# Strategies for Successful Continuity of Care through Health Network

MIGRANT CLINICIANS NETWORK

MCN

MIGRANT CLINICIANS NETWORK

MCN

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

Environmental and Occupational Health

Continuity of Care

Cancer Prevention

Violence Prevention

Training & Technical Assistance Services

# MCN Office Locations

# MCN's primary constituents

- Migrant
  Mobile poor
  Immigrants
- Clinicians
  - Health educators
  - Nurses
  - Primary care providers
  - Dentists
  - Social workers
  - CHWs
  - Outreach workers
  - Medical assistants
- Federally funded Migrant & Community Health Centers
- State and local health departments










Agriculture has traditionally been one of the sectors that has most relied on migratory labor

# Changing Patterns

Increasing number of H-2A workers

More males traveling alone

More established in rural communities as seasonal workers

Less trans-border crossing

Engaged in other industries during the off season (construction, meat processing, dairy and others)

Increasing number of indigenous agricultural workers

Less available housing (more dispersion of population)

Source: Passel, 2006

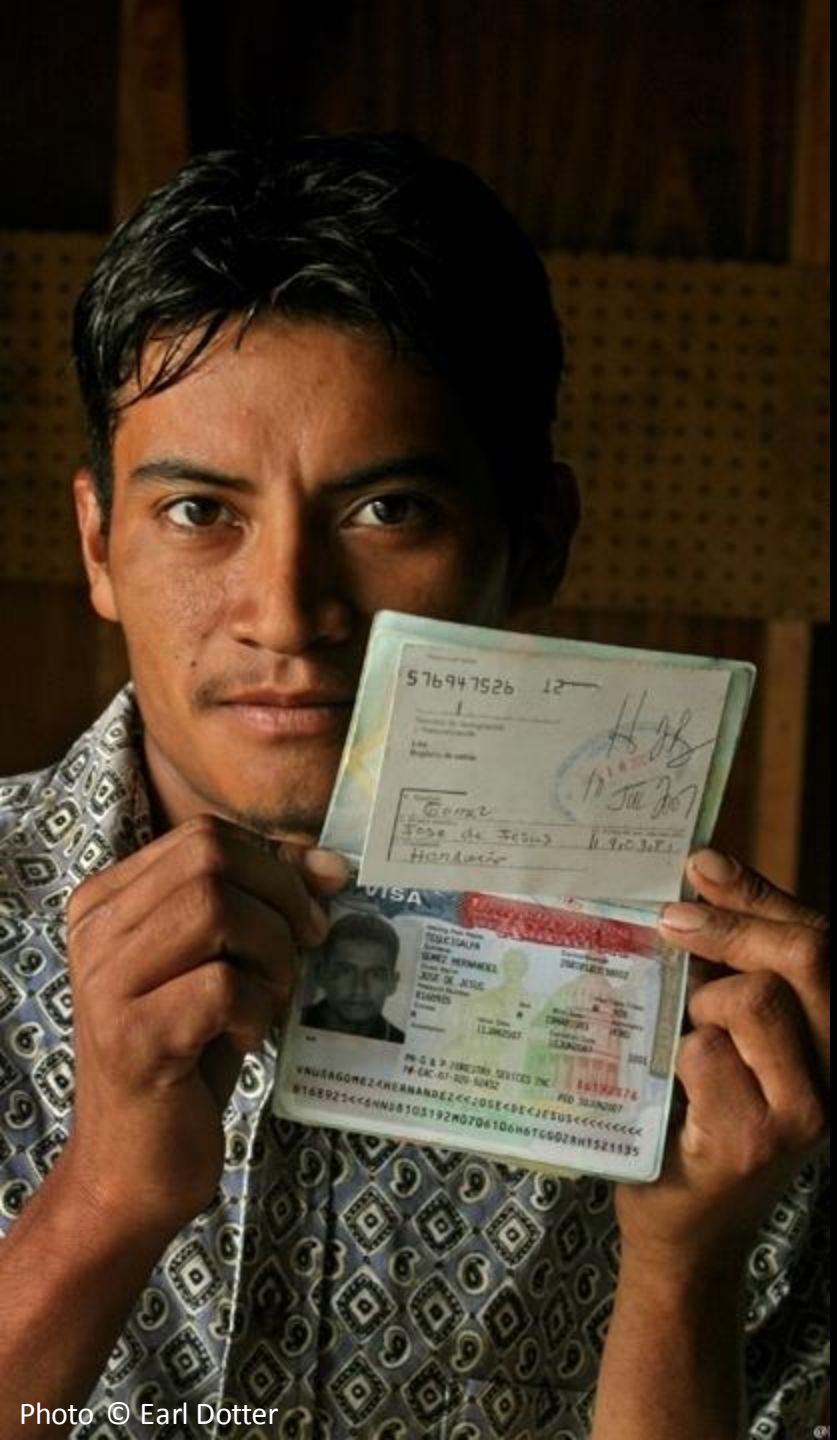



Photo © Earl Dotter

# Barriers to Care and Healthy Lifestyles

- **Constant mobility** causing discontinuity of care
- **Immigration status** of patient and/or family members
- **Racism** that motivates policies or actions that frighten members of particular racial/ethnic groups.
- **Confusion about U.S. health systems**

**Cultural adaptations**

- Culturally sensitive education
- Appropriate language and literacy levels
- Address cultural health beliefs & values

**Mobility adaptations**

- Portable medical records & Bridge Case Management
- EHR transmission to other C/MHCs

**Appropriate service delivery models**

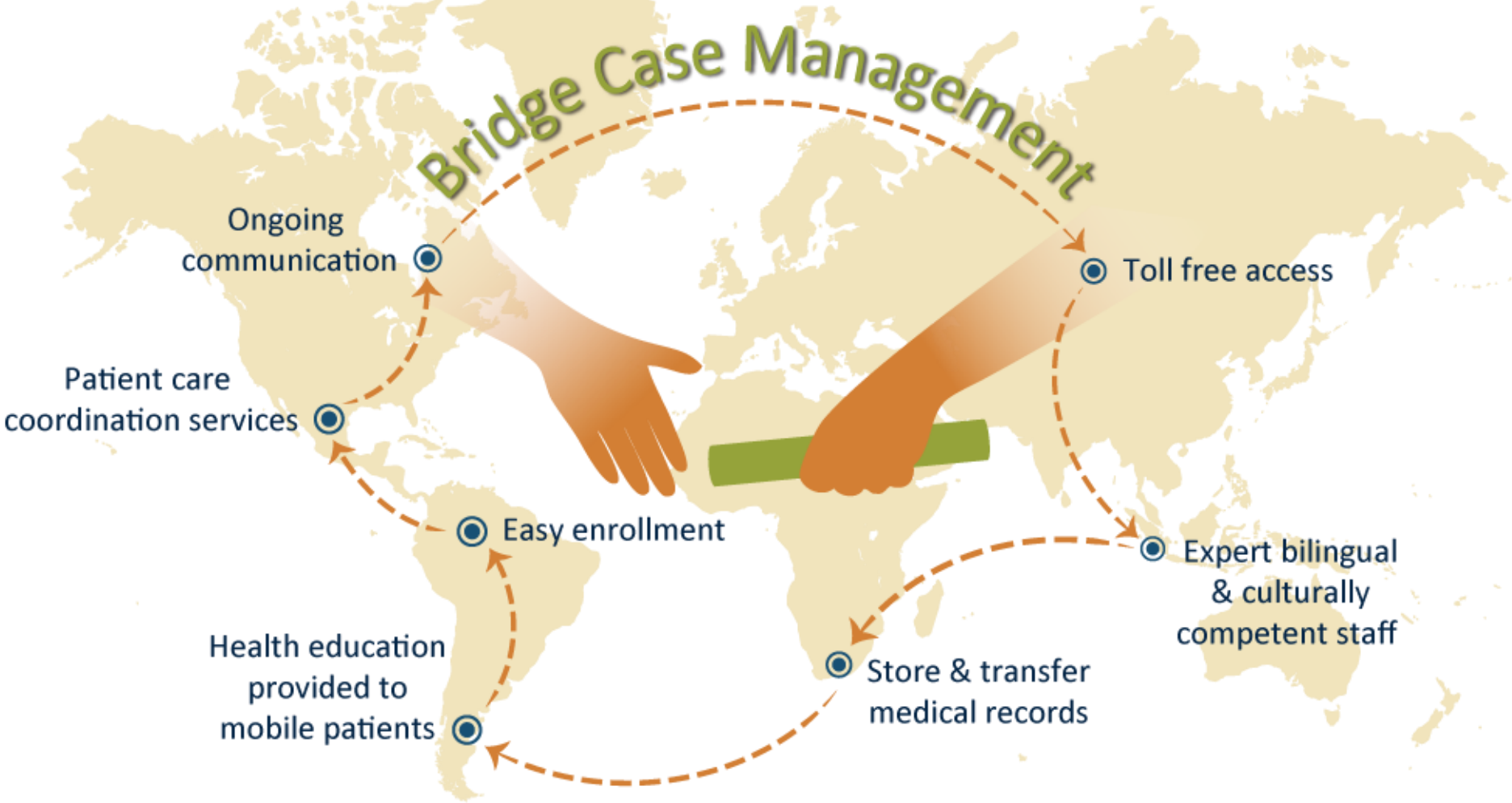
- Case Management
- Lay health promoters (Promotores/as)
- Outreach & enabling services
- Coordination with schools and worksites
- Mobile Units


