MIGRANT CLINICIANS NETWORK

Health Network: A Care Coordination Program for Patients Who Move During Treatment

MIGRANT CLINICIANS NETWORK

MCN

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

Cutting Edge Programming

Resources and Dissemination

Advocacy and Policy

Research and Knowledge Mobilization

Clinical Support and Capacity Building

MIGRANT CLINICIANS NETWORK

Office Locations

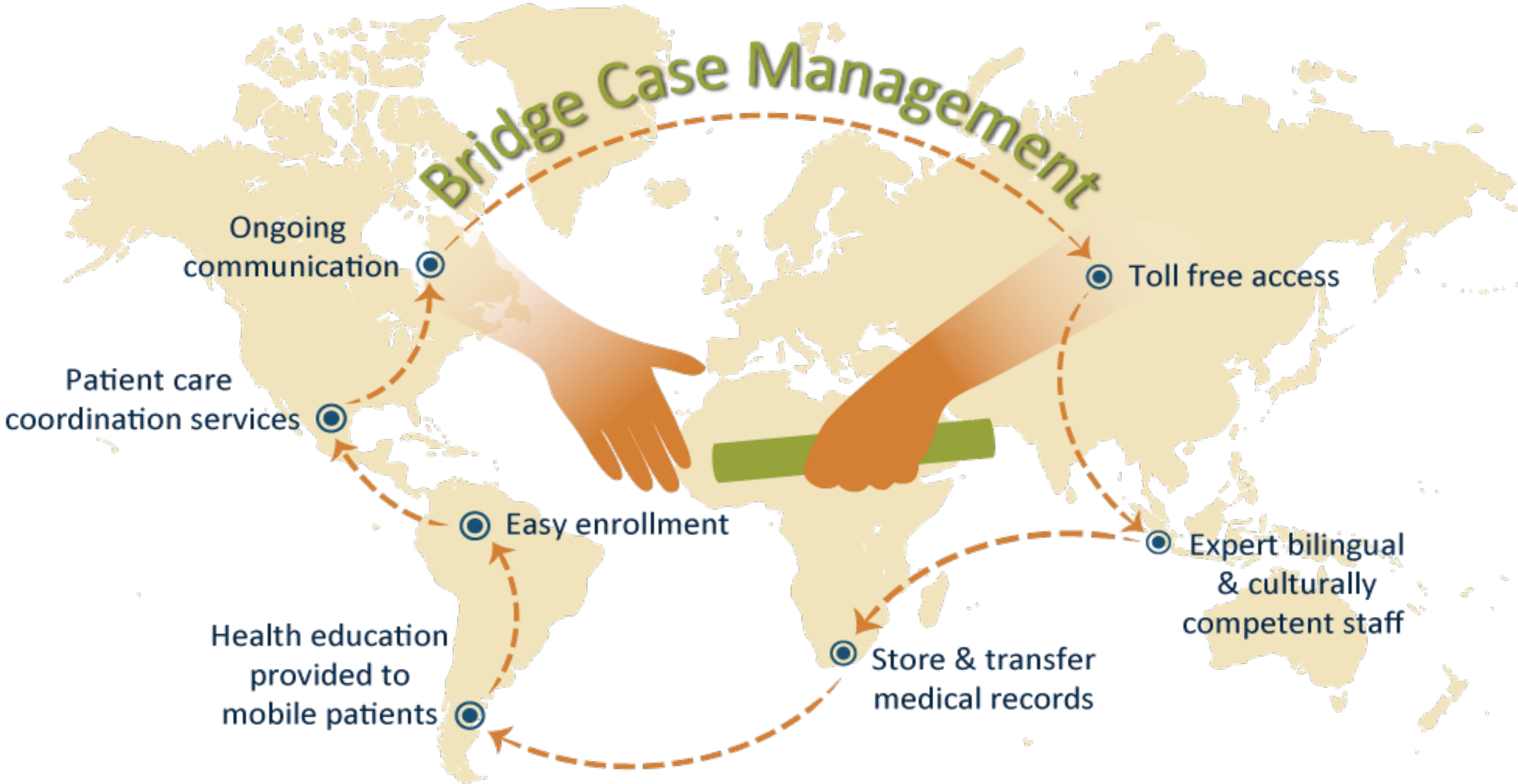
10,000 + constituents

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

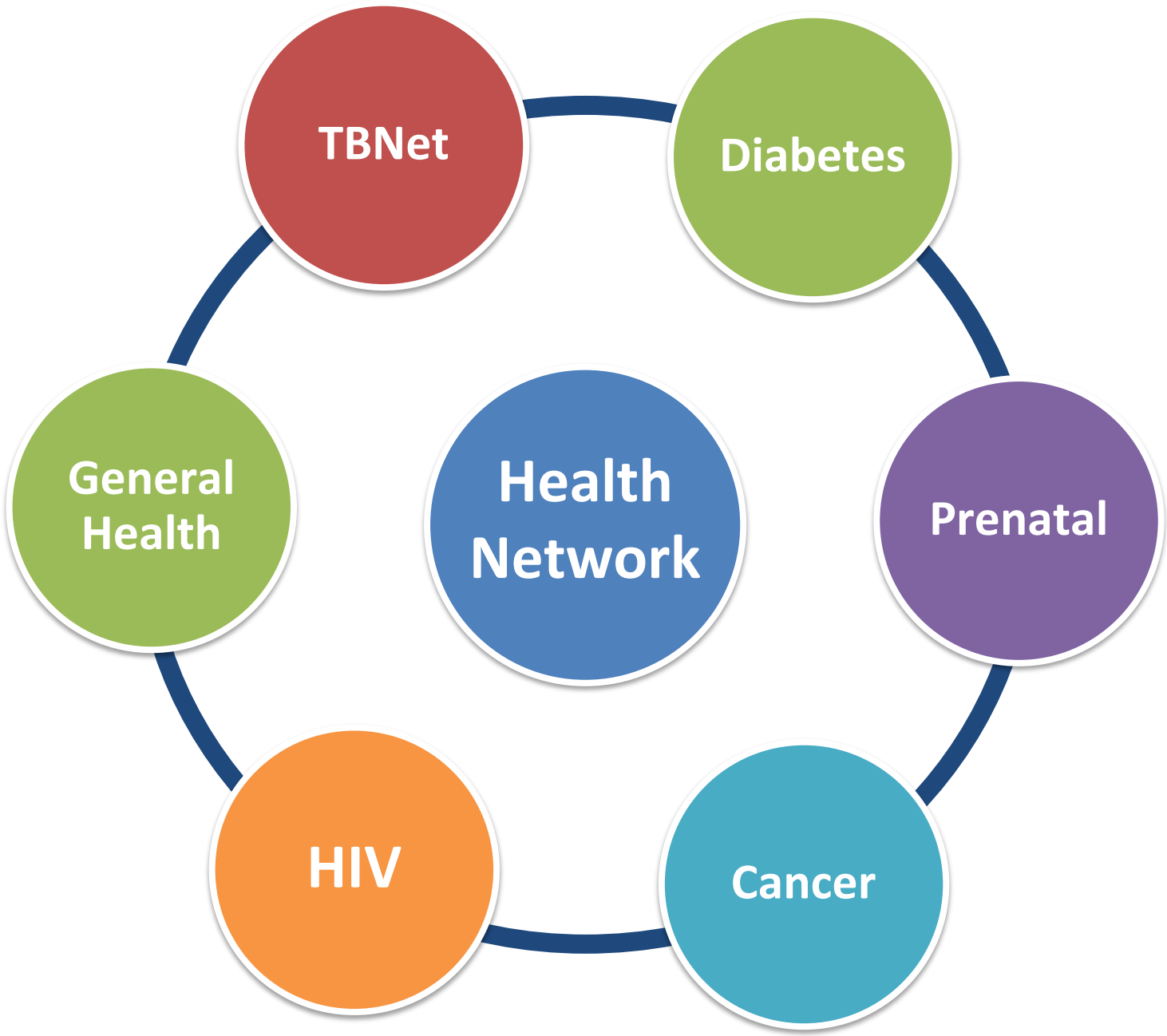
Photo by Earl Dotter


Training
Resource Development
Advocacy and Policy
Technical Assistance
Information Dissemination
Program Development
Networking
MIGRANT CLINICIANS NETWORK
MCN

