Continuity of Care Among Foreign Transfers

Olivia Hayes and Deliana Garcia, MA

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


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

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

10,000 +
constituents

Cultural adaptations

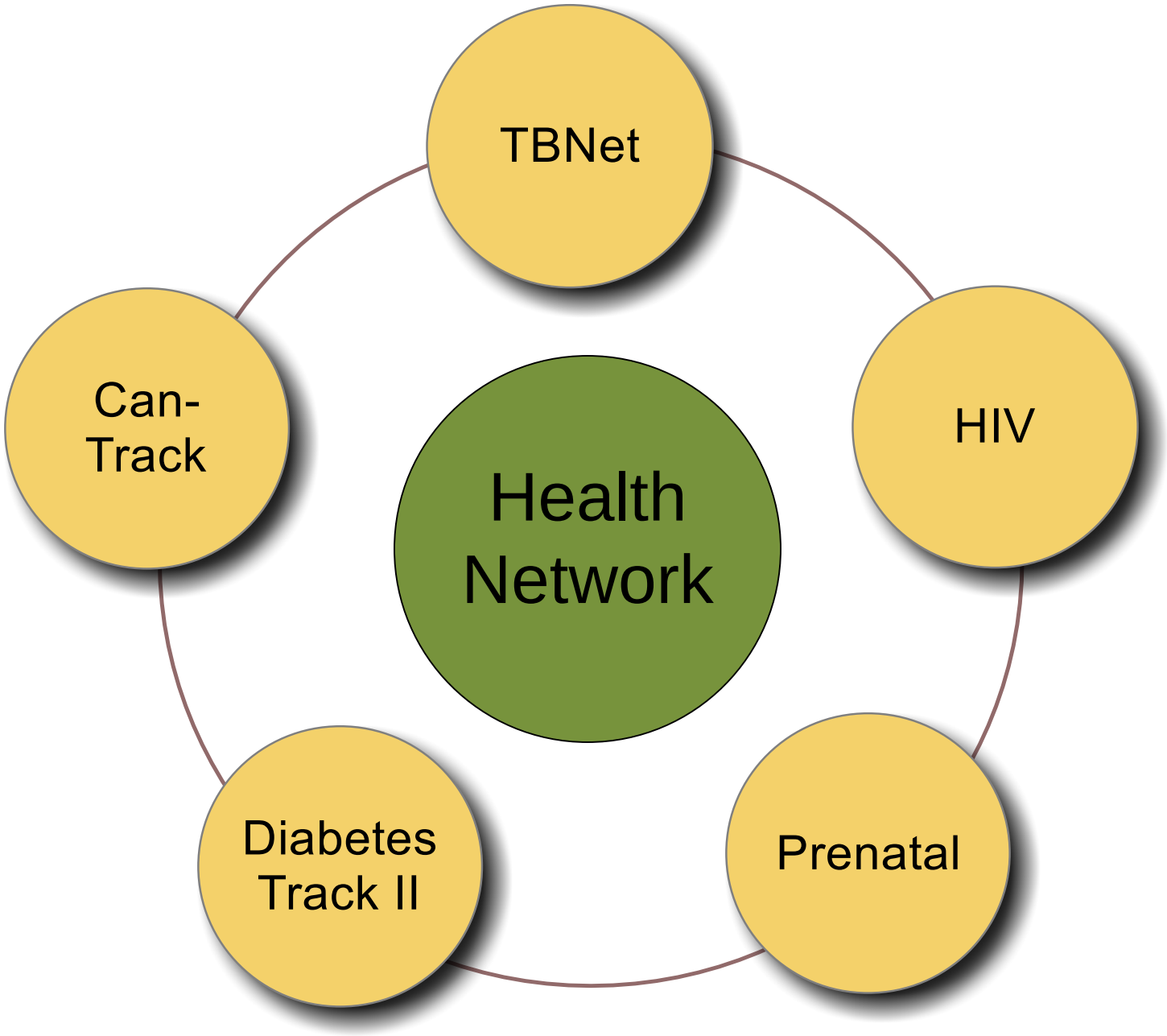
- Culturally sensitive education
- Appropriate language and literacy levels
- Address cultural health beliefs & values

