




Photo © Earl Dotter

Creating a Migrant Centered Medical Home



*A force for health justice for the
mobile poor*

A grayscale photograph of three healthcare professionals, two women and one man, standing side-by-side and smiling. They are all wearing white lab coats. The man on the right has a stethoscope around his neck. The background is plain white.

“The patient-centered medical home is a model for care provided by primary care clinician (change from physician) practices that seeks to strengthen the clinician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship.”

NCQA (www.ncqa.org)

What are the Benefits of PCMH Recognition?

- Indicator of quality of care
- Increase health centers' competitiveness in the marketplace
- Supports health centers' expansion and QI efforts
- Potential increase in future reimbursements
- PCMH pilot/demonstrations projects (CMS, State Medicaid Agency, Health Plans, etc.)

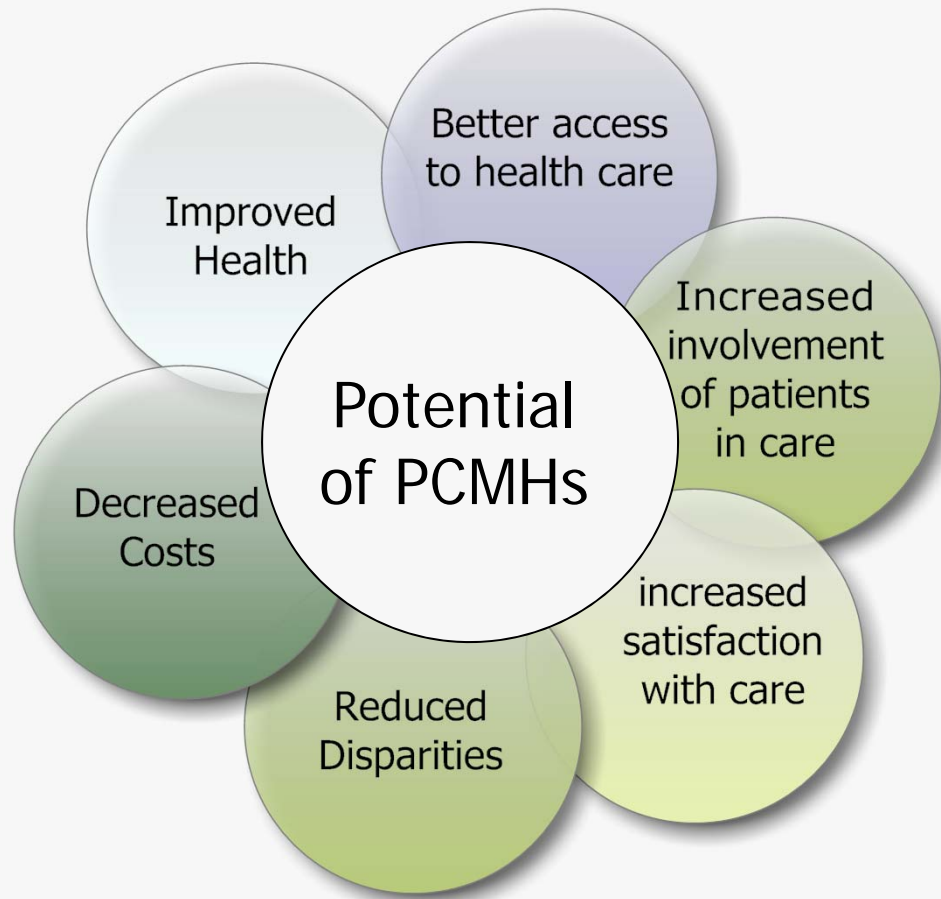
Two pieces of the PCMH puzzle...

NCQA

- Clear criteria
- Expert assistance
- Ongoing support

Primary Care


- Foundation of health system
- First point of contact
- Access to care



1967

Concept
introduced
by American
Academy of
Pediatrics

PCMH expanded to include



Health services
that are
"accessible,
accountable,
comprehensive,
integrated,
patient-centered,
safe, scientifically
valid, and
satisfying to both
patients and their
physicians"

What Defines a Medical Home?

- Personal clinician
- Clinician directed practice
- Whole person orientation
- Coordinated Care
- Quality and safety
- Enhanced access
- Payment



Photo © Earl Dotter

What about patients who move?

- Personal physician?
- Physician directed medical practice?
- Whole person orientation!
- Care is coordinated and/or integrated!
- Quality and safety!
- Enhanced access!
- Payment for added value work!

Personal Clinician

- Changed in 2011 by NCQA to include NP, PA and CNM providers.
- For mobile patients a team of providers in many locations but “virtually” connected
- Trust
- Consistency of message about your health
- Cultural understanding/
Linguistically appropriate communication