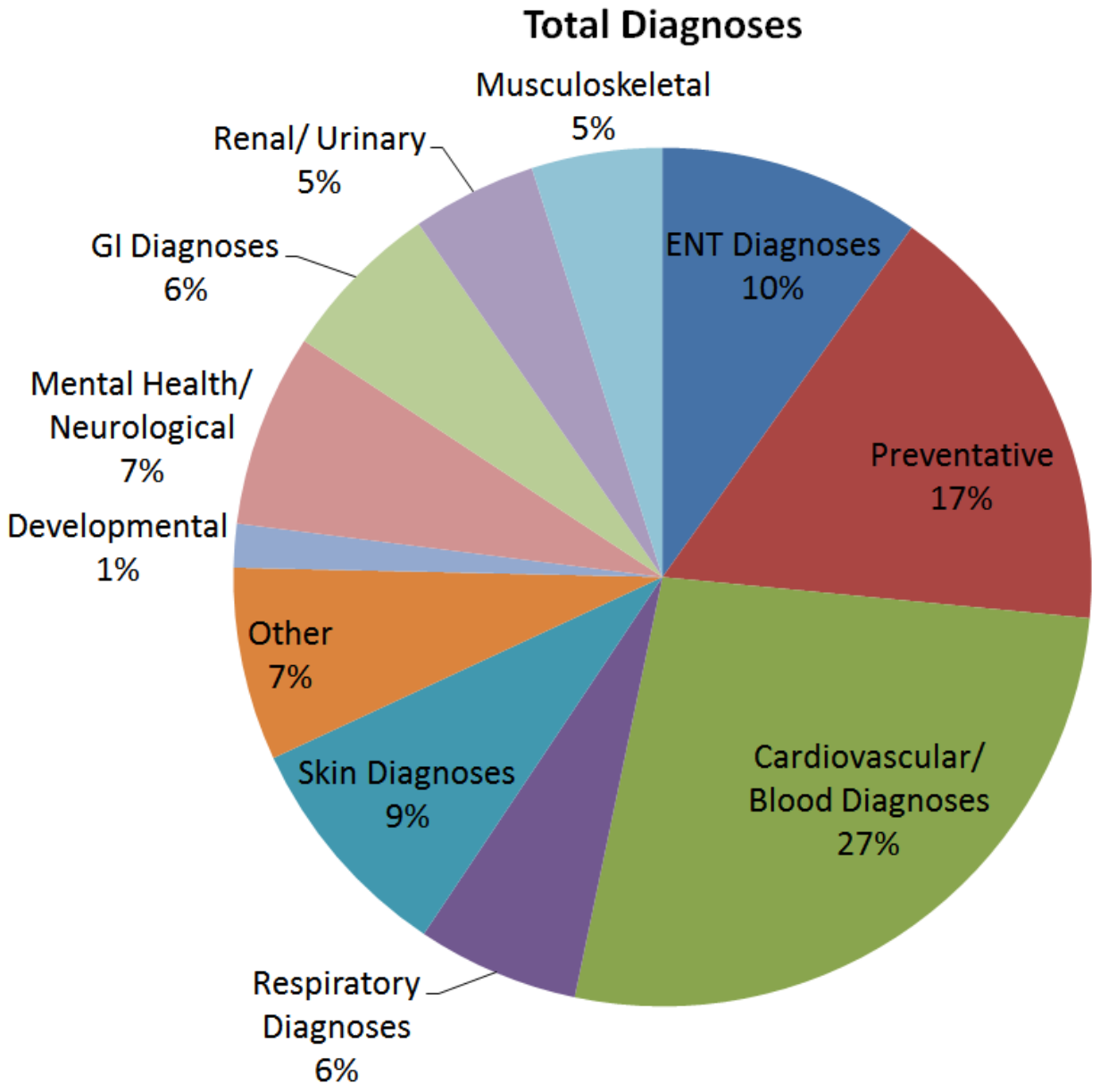

24 Years of
Innovation
Photo by Earl Dotter


Bridge Case Management
Ongoing communication
Toll free access
Patient care coordination services
Easy enrollment
Expert bilingual & culturally competent staff
Health education provided to mobile patients
Store & transfer medical records

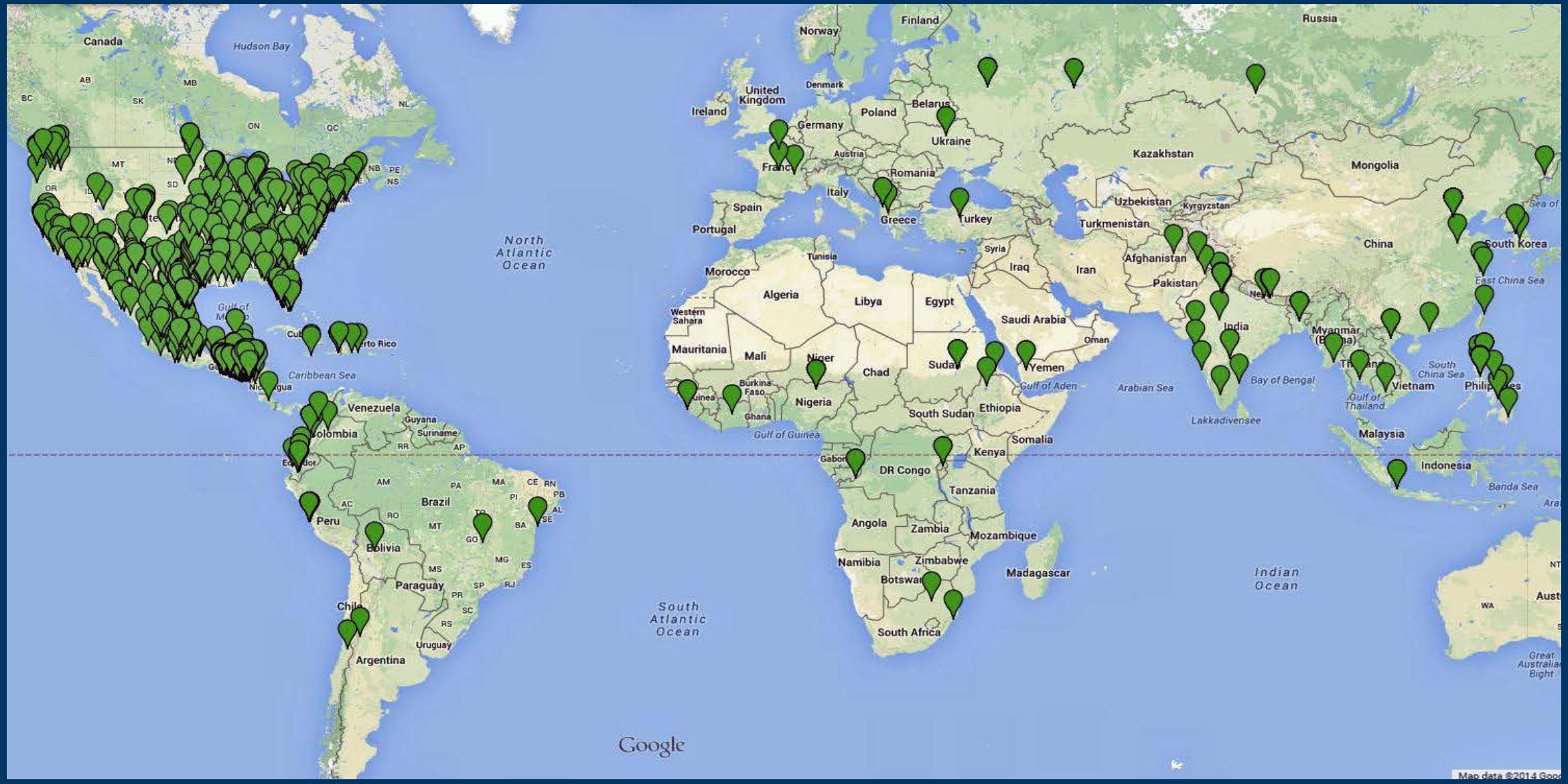
MCN’s Health Network does not discriminate on the basis of immigration status and will not share personal patient information without patient permission.