Mobility adaptations

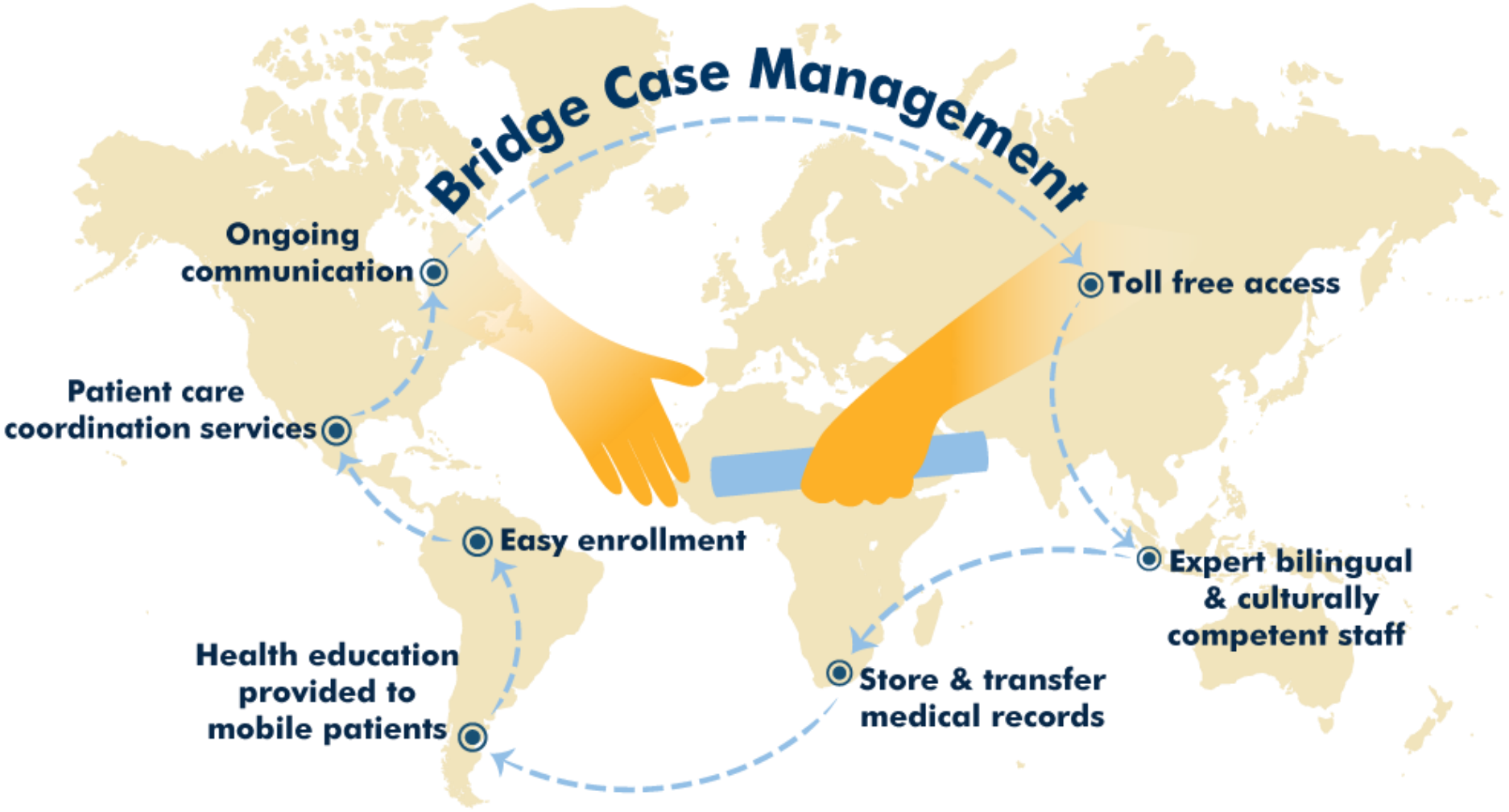
- Portable medical records & Bridge Case Management
- EHR transmission to other C/MHCs

Appropriate service delivery models

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


TBNet
Can-
Track
HIV
Health
Network
Diabetes
Track II
Prenatal

MCN's TBNet provides continuity of care to mobile patients and their providers



Nationality TBNet 2005-2016

Country (89Total Countries)	Total Class 3 patients (2,062 total patients)	Percent of total patients
Honduras	531	25.8%
Mexico	409	19.8%
Guatemala	362	18.5%
El Salvador	171	8.3%
India	92	4.5%
China	47	2.3%
Philippines	38	1.8%
Ecuador	36	1.6%
Peru	33	1.6%
Nicaragua	32	1.7%
United States	31	1.5%
Haiti	24	1.2%
Vietnam	25	1.2%
Honduras; Mexico; Guatemala; El Salvador	**1,473**	**71.4%**

1,668 Complete Treatment *

85.02%

TBNet 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

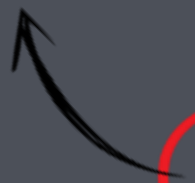
MCN's TBNet does not discriminate on the basis of immigration status and will not share personal patient information without patient permission

- Confidentiality is critical to all MCN staff and all TBNet 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
- Patient confidentiality

Must have the participant's signature



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 ❑ Prenatal Care ❑ Cancer ❑ Diabetes	❑ 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:

(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 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 conse 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

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

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.

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 TBNet staff

Contacts patients on a scheduled basis (monthly for TB patients/ dependent on travel plans)

Contacts clinics monthly

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

Reports back to the enrolling clinic and notifies them of outcomes

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

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
  Health Network Staff: 512-327-2017 or hn@migrantclinician.org