Photo © Ed Zuroweste

Whole Person Orientation



Coordinated / Integrated Care

Fast

Smooth

Focused

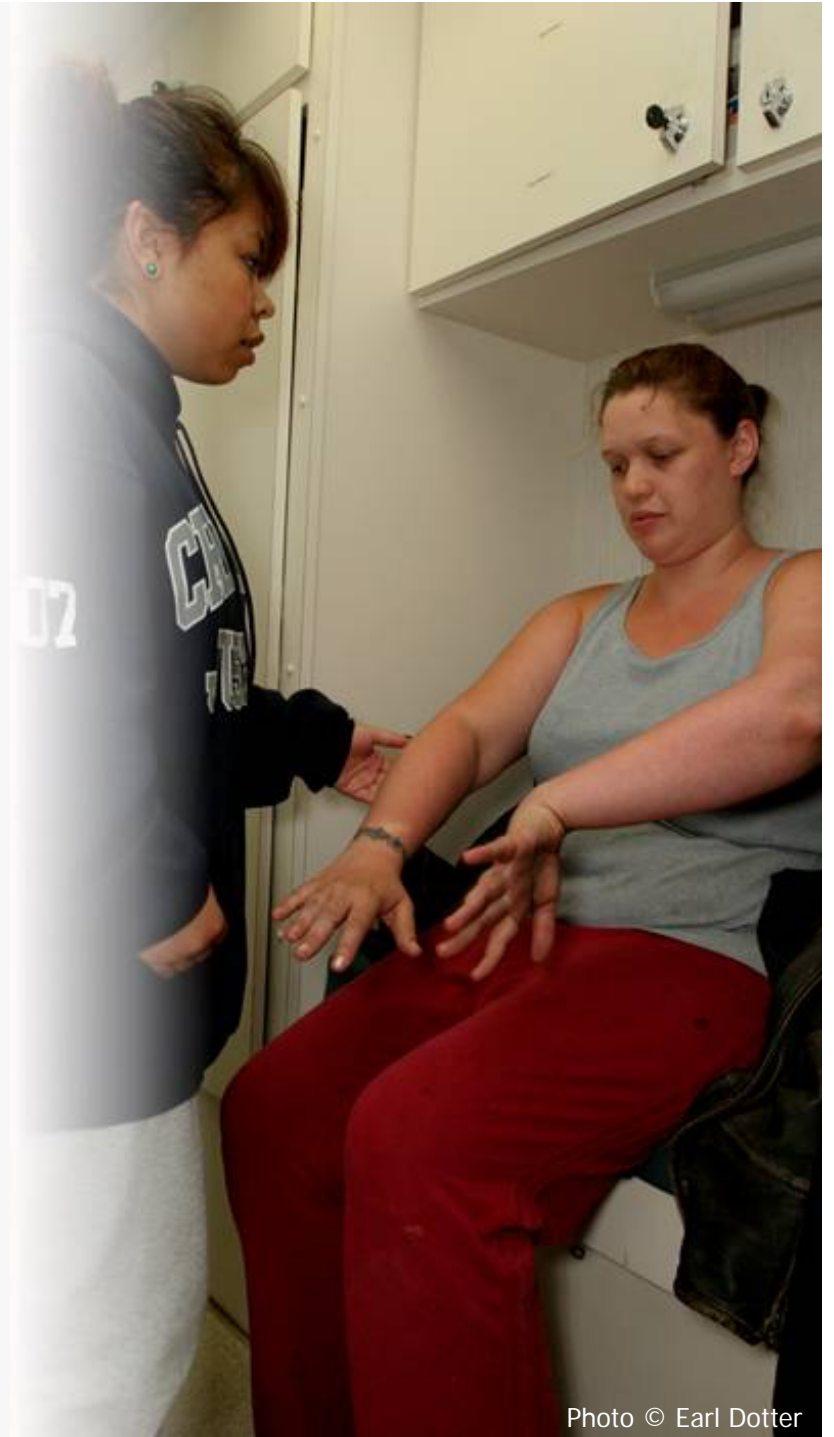
Enhanced Access

- Multiple ways into the home
 - outreach, community health workers/ promotoras; Migrant Voucher programs; mobile clinics
- Robust tracking and follow-up systems, (may need to be “virtual”)
- Outreach that goes out!



Payment for Added Value Work

A health care service delivery system that has significantly greater value than current US “fast food health care”



Support for Medical Home

- The National Committee for Quality Assurance released a set of voluntary standards for the recognition of physician practices as medical homes. Updated January 2011
- The New England Journal of Medicine published recommendations for the success of medical homes that included increased sharing of information across health care providers

NCQA 2011 Content and Scoring

- Standard 1: Enhance Access and Continuity
- Standard 2: Identify and Manage Patient Populations
- Standard 3: Plan and Manage Care
- Standard 4: Provide Self-Care and Community Support
- Standard 5: Track and Coordinate Care
- Standard 6: Measure and Improve Performance

PPC-PCMH Content and Scoring

■ 6 Standards

➤ 2-7 Elements/Standard (28 total with 6 Must Pass Elements)

- 3-6 Factors (152 total some are Critical factors—need to pass)

■ There is a very comprehensive 2 part PowerPoint presentation (150 slides) with detailed instructions on how to complete this survey to qualify

<http://www.ncqa.org/tabid/631/default.aspx>

PPC-PCMH Content and Scoring

Standard 1: Enhance Access and Continuity

- | | |
|---|---------------|
| A. Access During Office Hours | ** (4) |
| B. Access After Hours | (4) |
| C. Electronic Access | (2) |
| D. Continuity | (2) |
| E. Medical Home Responsibilities | (2) |
| F. Culturally and Linguistically Appropriate Services (CLAS) | (4) |
| G. Practice Organization | (4) |
| | (20) |

****Must Pass Elements**

SIX MUST PASS Elements

- Access During Office Hours
- Using Data for Population Management
- Self-Care Process
- Referral Tracking and Follow-up
- Care Management
- Implements Continuous Quality Improvement

Rationale for Must Pass Elements

- Identifies critical concepts of PCMH
- Helps focus Level 1 practices on most important aspects of PCMH
- Guides practices in PCMH evolution and continuous quality improvement
- Standardizes “Recognition”



Definitions for Recognition as PCMH

- **Factors** –A scored item in an element.
- **Critical Factors** - Are identified in the scoring section of the element.
- **Explanation** -Specific requirements that a practice must meet and guidance for demonstrating performance against the factor.
- **Examples/Documentation** -Each factor must be documented.