TBNet
Diabetes
General Health
Health Network
Prenatal
HIV
Cancer

General Health




Over 12,000 total
HN enrollments



2,951 total clinics in U.S. and over **114** countries

Health Network Enrollment Criteria

1

Patient is:

- Mobile / Migrant
- Thinking of leaving area of care

2

Patient has:

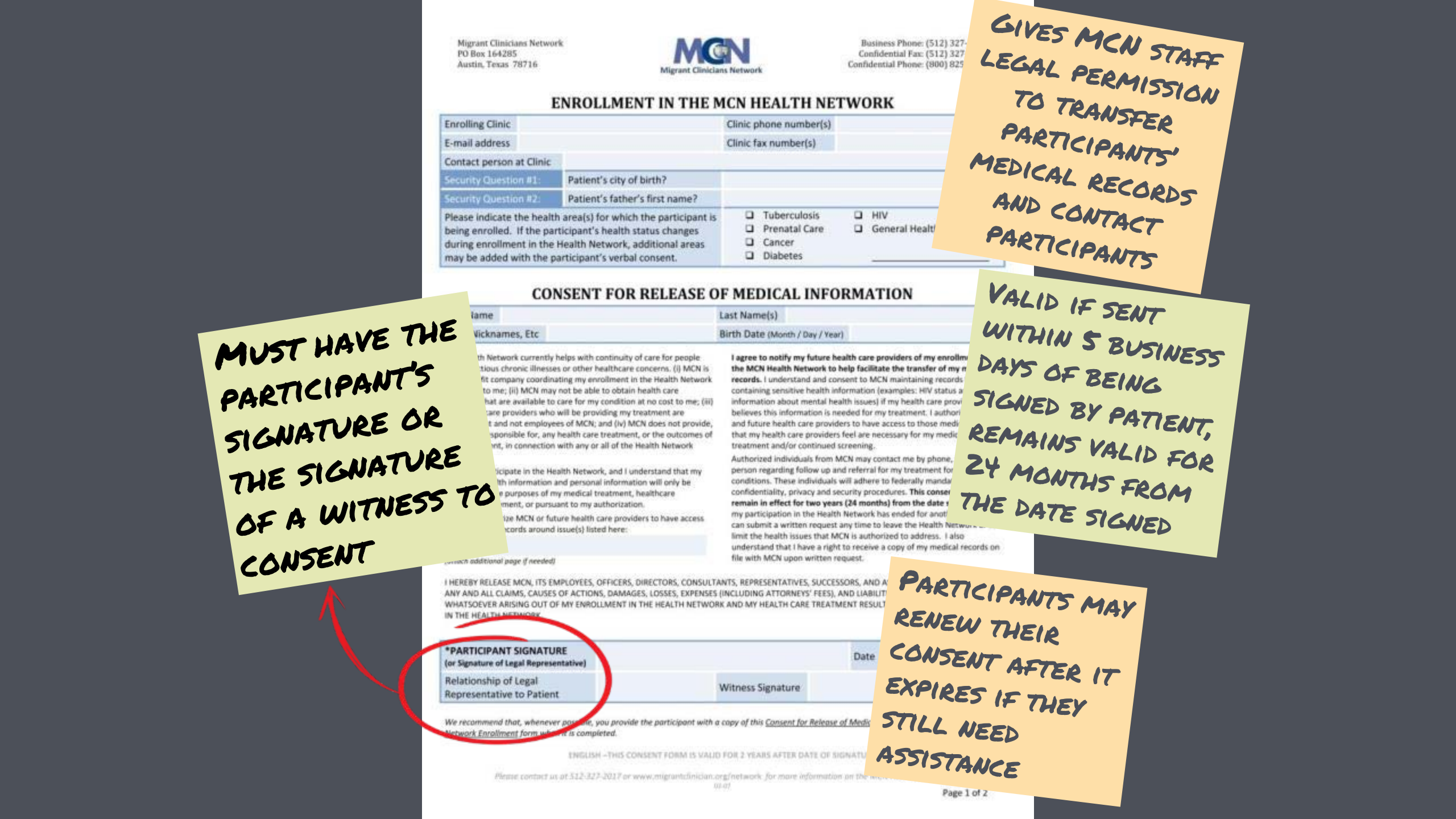
- Need for clinical follow-up
- Working phone number or family member with phone number
- Signed MCN consent form
- Clinical base or enrolling clinic

