Health Network

Providing Continuity of Care for Patient Populations on the Move

Presented by:
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2023 Midwest Forum

Providing Continuity of Care for Patient Populations on the Move

Patient Centered Medical Homes (PCMHs) greatly improve continuity of care for patient outcomes and experiences with health care settings. However, the advances of a PCMH tend to be focused on geographically stable populations. Robust medical home transformation can also include assuring continuity of care services for patients experiencing barriers to health care due to mobility.

Learning Objectives:

Upon completion of this session, you will be able to:

- Understand the adapted PCMH model and know how to identify mobile patients at risk of loss to follow up.
- Describe the enrollment process for enrolling patients into Health Network and learn the benefits of enrolling patients at risk of loss to follow up.
- Gain strategies and resources for providing continuity of care for mobile patients like agricultural workers.

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.

Where We Are

Migration

In 2005 there were **195** million international migrants

= 3.1%

United Nations, Department of Economic and Social Affairs, Population Division (2009). *Trends in International Migrant Stock: The 2008 Revision* (United Nations database, POP/DB/MIG/Stock/Rev.2008). and *2005 World Population Data Sheet*

In 2020 there were **281** million international migrants

= 3.6%

United Nations, Department of Economic and Social Affairs, Population Division (2009). *Trends in International Migrant Stock: The 2008 Revision* (United Nations database, POP/DB/MIG/Stock/Rev.2008). and *2005 World Population Data Sheet*

United Nations 2017 revision of World Population Prospects

Recent Shifts in Migration

- Increase in refugees coming to the U.S.
- Shift in population seen at border sites (Haitian, Eastern Europe, Columbia, Venezuela, Peru, and Russia)
- Continued influx of migrants from Central America and Mexico
- Agricultural work continues to be lowest rung on the economic ladder.

Agricultural Work

What Impacts Agricultural Worker Health?