PPC-PCMH Content and Scoring

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	*85-100	6 of 6
Level 2	*60-84	6 of 6
Level 1	*35-59	6 of 6
Not Recognized	*0-34	< 6

*Note: These numbers have changed from the 2010 guidelines

NCQA-PCMH Content and Scoring

- 1,506 sites and 7,677 clinicians (as of 12/31/10) have earned PCMH Recognition nationally
- 525 FQHCs are enrolled in the PCMHHI. (10/12/2011)
- 48 FQHC sites representing 16 Grantees in the PCMHHI are recognized - 10 at Level 1 and 38 at Level 3.
- 146 FQHC sites recognized by NCQA external to the PCMHHI (10/12/2011)
- 242 Grantees have submitted NOIs which represents (786 FQHC sites)
- 904 CHCs have applied for the recent BPHC grant opportunity to fund work on PCMH (10/12/2011)

(total 1,314 Organizations with 8,100 sites)

PCMH 2011 and Meaningful Use

PCMH closely aligned with MU	Associated PCMH 2011 Standard
1. Electronic prescribing	1. 3E: Use Electronic Prescribing
2. Drug formulary, drug-drug,	2. 3E: Use Electronic Prescribing drug allergy checks
3. Maintaining an up-to date Problem list/med list	3.2B: Clinical Data Problem list of current and active diagnoses and medications
4. Recording demographics on all patients	4.2A: Patient Information preferred language gender, race, ethnicity and date of birth

PCMH 2011 and Meaningful Use

PCMH closely aligned with MU	Associated PCMH 2011 Standard
5. Recording and charting changes	5. 2B: Clinical Data in vital signs
6. Recording smoking status	6. 2B: Clinical Data
7. Reporting ambulatory quality	7. 6F: Report Data Electronically measures
8. Implementing clinical decision support rules...	8. 3A: Implement Evidence-Based Guidelines

Meaningful Use Incentive Payments

- \$27 billion over 10 years, or as much as
 - \$44,000 (through Medicare) only physicians qualify
 - \$63,750 (through Medicaid) Along with physicians, NP, PA, CNM qualify
- Per clinician
- Payments started January 2011

Medical Home for Mobile Patients



Photo © Earl Dotter

Patients on the move need:

- To know where services are located
- To have access to “extended hours” of service
- Transportation services
- Affordable care that often requires advocacy
- Access to their medical records
- Need cultural competent care at every level



Added Components that are required for MHC to provide a medical home

- Outreach (integral part of health care team)
- Case management
- Interpretation
- Translation of all written material in a appropriate literacy level





Photo © Earl Dotter

Added Components that are required for MHC to provide a medical home

- Emphasis on self management of chronic illnesses
- Patient navigation/Case management that may need to be “virtual”

Medical Home is a Team Sport

- Change old habits/delegate/re-assign duties/standing orders/system re-design
- Staff works together for the benefit of the patient
- Use staff to their full potential—push the envelop be innovative
- Listen to the patients—make them an integral member of the team

Standards for PCMH for Migrants

- Cultural and Linguistic Competency
- Outreach to community
- Reliance on Community Health Workers (Promotoras)



Paradigm Shift

- Use of Outreach workers/Promotoras/Community workers—No longer an “Add on” Enabling Services
- Alternative Practice Models: Migrant Voucher Programs —Need to be part of the Team of Providers
- They are all an integral/essential clinical service delivery component to our health care system and should be covered by appropriate payment system.

PERIOD—END DISCUSSION!!

Paradigm Shift

- Now have window of opportunity to “prove” the value of these services and share our knowledge with the private sector and other partners: But need
 - **Data—Data—Data**
 - Best practices
 - Innovative practices
 - Examples of Business case
 - Two great National Cooperative Agreement organizations to help you (Health Outreach Partners/Migrant Health Promotion)



Personal Provider and Patient Centered?

- Cannot have both with a migrant farmworker
 - Must be patient centered and therefore develop a “network” of personal providers at possibly several health centers over the course of years.

Standards for PCMH for Migrants

- Cross Borders Tracking
(County, State, National)
- Cross Borders Case
management and Patient
Navigation
- Emphasis on Patient
Education/Self-
management



How do we do that?