- 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

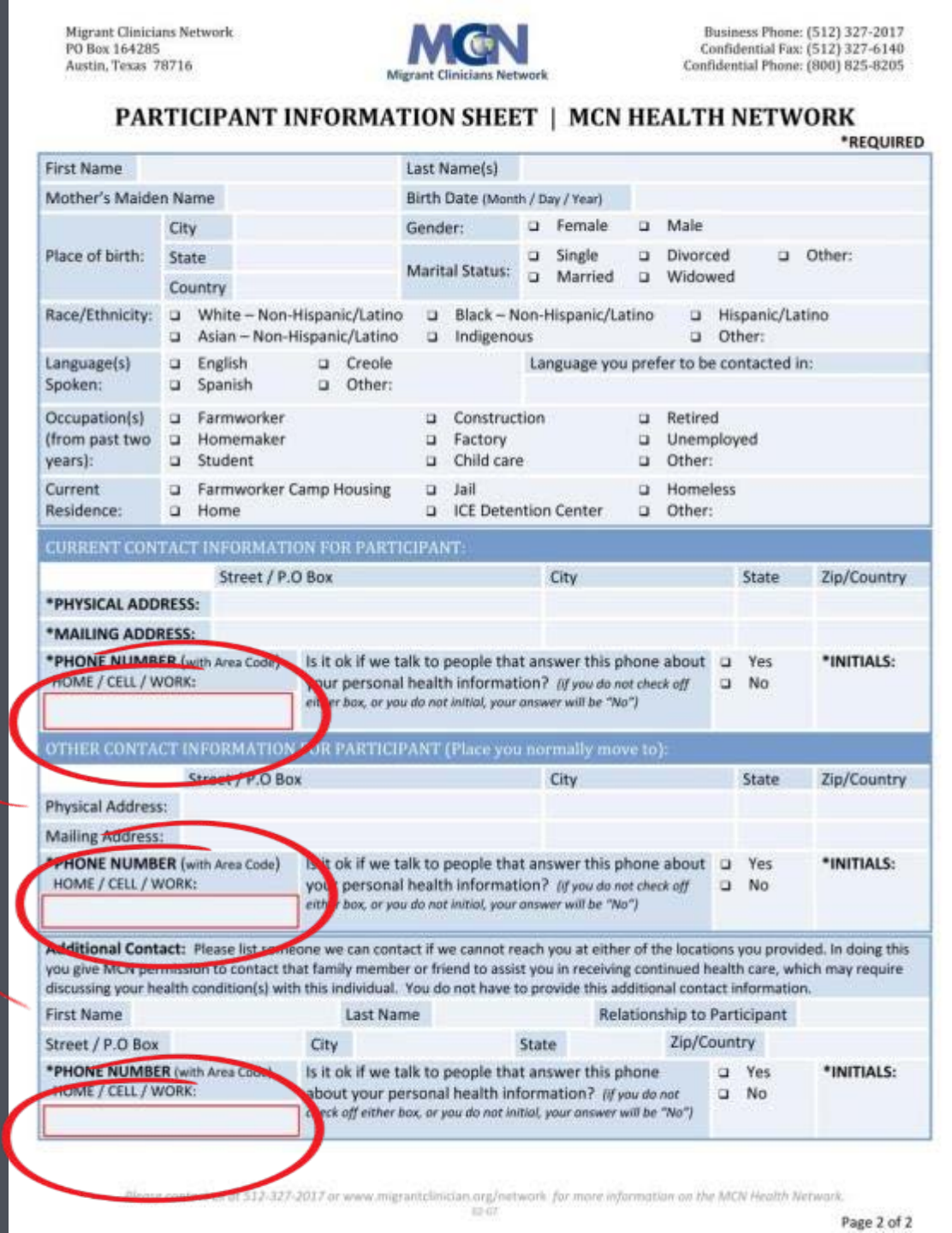
Participant Benefits

- A clinic / doctor / nurse is waiting
- Updated records are forwarded to clinic / patient
- Toll free number in the U.S. and Mexico
- Better understanding and diagnosis of condition
- Completion results stored in patient file

Forms Required for Enrollment


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
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
Cancer
Diabetes
CONSENT FOR RELEASE OF MEDICAL INFORMATION
Last Name(s)
Birth Date (Month / Day / Year)
I agree to notify my future health care providers of my enrollm
the MCN Health Network to help facilitate the transfer of my m
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 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 fo
conditions. These individuals will adhere to federally manda
confidentiality, privacy and security procedures. This consen
remain in effect for two years (24 months) from the date