22 Years of
Innovation

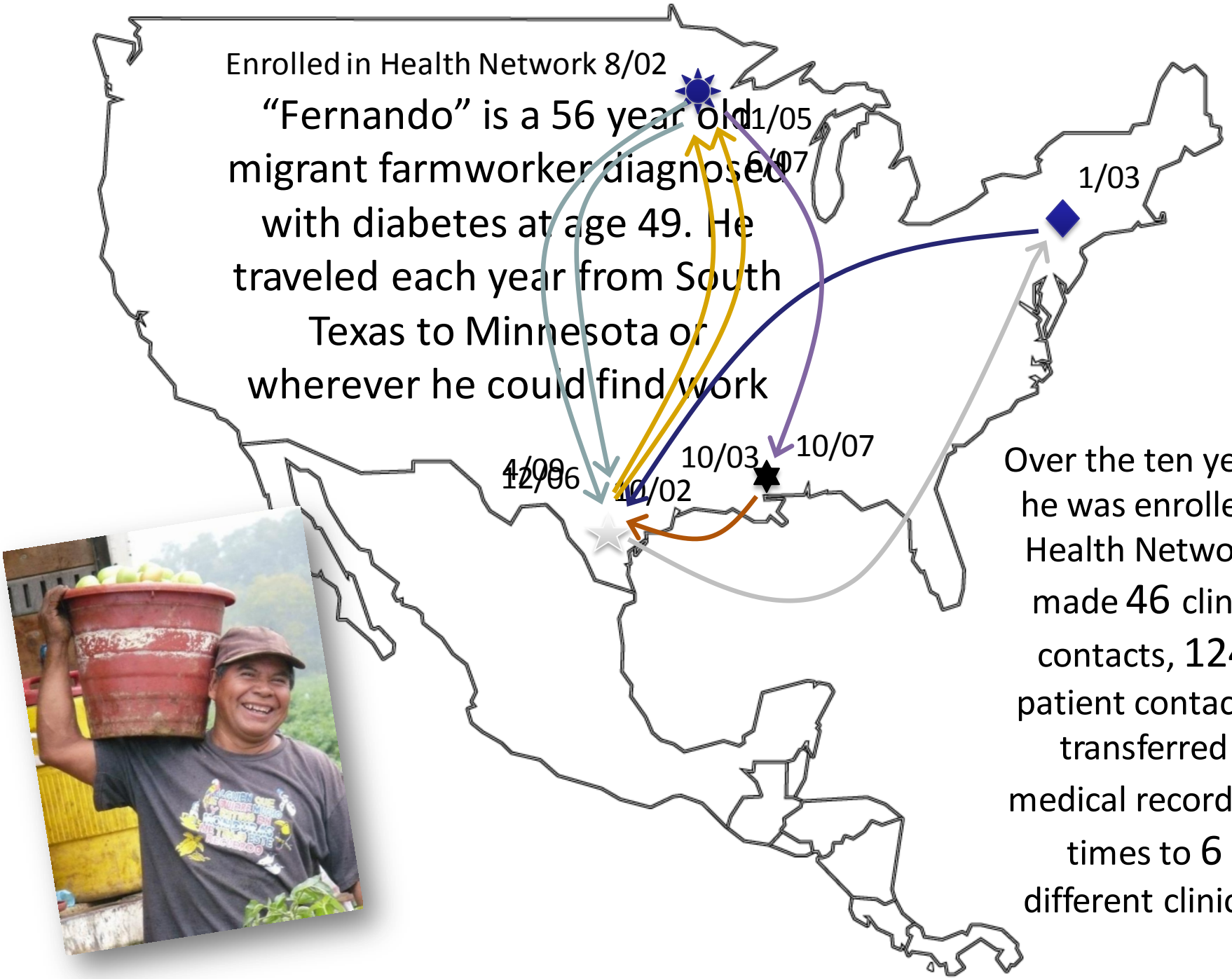
**Health Network is continuity of care for mobile Patients around the world**

