

Strategies for Successful Continuity of Care through Health Network



MIGRANT CLINICIANS **NETWORK**



"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



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

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)

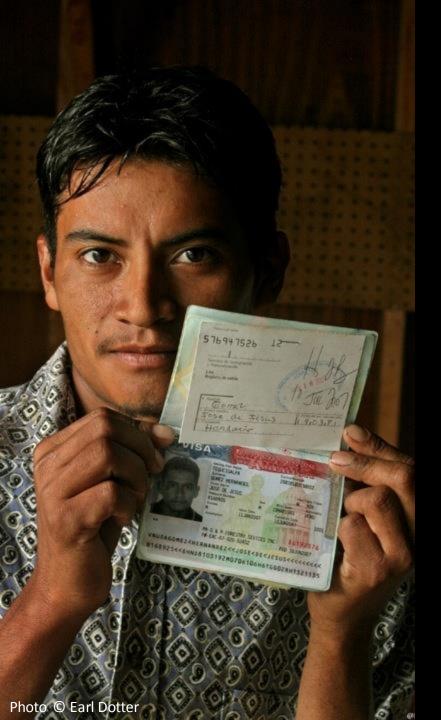


Increasing number of indigenous agricultural workers



Less available housing (more dispersion of population)

Source: Passel, 2006



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



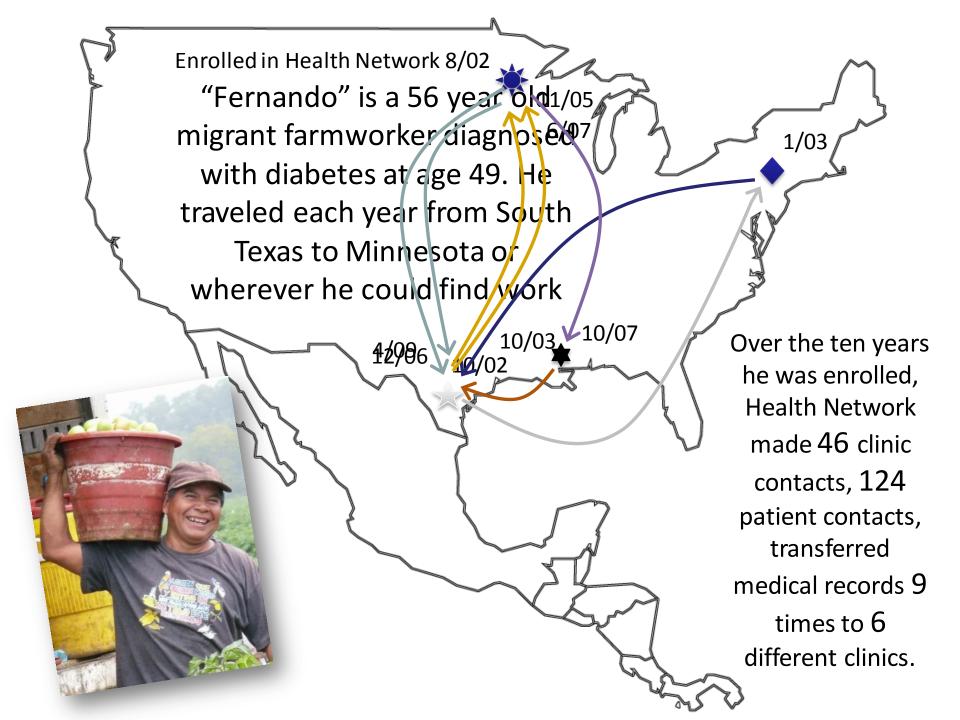


Health Network is continuity of care for mobile Patients around the world

"Mobile-Friendly" Care Management AND Referral Tracking and Follow-up Health Network