- EHRs will have to be capable of universal seamless exchange of information (Not gonna happen in near future!)
- Virtual Patient Navigation/Record transfer/Bridge Case-management (MCN's Health Network)
- Migrant Voucher Programs
- More collaboration with other M/CHC (electronic/telemedicine networks), and other partners—health dept. private providers, ERs

EHR

- You have to have one—Do it Smart, Get expert advise—join a network—take full advantage of incentives (meaningful use)
- Use data from population registries to drive Quality Improvement—don't just gather data, but also analysis/evaluate/modify/re-measure
- “I can be a much better family physician if I have an EHR—But an EHR will not make me a better FP”

Integration at many levels

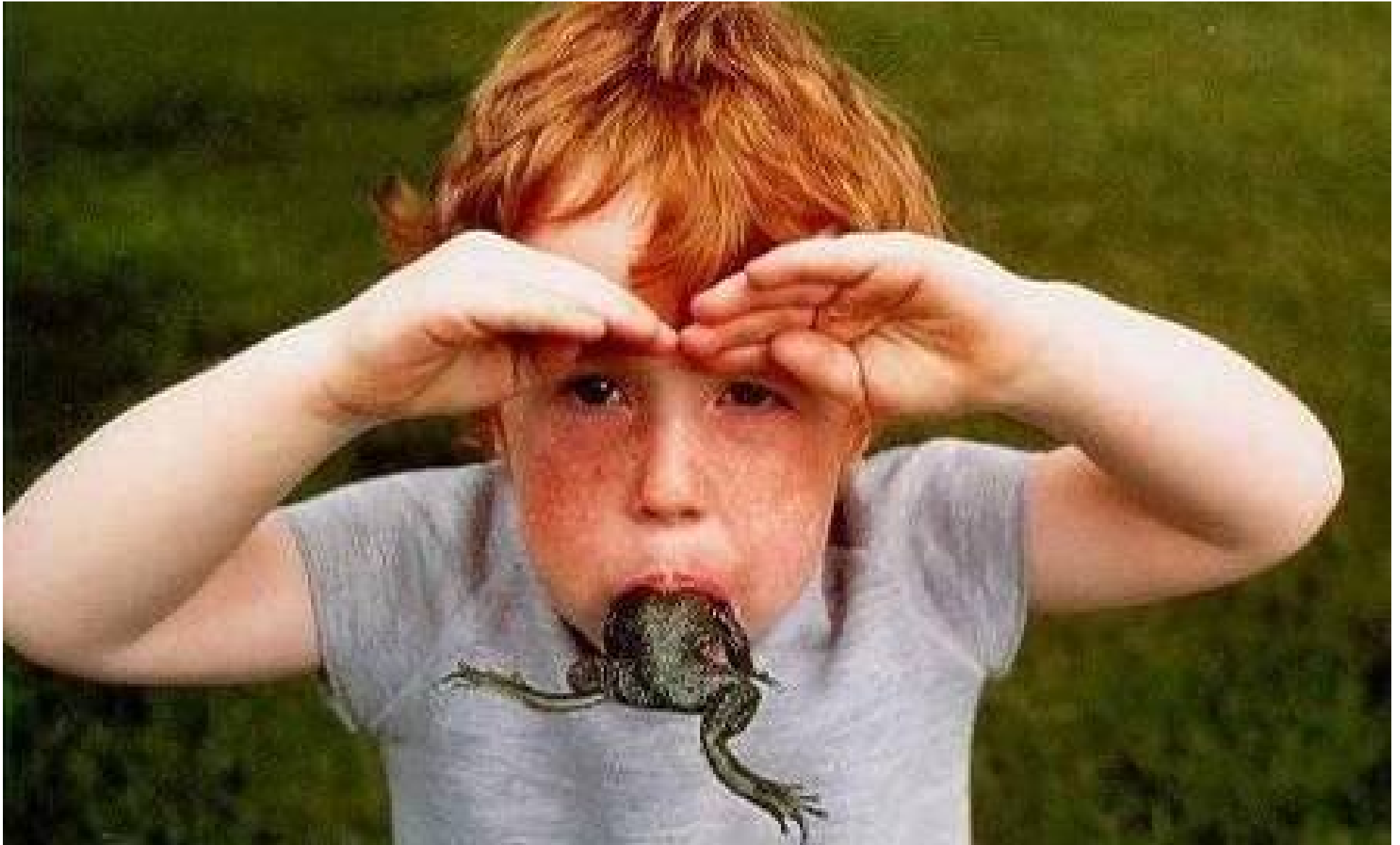
- Horizontal—oral health, behavioral health, specialty care
- Vertical—hospital, lab, primary care training programs, private providers