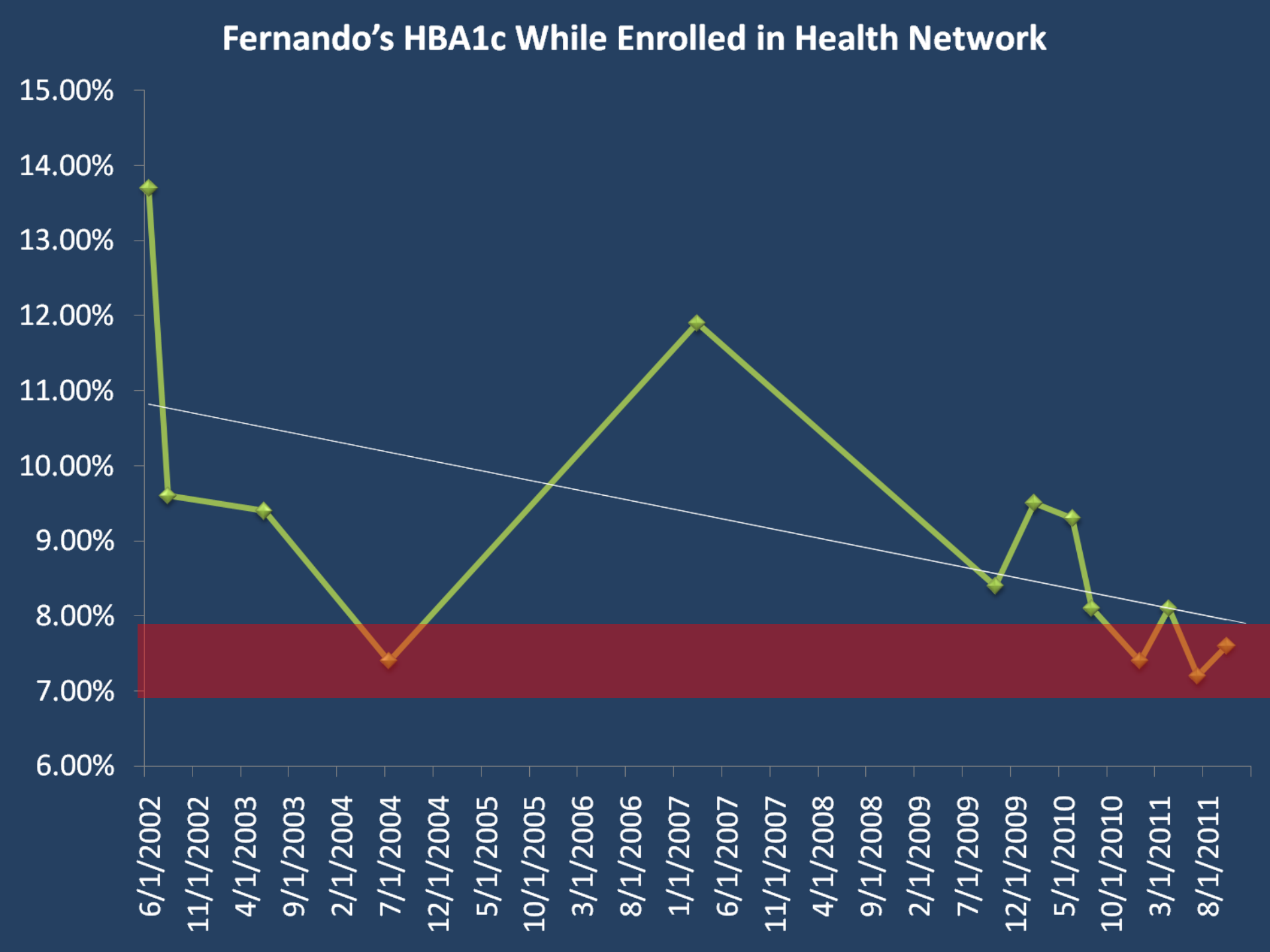
# “Mobile-Friendly” Care Management AND Referral Tracking and Follow-up