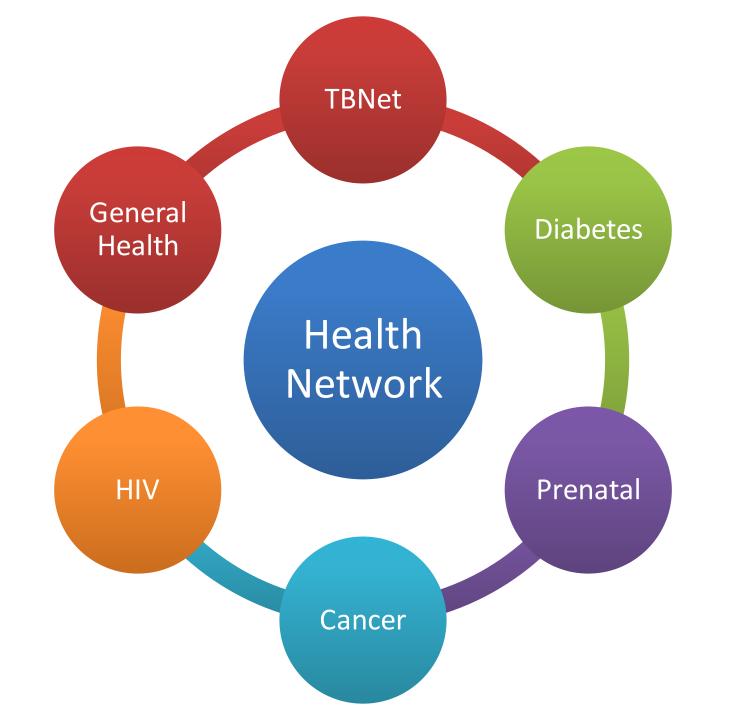


*The Health Resources and Services Administration (HRSA) and the Bureau of Primary Health Care (BPHC) provide an ongoing grant to provide continuity of care serves for mobile populations



Fernando's HBA1c While Enrolled in Health Network





Health Network Enrollment Criteria

Patient is:

- Already mobile/migrant OR
- Likely to move

Patient has:

- A need for clinical follow-upA working phone number or
 - 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 164205 Anstin, Texas 78716



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

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ENROLLMENT IN THE MCN HEALTH NETWORK

Enrolling Clinic		Clinic phone number(s)	
t-mail address		Clinic fax number(s)	
Contact person at Clinic			
Security Question #1:	Pat ent's city of birth?		
Security Question #2:	Patient's father's first name?		
being enrolled. If the parti	area;s) for which the participant is cipant's health status changes ealth Network, additional areas ticipant's verbal consent.	☐ Tuberculosis☐ Prenatal Care☐ Cancer☐ Diabetes	☐ HIV.☐ Seneral Health

First Name	Last Name(s)
Alias, Nicknames, Etc	Birth Date (Month / Day / Year)
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*PARTICIPANT SIGNATURE (cr Signature of Legal Representative)	Date
Relationship of Legal	Witness Signature

Migrant Clinicians Network Business Phone: (512) 327-2017 PO Roy 164285 Confidential Fax: (512) 327-6140 Confidential Phone: (800) 825-8205 Austin, Texas 78716 PARTICIPANT INFORMATION SHEET | MCN HEALTH NETWORK *REQUIRED First Name Last Name(s) Mother's Maiden Name Birth Date (Month / Day / Year) ☐ Female Gender: ☐ Male City ☐ Single □ Divorced ☐ Other: Place of birth: State Marital Status: ☐ Married ☐ Widowed ☐ White - Non-Hispanic/Latino ☐ Black - Non-Hispanic/Latino ☐ Hispanic/Latino Race/Ethnicity: Asian - Non-Hispanic/Latino ☐ Indigenous ☐ Other: ☐ English ☐ Creole Language you prefer to be contacted in: Language(s) ■ Spanish ☐ Other: Spoken: Occupation(s) ☐ Farmworker Construction ☐ Retired ☐ Homemaker (from past two Factory Unemployed Child care years): ☐ Student Other: ☐ Farmworker Camp Housing П ☐ Homeless ☐ Home ICE Detention Center Other: Street / P.O Box City Zip/Country *PHYSICAL ADDRESS: *MAILING ADDRESS: *PHONE NUMBER (with Area Code) Is it ok if we talk to people that answer this phone about \(\pi\) Yes *INITIALS: HOME / CELL / WORK: your personal health information? (if you do not check off either box, or you do not initial, your answer will be "No") Street / P.O Box City Zip/Country Physical Address: Mailing Address: *PHONE NUMBER (with Area Code) *INITIALS: Is it ok if we talk to people that answer this phone about
Yes HOME / CELL / WORK: either box, or you do not initial, your answer will be "No") 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 Zip/Country Street / P.O Box State *PHONE NUMBER (with Area Code) Is it ok if we talk to people that answer this phone ☐ Yes *INITIALS: HOME / CELL / WORK: about your personal health information? (if you do not □ No check off either box, or you do not initial, your answer will be "No")