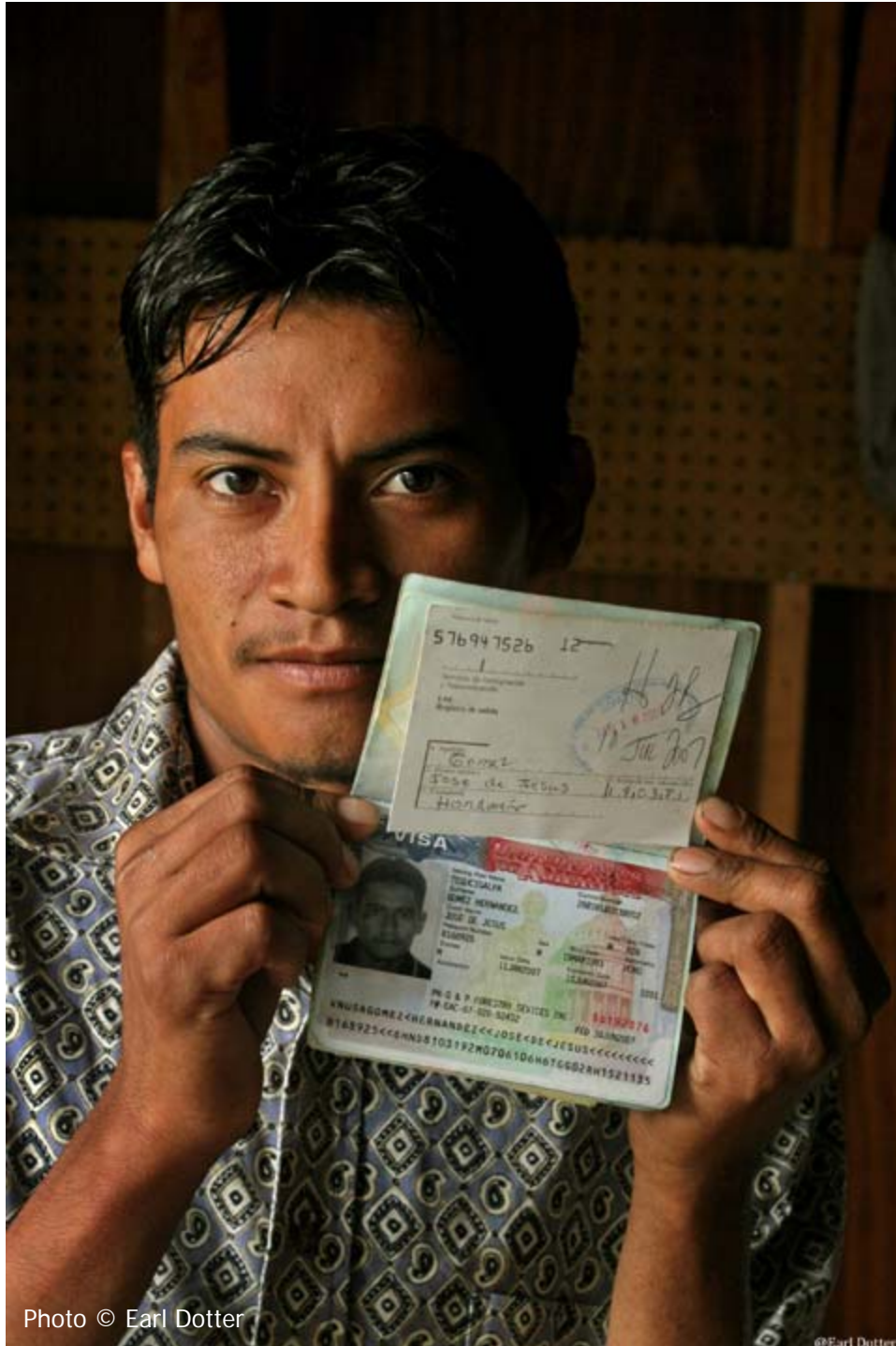
We should be
measuring
Outcomes not
patient Visits

HRSA RESPONSE to GAO Inquiry

“Instead of productivity, BPHC has transitioned to using cost per patient to evaluate efficiency. This measure is consistent with the “medical home” model, as it encourages providers to offer preventive and other services during visits initiated for other purposes.”



Payment system must be restructured but the process may not be pretty.



Healthcare / Immigration Reform

Big overlap, link,
challenge between
these current
national issues

Advocacy

- Now more than ever
- If not us then who!?