# **Health Network**




*The Health Resources and Services Administration (HRSA) and the Bureau of Primary Health Care (BPHC) provide an ongoing grant to provide continuity of care serves for mobile populations


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 he could find work
11/05
6/07
1/03
10/03
10/07
4/08
12/06
10/02
Over the ten years he was enrolled, Health Network made 46 clinic contacts, 124 patient contacts, transferred medical records 9 times to 6 different clinics.


Fernando's HBA1c While Enrolled in Health Network
15.00%
14.00%
13.00%
12.00%
11.00%
10.00%
9.00%
8.00%
7.00%
6.00%
6/1/2002
11/1/2002
4/1/2003
9/1/2003
2/1/2004
7/1/2004
12/1/2004
5/1/2005
10/1/2005
3/1/2006
8/1/2006
1/1/2007
6/1/2007
11/1/2007
4/1/2008
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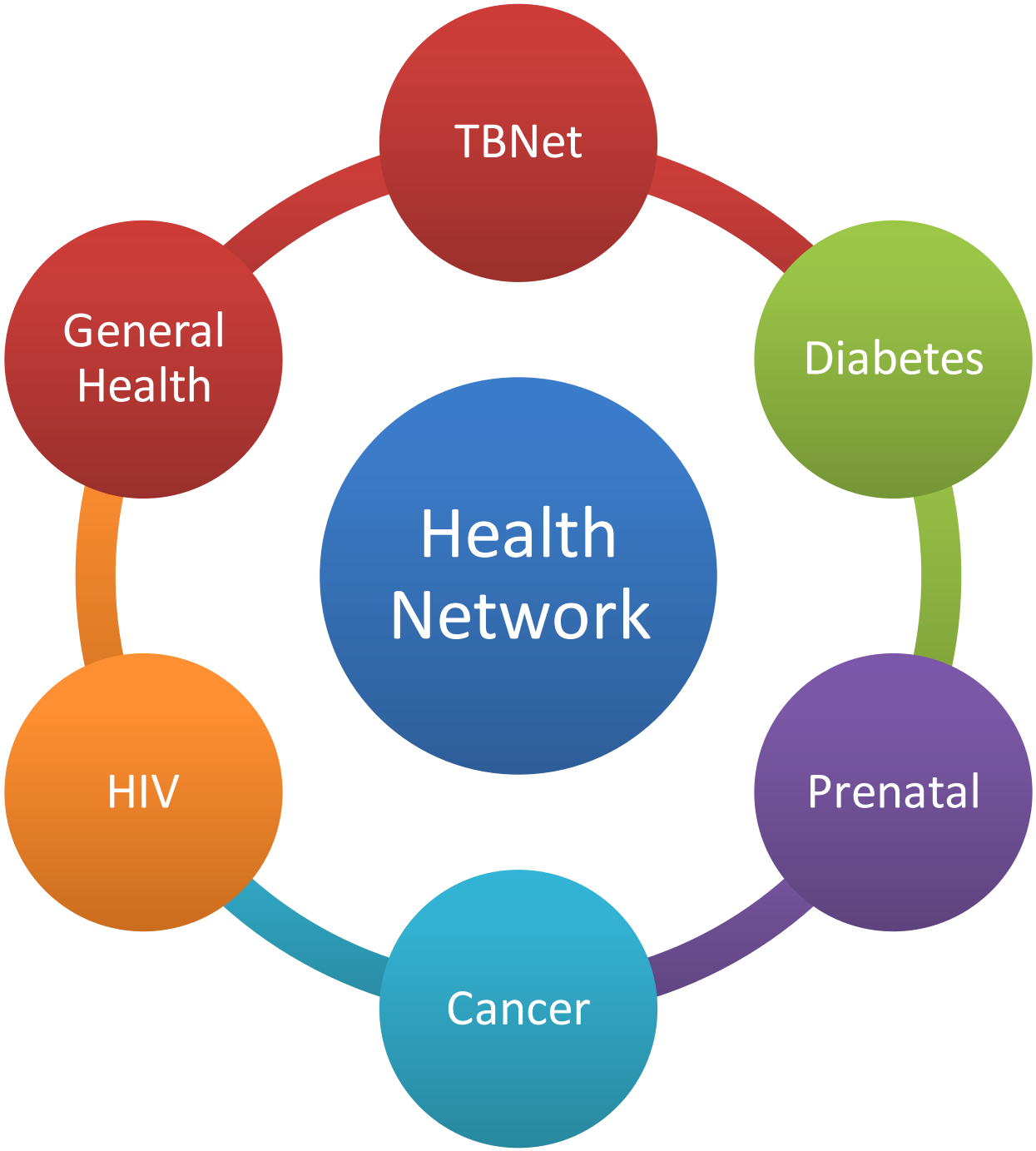
7/1/2009
12/1/2009
5/1/2010
10/1/2010
3/1/2011
8/1/2011