my participation in the Health Network has ended for anot
can submit a written request any time to leave the Health Netw
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 A
ANY AND ALL CLAIMS, CAUSES OF ACTIONS, DAMAGES, LOSSES, EXPENSES (INCLUDING ATTORNEYS' FEES), AND LIABILIT
WHATSOEVER ARISING OUT OF MY ENROLLMENT IN THE HEALTH NETWORK AND MY HEALTH CARE TREATMENT RESULT
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 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
Page 1 of 2
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
MUST HAVE THE PARTICIPANT'S SIGNATURE OR THE SIGNATURE OF A WITNESS TO CONSENT
PARTICIPANTS MAY RENEW THEIR CONSENT AFTER IT EXPIRES IF THEY STILL NEED ASSISTANCE

MUST HAVE THE WORKING PHONE NUMBERS OR E-MAIL



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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.

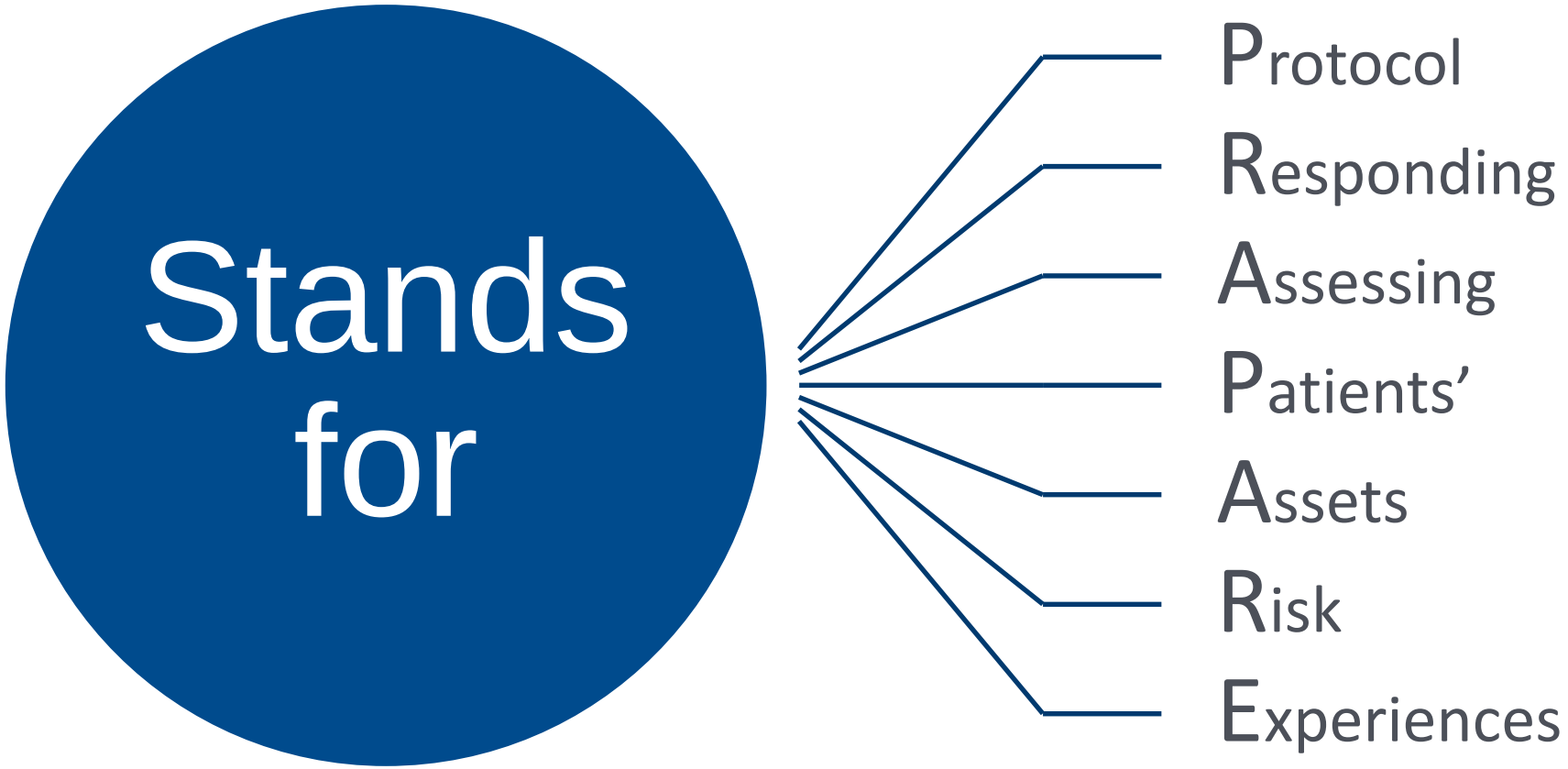
First Name	Last Name	Relationship to Participant	
Street / P.O Box	City	State	Zip/Country

