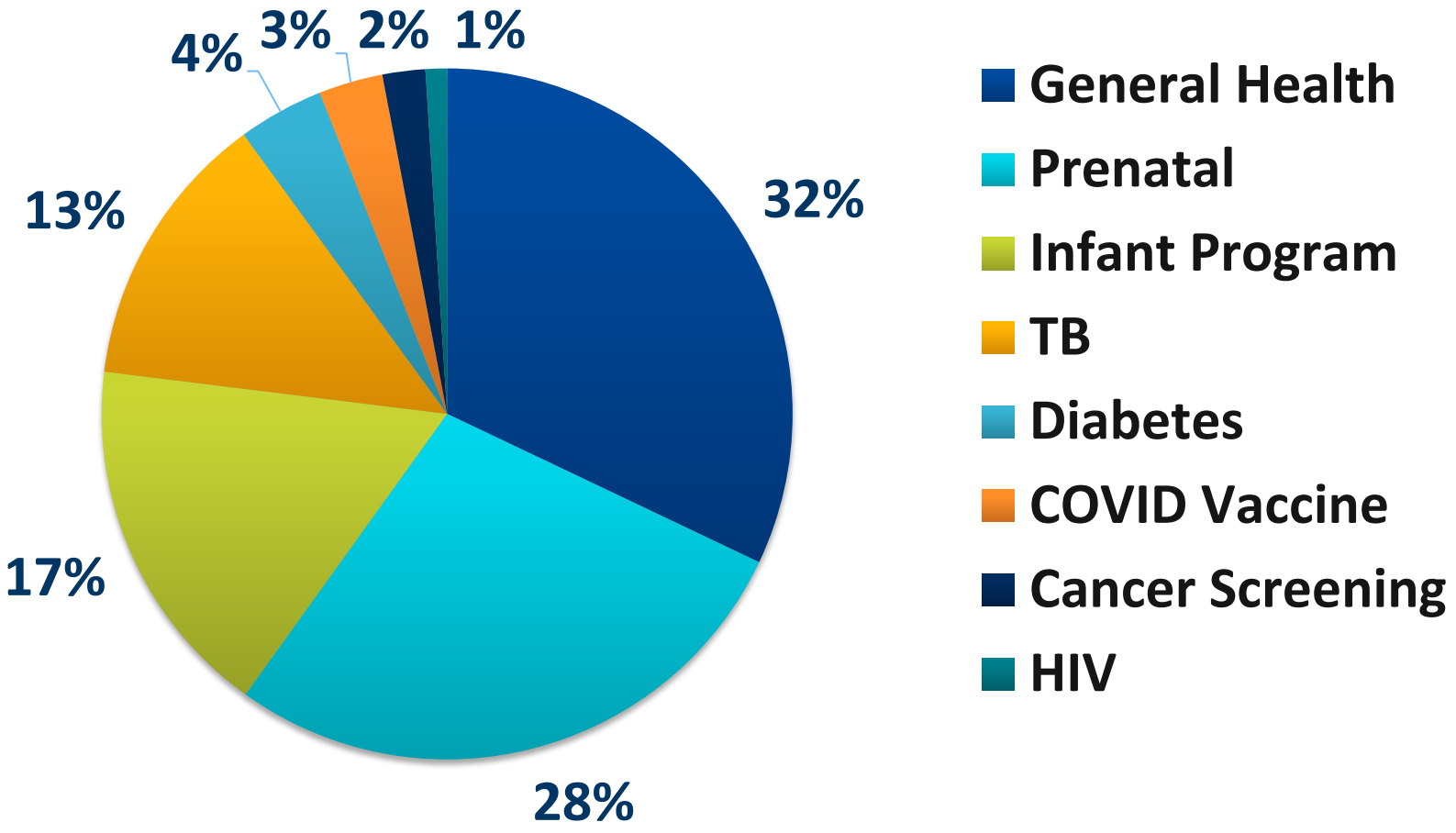


How Can MCN's Health Network Have such a high completion rate to 114 countries??

- 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




UNICEF/ECU/2020/Arcos

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

UNICEF/ECU/2020/Arcos

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.


UNICEF/ECU/2020/Arcos

Example of Patient Enrollment Summary

María 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 MCN. I will follow the HN associate's 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

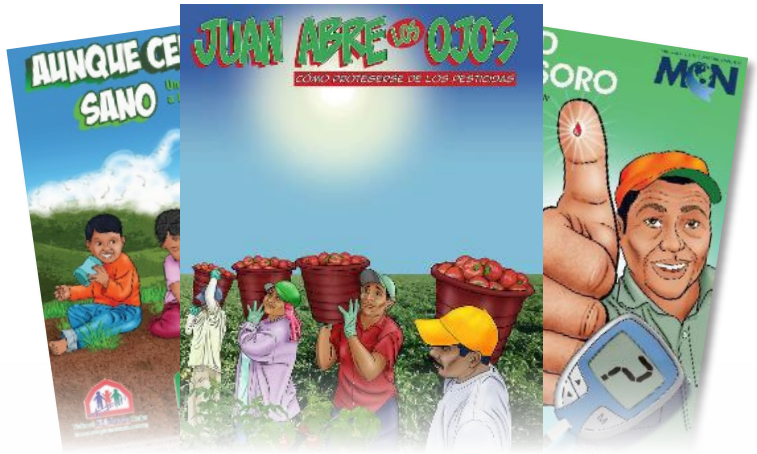
Who do you send the referral to for SCAN?

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

Contact me for further instructions:
cvelasquez@migrantclinician.org

Connect with MCN!



Access our latest resources

Get updates from the field

Attend our virtual trainings

and a lot more at

www.migrantclinician.org

@tweetMCN | @migrantclinician | @migrantcliniciansnetwork

Contact Us

- 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:

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

MIGRANT CLINICIANS NETWORK
HealthNetwork

Please remember to submit the evaluation.

Your thoughts are important to us! We use your evaluation responses to improve our online webinars.

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!**

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