TBNet
Diabetes
Prenatal
Cancer
HIV
General Health
Health Network

# Health Network Enrollment Criteria

1

**Patient is**:

- Already mobile/migrant OR
- Likely to move

2

**Patient has**:

- A need for clinical follow-up
- A working phone number or family member with a phone number
- A signed MCN consent form
- Clinical base or enrolling clinic


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

# Forms Required for Enrollment

# Forms Required for Enrollment

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.

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

## 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 administration 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 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 these 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 any 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 HEALTHCARE 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



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PO Box 164285
Austin, Texas 78716

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

## 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:

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*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.

| | | | | | |
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| First Name | | Last Name | | Relationship to Participant | |
| Street / P.O Box | | City | | State | Zip/Country |

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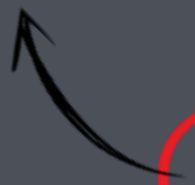
*INITIALS:

**Must** have the participant's signature



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

Migrant Clinicians Network
PO Box 164285
Austin, Texas 78716

Migrant Clinicians Network

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

## ENROLLMENT IN THE MCN HEALTH NETWORK

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- ❑ Tuberculosis
- ❑ HIV
- ❑ Prenatal Care
- ❑ General Healt
- ❑ Cancer
- ❑ Diabetes

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

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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.

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*(attach additional page if needed)*

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| | | | |
|---|---|---|---|
| ***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 Medic Network Enrollment form when it is completed.*

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

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

**Must** have the working phone numbers / e-mail

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

# 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 / State / Country | | Gender: ❑ Female ❑ Male | |
| | | Marital Status: ❑ Single ❑ Divorced ❑ Other: ❑ Married ❑ Widowed | |
| 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 |

| | | | |
|---|---|---|---|
| *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: |

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

# 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

# Important Things To Do When Filling Out the Enrollment Forms

**Be sure to**:

1. Provide accurate phone/e-mail for patient
2. Have the patient sign the consent form and confirm all the contact information (including country/area codes) being provided
3. Fax the signed forms and medical records to Health Network staff within 5 days

# Tools for Maintaining a Patient in Care

ATTENTION PROVIDERS: This client is a user of the MCN Health Network. MCN can help you access:

ATENCIÓN PROVEEDORES: Este paciente es usuario de la Red de Salud MCN. MCN les puede ayudar a encontrar:

This patient's medical record • *El expediente médico de este paciente*
This patient's lab results • *Los resultados de laboratorio de este paciente*
Financial assistance for his/her health care • *Ayuda económica para el cuidado de su salud*