***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.

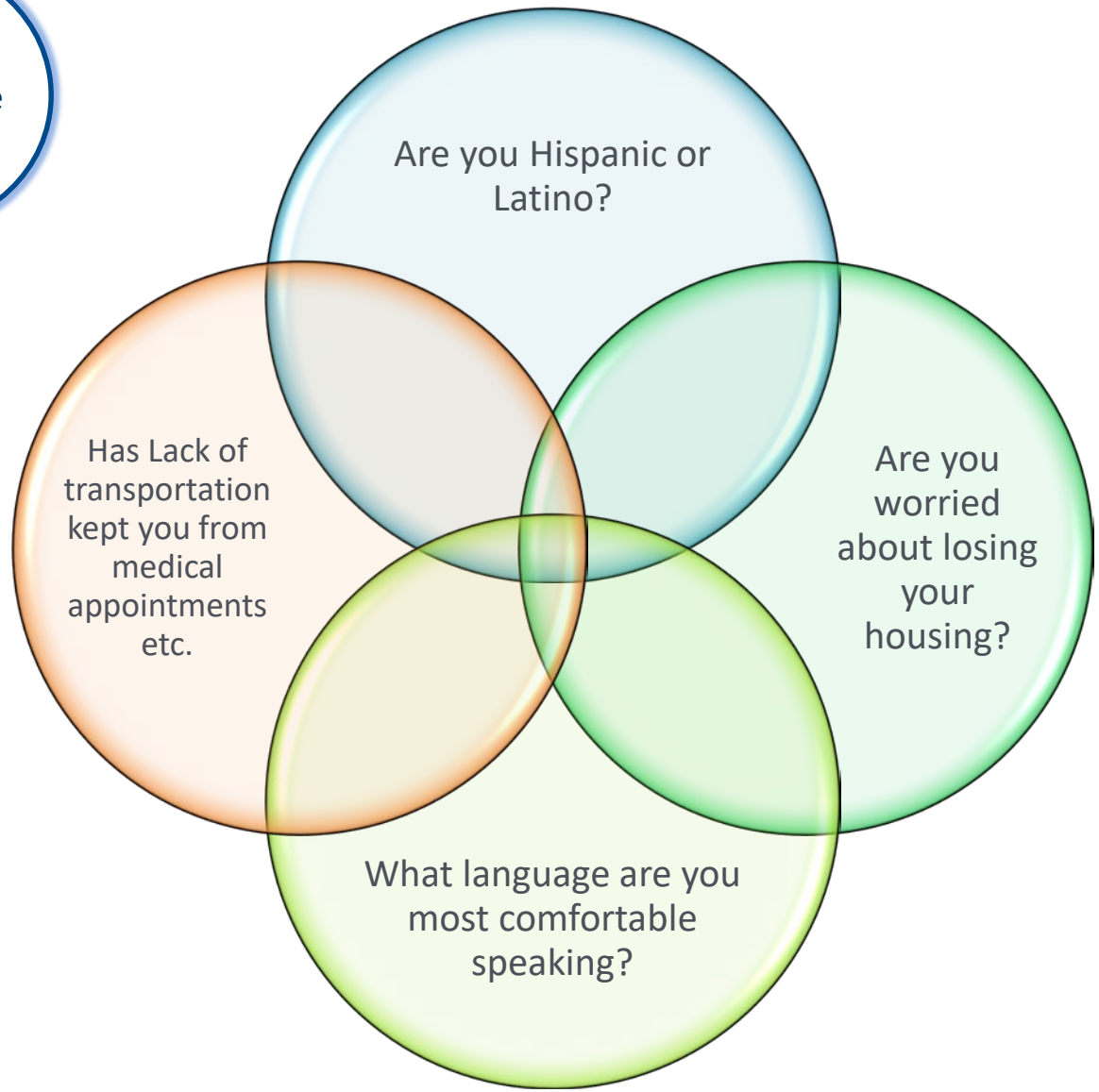
Optional Information for Enrollment

PRAPARE



PRAPARE DATA

21 questions to determine SDOH issues



2 Ways to Enroll

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

Regardless of which option you pick, we will need…

1. The signed consent form
2. The contact information
3. The medical record or summary

before we can provide the navigation for the patient.