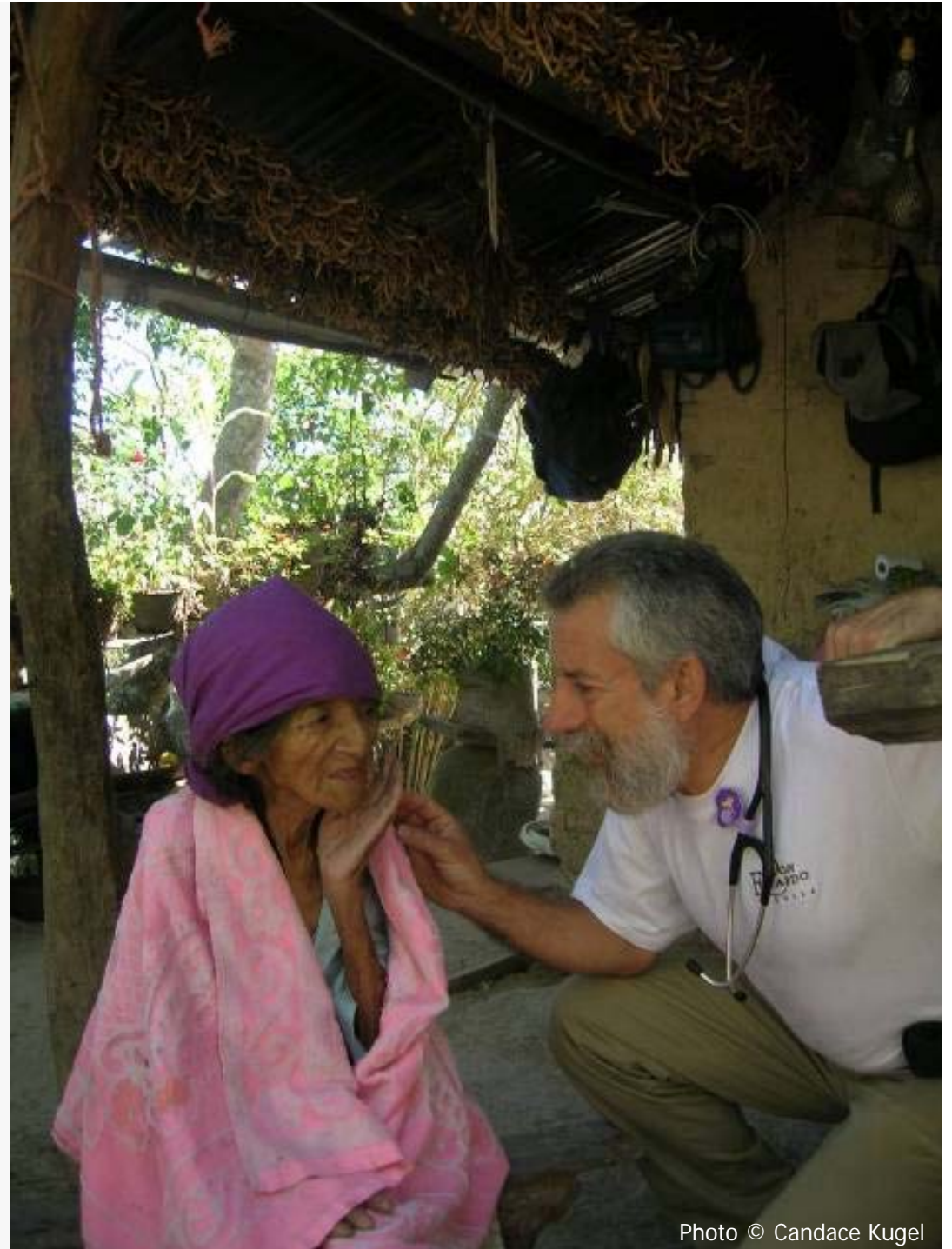


Photo © Candace Kugel

What is MCN's Health Network?

- Patient Navigation; Medical Record transfer; "Bridge Case-Management Program
- Continuity of care services for mobile populations who cross county, state and national borders for work
- Bridge between mobile patients and their providers no matter where they travel.



Photo © Alan Pogue

What is bridge case management?