This is a free service. • *El servicio es gratis.*

Call 1-800-825-8205
*De México* 01-800-681-9508

MCN Health Network

Medical Records and Care Coordination Card
*Tarjeta de Expedientes Médicos y Coordinación de Salud*

1-800-825-8205
*De México* 01-800-681-9508
www.migrantclinician.org

*THIS IS NOT A MEDICAL INSURANCE CARD.*
*Esta no es una tarjeta de seguro médico.*

Make sure patients have the HN toll free number:

**800-825-8205**

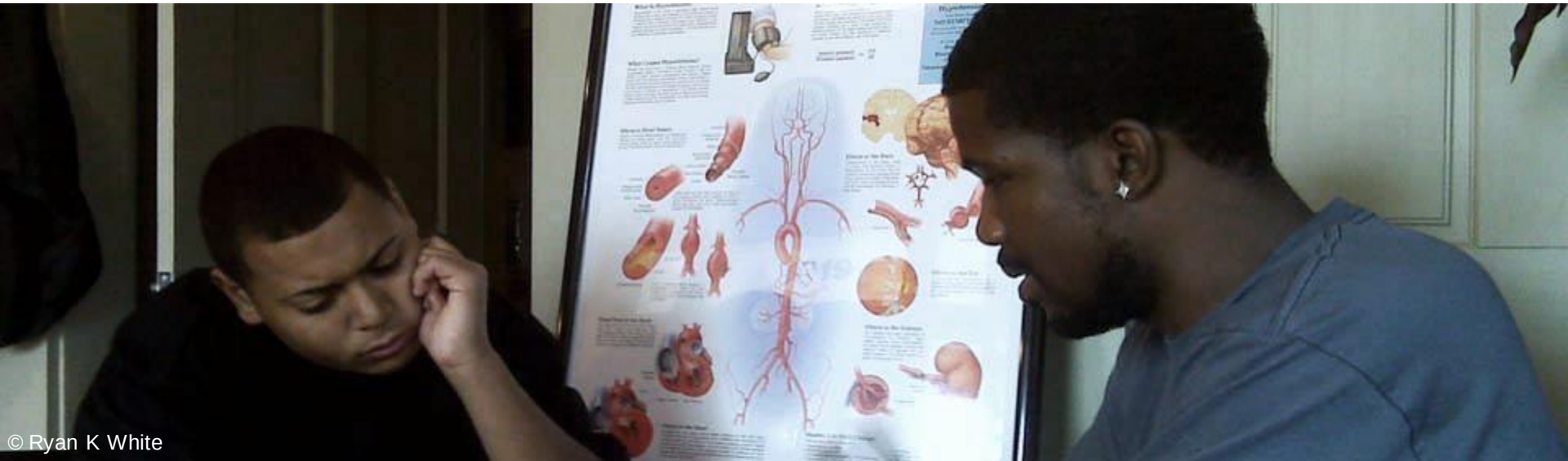
**or**

**01-800-681-9508** if calling from Mexico

# Educating patients

Explain…

- how Health Network keeps all patient information confidential
- the benefits of receiving support
- how they will receive an initial call from a Texas number (512 area code) and they MUST answer and speak the Health Network Associate in order to receive assistance




# Maximizing Health Network

## *The Patient's Role…*

# Maximizing Health Network

Explain the patient responsibilities and expectations and how to make the best use of Health Network support…

- by informing Health Network of any phone or address changes
- by contacting Health Network staff after arriving in a new area
- by staying on treatment as long as indicated
- by notifying new clinics of enrollment in HN

# Challenges to Success

- Staff turnover at clinics
- Patient Cooperation
- Identifying migrant patients
- Incorrect patient information
- Delay in enrollment

# Things to Consider

- Enrolling a patient in Health Network will provide you with an outcome report
- Patients will have year-round navigation services when enrolled in Health Network
- Patients and their families are more willing to participate if they are comfortable with MCN's bridge case management

# Additional enrollment resources at your finger tips


Informational Videos about Health Network


Download Enrollment Packets in English, Kreyol, Portuguese and Spanish

**www.migrantclinician.org**

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