Challenges to Success

- Staff turnover at clinics
  (#1 Challenge)
- **No single health center point of contact *(Close 2nd)***
- Patient Cooperation
- Identifying mobile patients
- Incorrect patient information
- Delay in enrollment

Single Point of Contact

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Austin, Texas 78716

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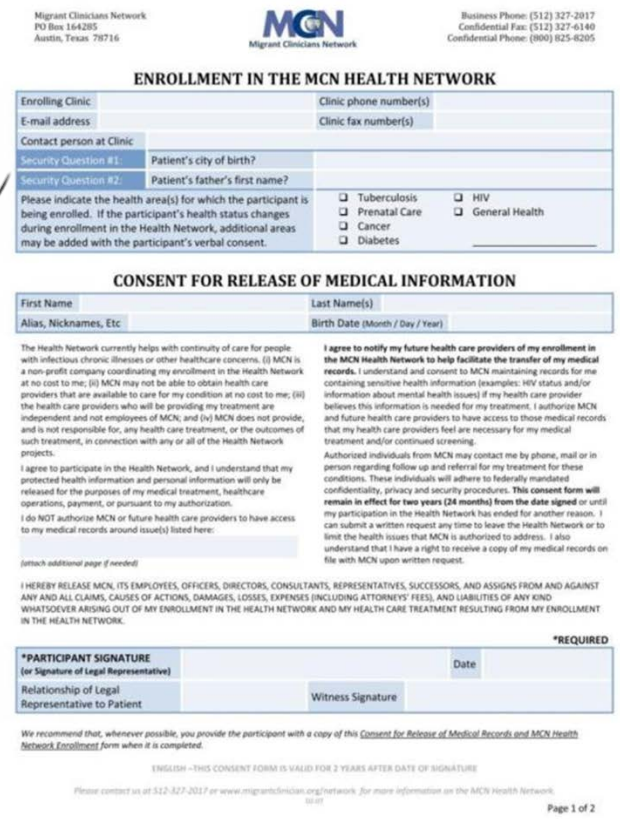
Confidential Fax: (512) 327-6140
Confidential Phone: (800) 825-8205

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)	



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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 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 those 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 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

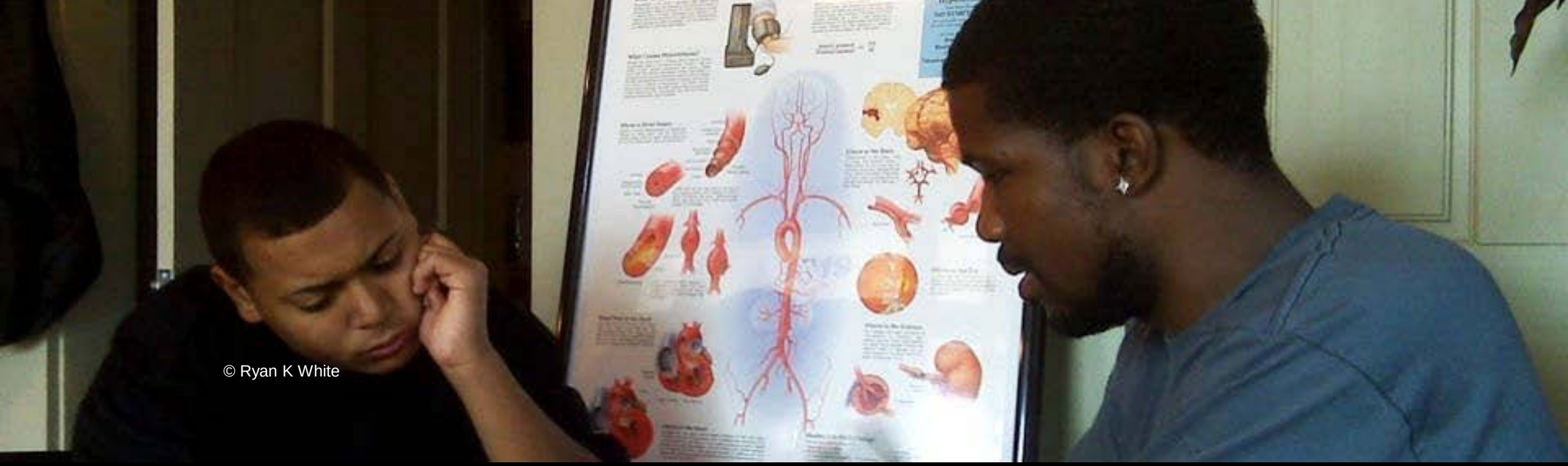
*PARTICIPANT SIGNATURE (or Signature of Legal Representative)		Date	
Relationship of Legal Representative to Patient		Witness Signature	