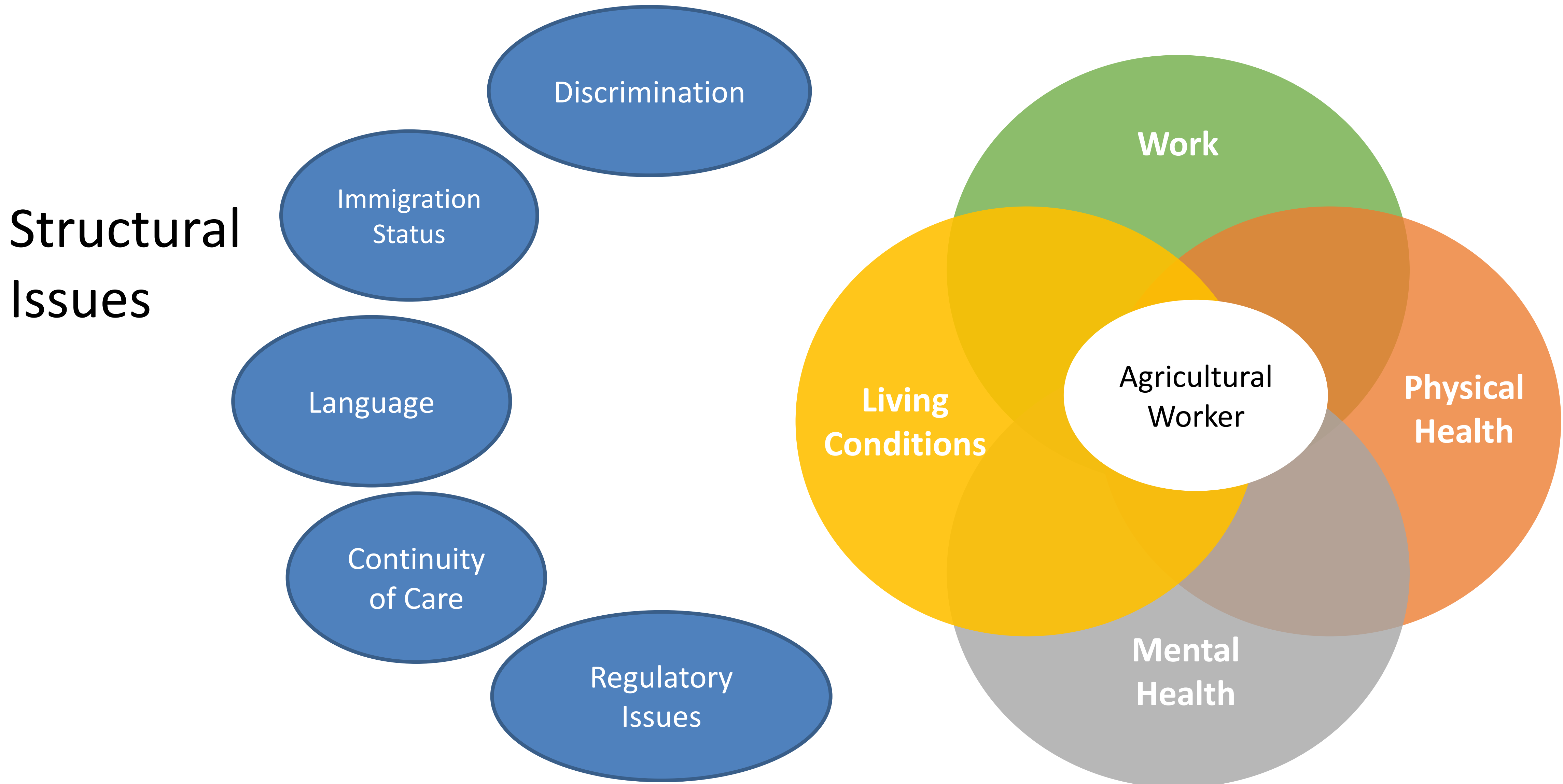


Photo © Earl Dotter

Physical Health

The health issues that face migrant and other mobile underserved populations are similar to those faced by the general population but are often magnified or compounded by their migration, living conditions, and occupation.

Photo by Tony Loreti for MHP Salud

Service Delivery Challenges

Continuity of Care

- Agricultural workers may seek care only when necessary
- Agricultural workers may move during treatment
- Communication between MHCs and other providers is difficult

Culture and Language

- Provision of multi-lingual services (reception, health education, prescriptions,, bilingual staff/translators, etc.)
- Relevant training and continuing education for staff

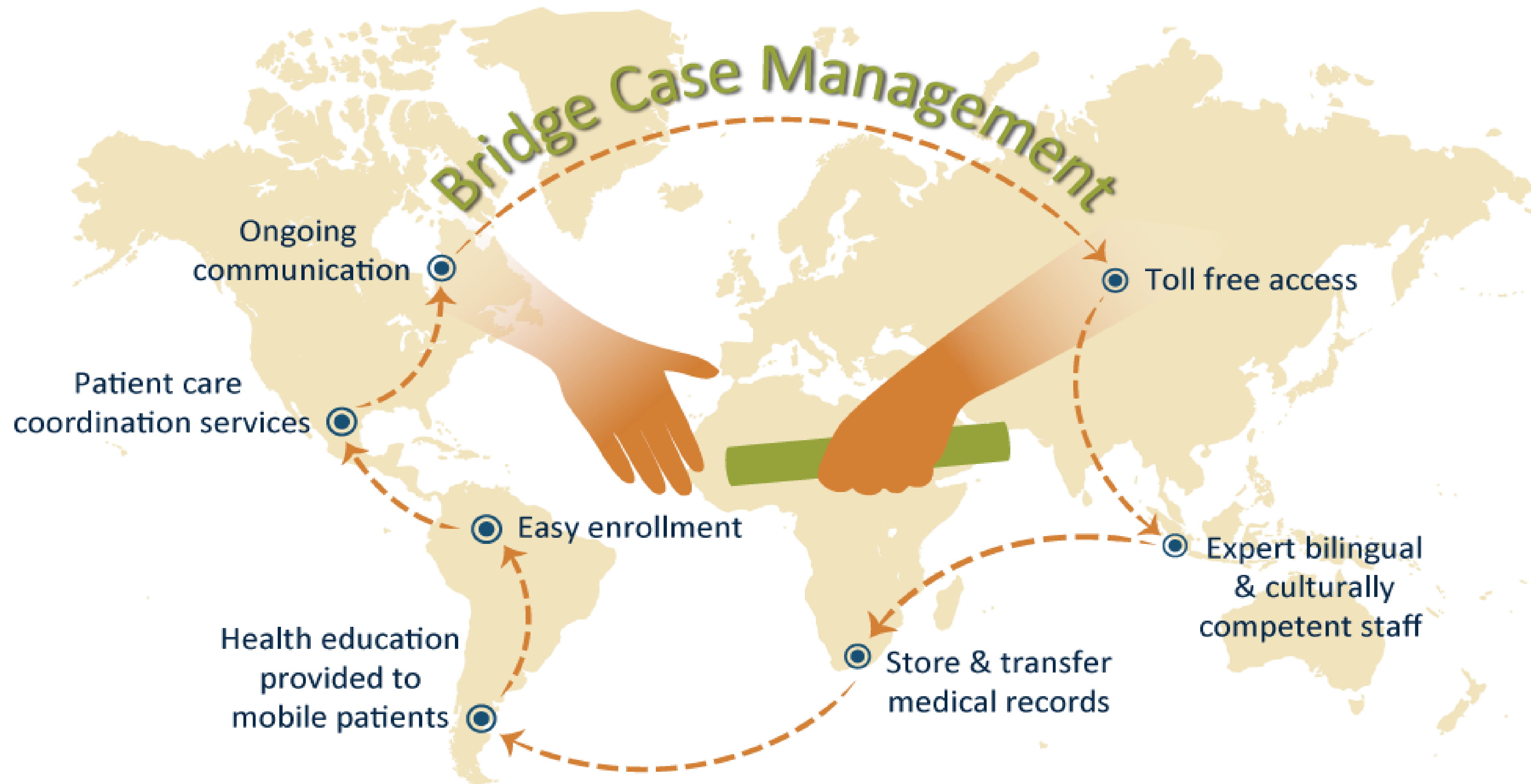
Exploring Effective Adaptations for Mobility and Culture