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

ENROLLMENT IN THE MCN HEALTH NETWORK

Enrolling Clinic		Clinic p	ohone number(s)		
E-mail address		Clinic f	ax number(s)		
Contact person at Clinic					
Security Question #1:	Patient's city of birth?				
Security Question #2:	Patient's father's first name?				
being enrolled. If the pa during enrollment in the	th area(s) for which the participant is irticipant's health status changes Health Network, additional areas participant's verbal consent.	0 0	Tuberculosis Prenatal Care Cancer Diabetes	0	HIV General Healt

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:

I agree to notify my future health care providers of my enrollm the MCN Health Network to help facilitate the transfer of my n 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 provibelieves this information is needed for my treatment. I authori and future health care providers to have access to those medithat 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 conditions. These individuals will adhere to federally mandal confidentiality, privacy and security procedures. This conser remain in effect for two years (24 months) from the date s my participation in the Health Network has ended for anot! can submit a written request any time to leave the Health Network.

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.

(attach additional page if needed)

I HEREBY RELEASE MCN. ITS EMPLOYEES, OFFICERS, DIRECTORS, CONSULTANTS, REPRESENTATIVES, SUCCESSORS, AND A ANY 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 RESULT IN THE HEALTH METHODS

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

We recommend that, whenever pos Me, you provide the participant with a capy of this Consent for Release of Media it is completed. twork Enrollment form wh

ENGLISH -THIS CONSENT FORM IS VALID FOR 2 YEARS AFTER DAYE OF SIGNATU

Valid if sent within 5 business days of being signed by patient, remains valid for 24 months from the date

Participants may renew their consent after it expires if they still need assistance

Must have the

participant's

signature

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

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PARTICIPANT INFORMATION SHEET | MCN HEALTH NETWORK

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Must have the working phone numbers numbers e-mail

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
- 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
- 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



Make sure patients have the HN toll free number:

800-825-8205

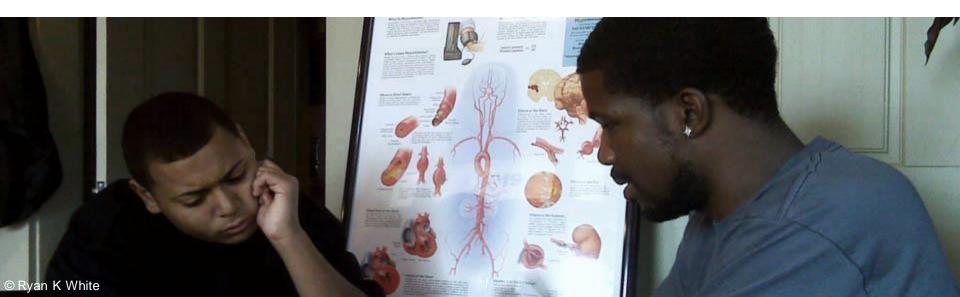
Or

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



THE RESIDENCE OF THE PARTY OF T

Download Enrollment Packets in English, Kreyol, Portuguese and Spanish

www.migrantclinician.org

Contact Us

Health Network telephone:

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800-825-8205 (U.S.)
01-800-681-9508 (from Mexico)
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- 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