Toll-free access

Health education

Ongoing communication

Care coordination services

Store & transfer medical records

Expert, bilingual, culturally-competent staff

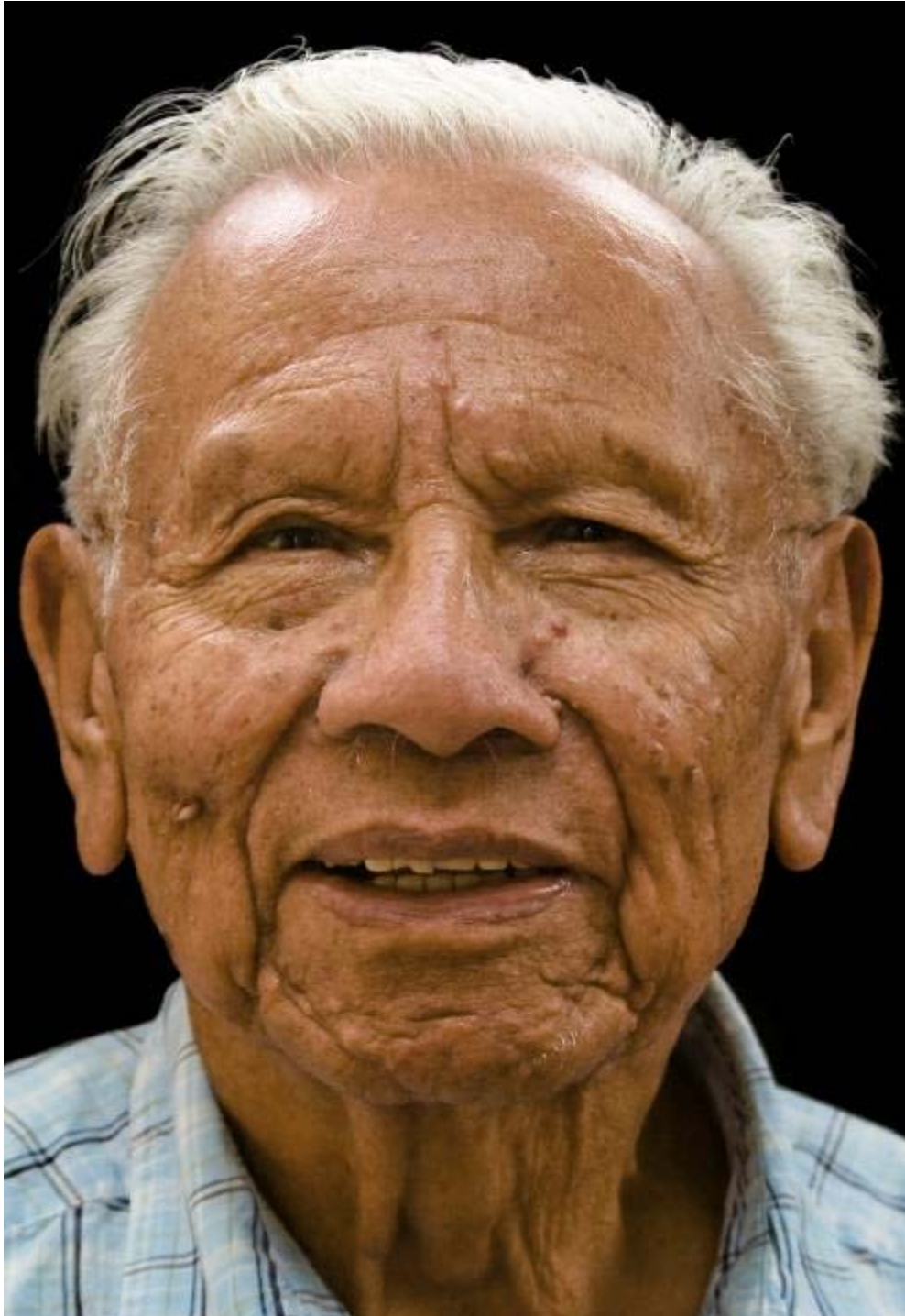


Health Network as Component of Medical Home

- Personal Primary Care Clinician (Case manager)
 - Trust,
 - consistency of message about your health,
 - cultural understanding,
 - “virtual” face time/translation of message



Photo © Shana Spitzman



Health Network

- Primary Care Clinician Directed Medical Practice
 - ▶ Never the provider of record
 - ▶ Consistent and repeated presentation of clinician instructions

Health Network

■ Whole Person Orientation

- Staff that understands the impact of mobility on health and access to health services
- Staff that assists in navigating complex systems for health care and other support services



Photo © Naomi Salz



Photo © Naomi Salz

Health Network

- Coordinated/Integrated Care
 - Direct communication with patient or other PHI-authorized person
 - Direct communication with health care provider
 - Consistent triangulation between patient and all providers necessary

Health Network

■ Quality and Safety

- Case manager assigned
- Chart audits conducted quarterly to evaluate consistency and quality of service
- Chief Medical Officer and CNM/FNP available on demand for rapid review of cases
- Chief Medical Officer reviews all cases before cases are closed

Health Network

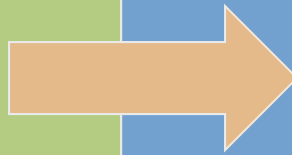
■ Enhanced Access

- Personal advocacy by HN Associate to service provider
- Personal knowledge of service providers
- On-going pursuit of service provider contacts



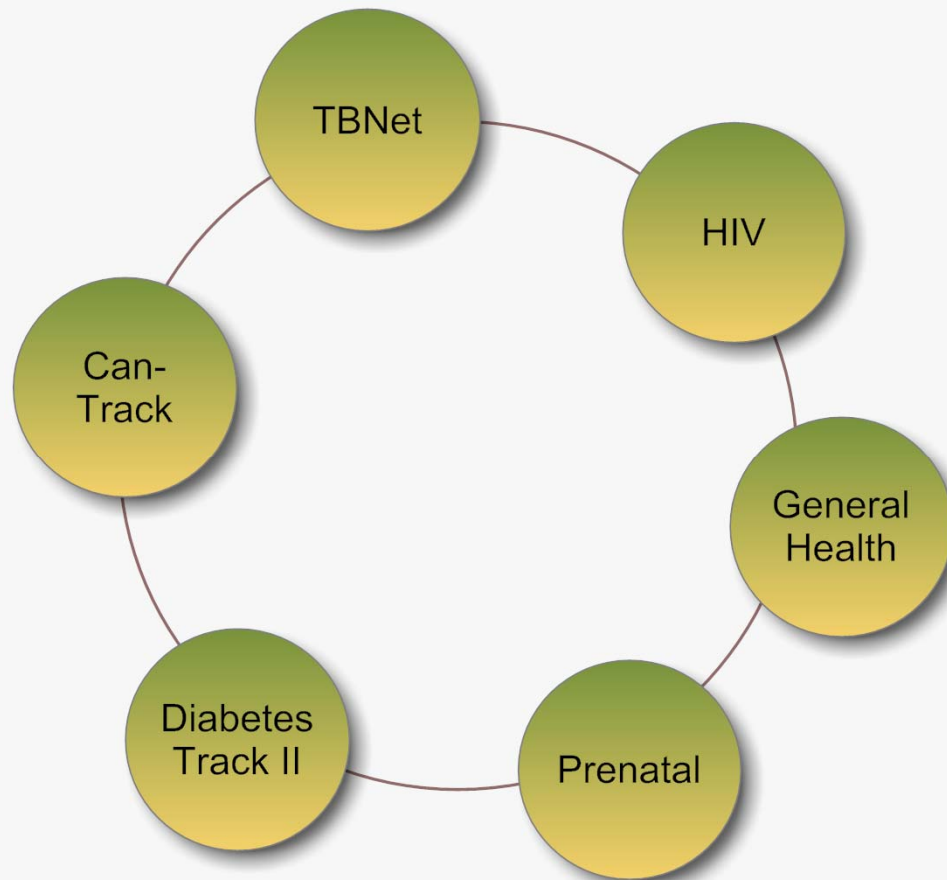
Challenges for Providers and Patients

- Obtaining completion dates
- Reluctance to test or screen for possible health issues
- Reluctance to start patients on treatment
- Support for patients in treatment who are inclined to leave care