Health Network

Eliminate health disparities due to patient mobility

©Earl Dotter

Care Management AND
Referral Tracking and Follow-up
Health Network



Over 15,100 total
HN enrollments

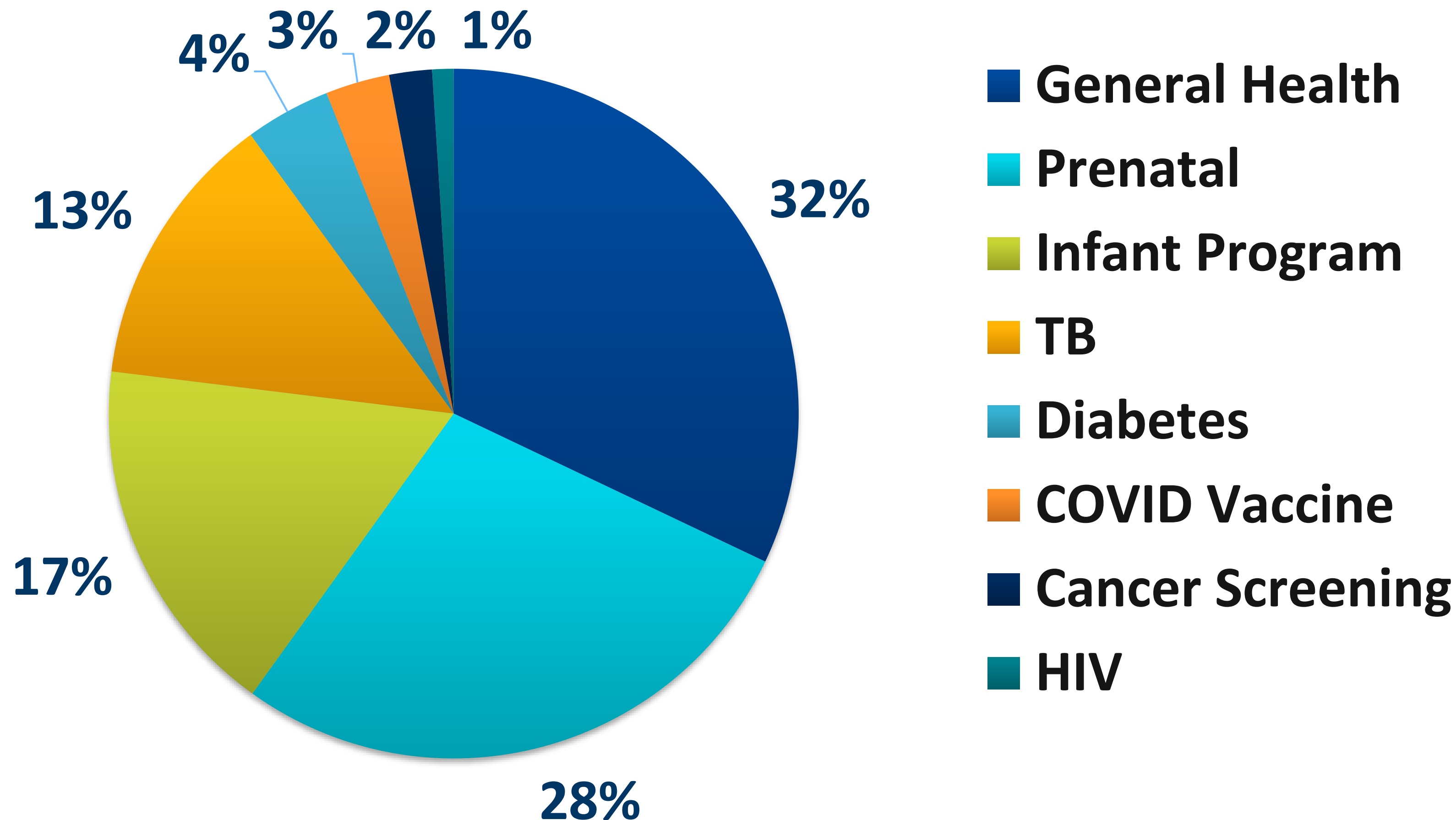
Over 3,000 total clinics in U.S. and **over 114 countries** engaged to eliminate mobility as an obstacle to continuity of care