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

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

Page 1 of 2



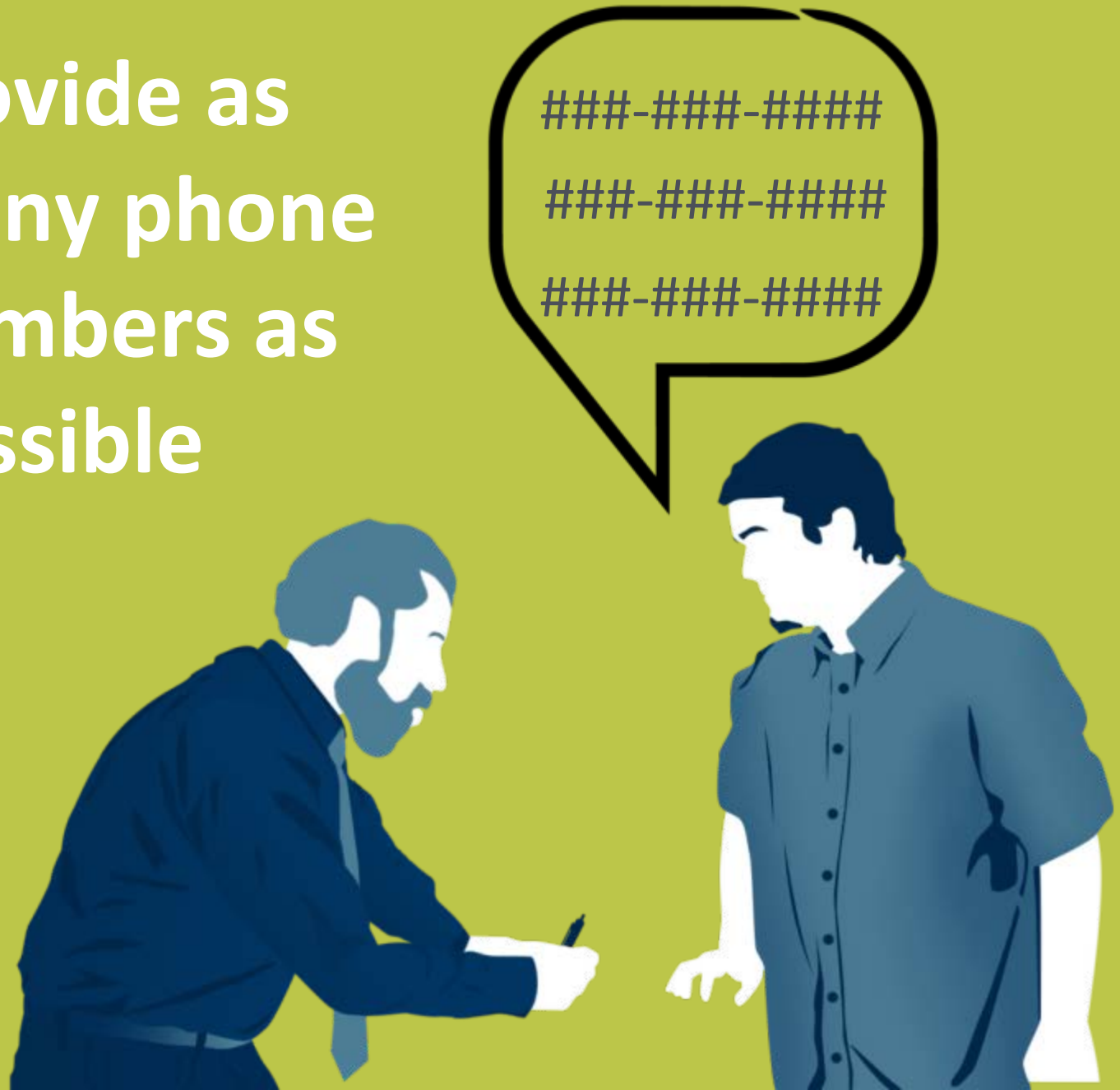
Educating patients (using your trust relationship)

- How HN works and how they will benefit from participating (clinical support)
- How to use HN
- How HN keeps all patient information confidential
- The benefits, responsibilities and expectations

Maintaining a Patient in Care

The Patient's Role…

Provide as many phone numbers as possible



Inform HN of any phone or address changes and contact HN staff after arriving in a new area

Stay on treatment as long as indicated

Notify new clinics of enrollment in HN

Team-Based Approach

Health Network Summary of Services

Contacts patients on a scheduled basis

Contacts clinics on a scheduled basis

Assists patients in locating clinics for services and resources.
Transportation/Scheduling

Reports outcome back to enrolling clinic

Tools for Maintaining a Patient in Care

Make sure patients have the HN toll free number:

800-825-8205

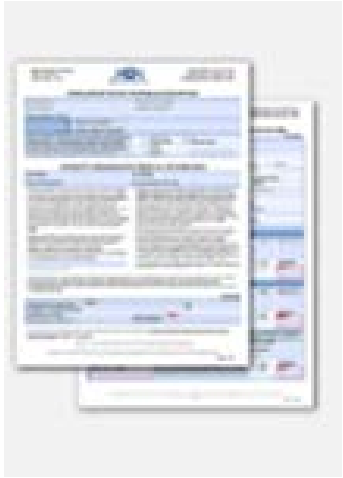
or

01-800-681-9508 if calling from Mexico

Enrollment resources at your fingertips:

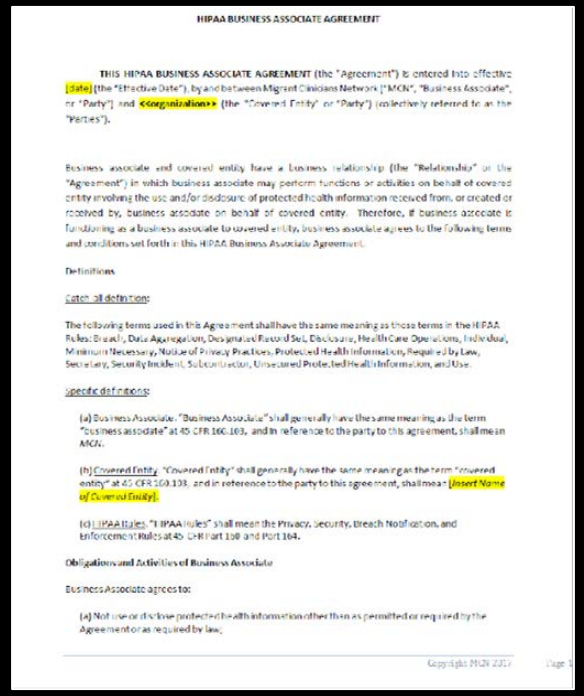
www.migrantclinician.org/services/network

Informational Videos about Health Network



Download Enrollment Packets in English, Kreyol, Portuguese and Spanish

Business Associates Agreements



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;

Copyright MCN 2017 Page 1

Required to be compliant with HIPAA

Health Network **IMPACT**

- Bridge between patients and their providers
- Fewer patients lost to follow up
- Higher % of patients completing or continuing treatment
- Treatment completion reports
- Improved patient participation

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:

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