Health Network Solutions


- Relays providers with completion dates
- Locates a clinic before a patient moves
- Tracks that patient through follow up and/or completion of treatment
- Provides health education
- Helps assure positive health outcomes
- Decreases overall health care costs



Consent Form

- Gives MCN staff legal permission to transfer participants' medical records and contact participants
- This form **must have** the participant's signature
- Valid if sent to HN staff within 5 business days of being signed by patient, and 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
110 Box 1642 Us
Amarin, Texas 78716



Migrant Clinicians Network

Business Phone: (817) 327-2017
Confidential Fax: (817) 327-6120
Confidential Phone: (800) 823-8205

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

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 enrollment in the MCN Health Network to 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 provider deems 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 or these conditions. These individuals will adhere to federally mandated confidentiality, privacy and security provisions. 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 issue that MCN is authorized to address. I also understand that I have a right to receive a copy of my medical records as filed with MCN upon written request.

I HEREBY RELEASE MCN, ITS EMPLOYEES, DIRECTORS, MANAGERS, COORDINATORS, REPRESENTATIVES, AGENTS, AND AGENTS THEREOF FROM ANY AND ALL CLAIMS, CAUSES OF ACTION, DAMAGES, LOSSES, EXPENSES (INCLUDING ATTORNEYS' FEES), AND OBLIGATIONS 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 request 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 817-327-2927 or enroll@mcnclinician.org for more information on the MCN Health Network.

PAGE 1 OF 2

Patient Information Form

■ It is critical to get as much contact information as possible, such as:

- Home, Cell, work numbers (area codes)
- E-mail address
- Friends and family in hometown
- family member who does not move in US / other countries that often/always knows where they are, etc.
- person who will take a message for you if we cannot get in touch with you

Migrant Clinicians Network
PO Box 164285
Austin, Texas 78716

MCN
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)	
City	State	Country	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Place of birth:		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"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Other:		Language you prefer to be contacted in:	
Occupation(s) [from past two years]: <input type="checkbox"/> Farmworker <input type="checkbox"/> Homemaker <input type="checkbox"/> Student		<input type="checkbox"/> Construction <input type="checkbox"/> Factory <input type="checkbox"/> Child care <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Other:	
Current Residence: <input type="checkbox"/> Farmworker Camp Housing <input type="checkbox"/> Home		<input type="checkbox"/> Jail <input type="checkbox"/> ICE Detention Center <input type="checkbox"/> Homeless <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	
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:

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

03-01
Page 2 of 2

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

After Enrollment...

- Once consent form received, address will be verified
- HN staff orients the patient
- Obtain more contact information
- HN staff discusses next steps with patient



How do I Start the Process?

- Now Covered by Grant BPHC
- NO COST to Health Center
- NO COST to patient
- MCN Staff can provide teleconference training for your staff.
- If you have additional questions about the program, you may also contact Ricardo Garay: 512-579-4508 or rgaray@migrantclinician.org

Case Study

- Nov 2005 American Cancer Society requests assistance obtaining services for Rosa. She has Cervical Cancer is pregnant has no pre-natal care and no insurance.
- Based on diagnosis, Depo Provera was discontinued without alternative offered.
- Rosa soon became pregnant.
- Treatment for her cervical cancer is not an option during her pregnancy.

Case Study

- Cancer made pregnancy “High Risk” requiring that she receive care from an ob-gyn physician, rather than through local health department or FP/CNM at a CHC.
- Few providers would care for a high risk pregnant woman without insurance. Rosa’s family makes too much to qualify for Medicaid and not enough to pay for insurance. (\$2500 for a family of 4)



Case Study

- MCN identified local ob-gyn who agreed to see Rosa for \$1200.
- MCN worked to find the funding.
- Harvest of Hope provided \$300 for the first office visit.
- Local church donated \$300 for 2nd visit and \$100 for the ultra sound (MCN negotiated a reduction from \$600).

Case Study

- Anonymous friend of MCN donated the final \$600 to complete pre-natal care.
- With the help of social worker from the health department, MCN arranged for food and clothing for family and WIC services
- She applied to Medicaid for delivery costs, but was denied and after much negotiations with the hospital charities and others, the bills including the cancer treatment were covered by BCCP.

- She delivered a healthy baby girl without complications
- She had LEEP procedure six weeks following her delivery





Photo © Robert Poole

- Her 3 month post-LEEP procedure Pap smear was normal
- She will be followed closely by Health Network for the next few years

Health Network

- Yet remaining- Payment for Added Value Work
 - ▶ Value added services are geographically constrained
 - ▶ Systems of care continue to be viewed as within catchments rather than across catchments



Health Network like a Medical Home is...

- an approach to providing comprehensive primary care...
- that facilitates partnerships between individual patients, and their personal providers

- May allow better access to health care
- Increase satisfaction with care
- Improve health
- Are associated with better health
- Lower overall costs of care, and
- Reductions in disparities in health

References: PCMH and Meaningful Use

- <http://www.ncqa.org/tabid/1316/Default.aspx> (Site for information on PCMH recognition from National Center Quality Assurance)
- <http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html> (Site for information on PCMH initiative BPHC)

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
Ricardo Garay: 512-579-4508 or
rgaray@migrantclinician.org



Photo © Candace Kugel

Contact:

www.migrantclinician.org