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



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

CONFIDENTIAL

- ✓ **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

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

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

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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 ☐ Married ☐ Divorced ☐ Widowed ☐ Other:

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

…de) 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

…de) 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	

…e) Is it ok if we talk to people that answer this phone about your personal health information? *(if you do not* ☐ Yes ☐ No *INITIALS:

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

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 enrollm... the MCN Health Network to help facilitate the transfer of my r... 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 prov... believes this information is needed for my treatment. I author... and future health care providers to have access to those med... that my health care providers feel are necessary for my medi... 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 reas... 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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Relationship of Legal Representative to Patient		Witness Signature	

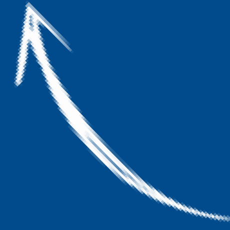
We recommend that, whenever possible, you provide the participant with a copy of this Consent for Release of Medical Records and MCN Health Network Enrollment form when it is completed.

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

Must have the participant's signature



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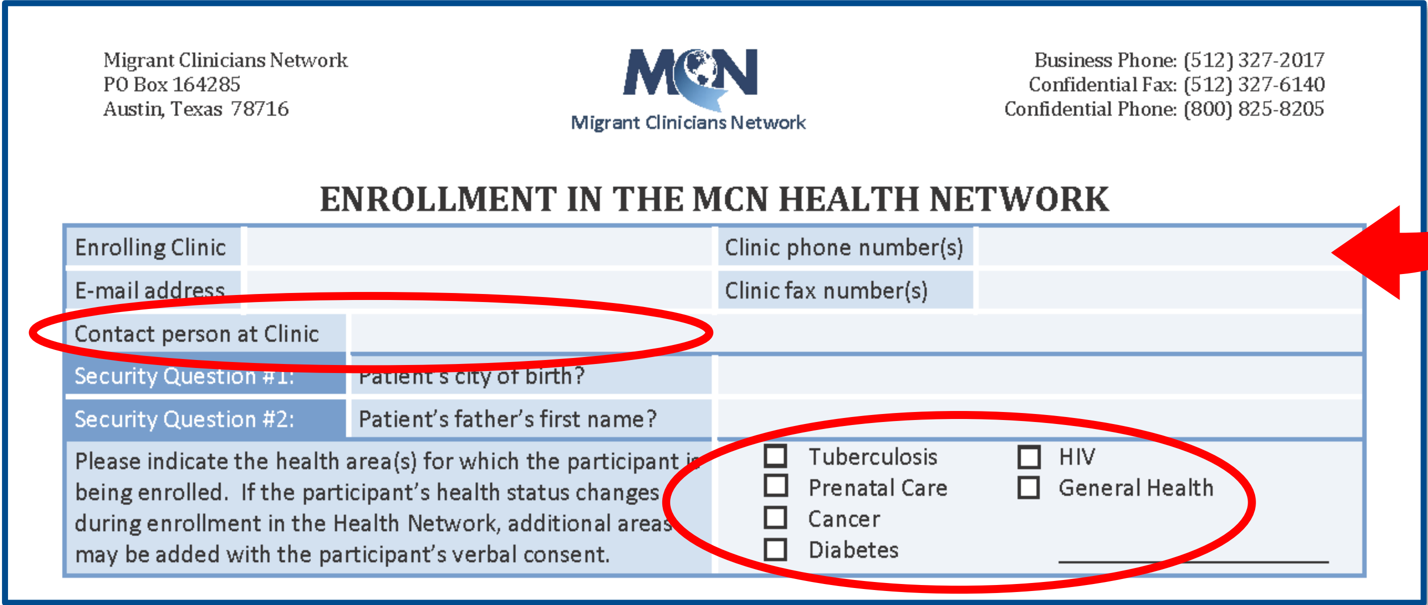
Single Point of Contact at the Health Center



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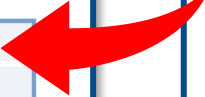

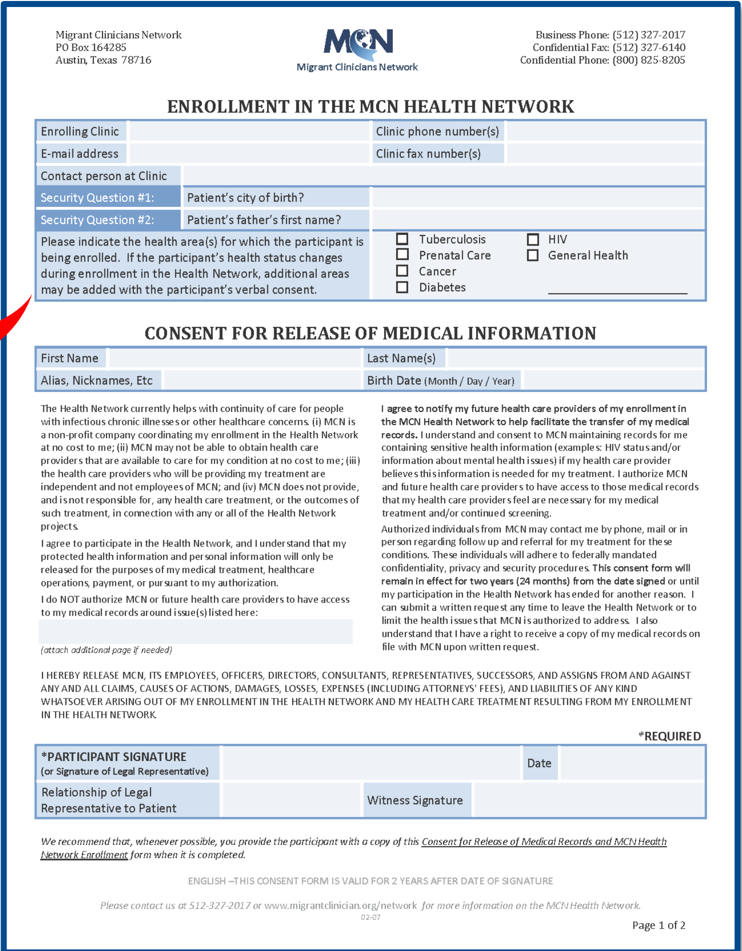

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Please contact us at 512-327-2017 or www.migrantclinician.org/network for more information on the MCN Health Network.

02-07

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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

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

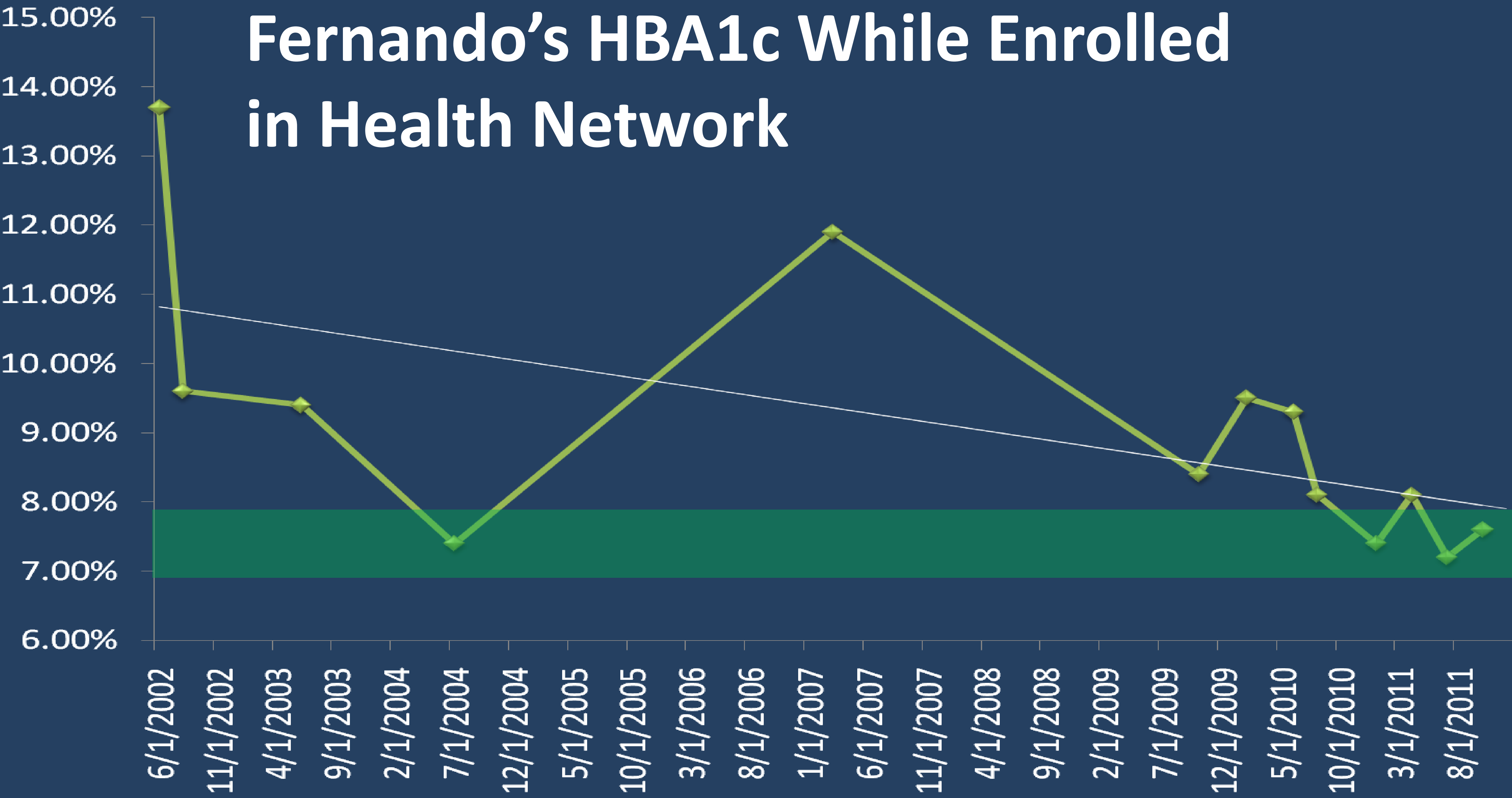
Inform Health Network (HN) Associates of any phone or address changes and contact HN staff after arriving in a new area

Continue treatment as long as indicated by their physician

Enrolled in Health Network Year 1

Over th… ars he was … Network … ontacts, … tacts, … ical … to … 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
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
9/1/2008
2/1/2009
7/1/2009
12/1/2009
5/1/2010
10/1/2010
3/1/2011
8/1/2011

Contact Us

- Health Network telephone: **800-825-8205** (U.S.)
- Health Network fax: **512-327-6140**

MCN website: http://www.migrantclinician.org/

For questions when enrolling your patients, please contact Alma Colmenero: acolmenero@migrantclinician.org or (512) 579-4510

To Schedule additional trainings like the one today, please contact Theressa Lyons-Clampitt tlyons@migrantclinician.org

Connect with MCN !

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Attend our virtual trainings

and a lot more at

www.migrantclinician.org

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Please remember to submit the evaluation. MCN values your opinions and suggestions. We use the information you provide to update and improve all our educational offerings. Do take a few moments to complete the evaluation. Thank you!