# Red de Salud

Un programa de coordinación de cuidados para pacientes que se movilizan durante el período del tratamiento

A Care Coordination Program for Patients Who Move During Treatment

MIGRANT CLINICIANS NETWORK

MIGRANT CLINICIANS NETWORK

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.

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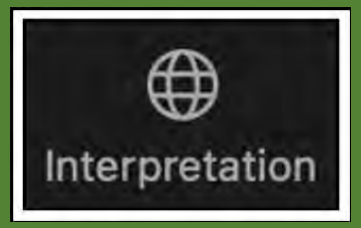
**Nuestra misión** es crear soluciones prácticas en la intersección entre la vulnerabilidad, la migración y la salud.
**Nuestra visión** es alcanzar un mundo justo y equitativo en salud, donde la migración nunca sea un impedimento para el bienestar.

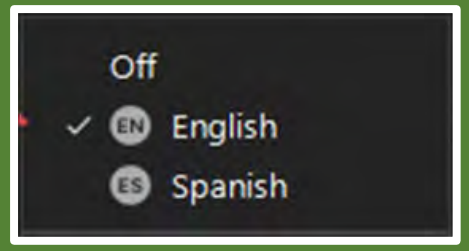
# Simultaneous Interpretation in Zoom

From your computer's Zoom toolbar, click on the **Interpretation icon (globe icon).** Select your desired language in the pop-up menu. Your desired language is the language you want to hear during the presentation.

**Click this icon**




**Select the language you want to hear**



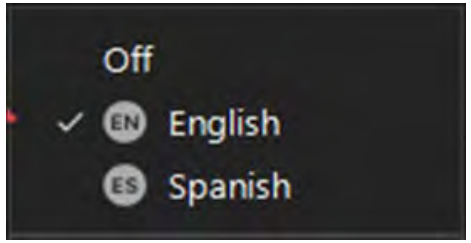

From your **cellphone**, click the "**more options**" and select interpretation to select your desired language.

# Función de interpretación simultánea en Zoom

Desde la barra de herramientas de zoom de su computadora, haga clic en el ícono de interpretación (el ícono se ve como un mundo). Va a aparecer un menú. Seleccione el idioma de su preferencia. Este será el idioma que escuchará durante la presentación.

**Haga clic en este icono**


**Seleccione el idioma que desea escuchar**




Desde su **teléfono celular** haga clic o pulse en **más opciones** y seleccione interpretación para elegir el lenguaje que desea escuchar.

# Objetivos de Aprendizaje

Al finalizar esta presentación,
los participantes podrán.....

- Comprender qué pacientes son elegibles para la continuación de los servicios de atención proporcionados por Health Network.
- Describir los beneficios a los pacientes inscritos en Health Network para la continuidad de los servicios de atención.
- Describir los documentos necesarios para inscribir a un paciente en Health Network.
- Comprender los desafíos para mantener un programa de continuidad de la atención para los pacientes móviles.

# Learning Objectives

At the conclusion of this presentation,
participants will be able to.....

- Understand which patients are eligible for continuation of care services provided by Health Network
- Describe the benefits to patients enrolled in Health Network for continuity of care services
- Describe the documents needed to enroll a patient in Health Network
- Understand the challenges to sustaining a continuity of care program for mobile patients

# DECLARACIÓN SOBRE EL CONFLICTO DE INTERESES

MIGRANT CLINICIANS NETWORK

MCN

No tenemos ningún interés real o aparente relacionado con esta presentación, ni tenemos relación alguna con productos o compañías farmacéuticas, fabricantes de dispositivos biomédicos y/u otras corporaciones cuyos productos o servicios estén relacionados con las áreas terapéuticas pertinentes.

# MIGRANT CLINICIANS NETWORK (MCN) ESTÁ ACREDITADA COMO PROVEEDOR AUTORIZADO DE EDUCACIÓN CONTINUA PARA ENFERMERÍA POR LA COMISIÓN DEL CENTRO DE ACREDITACIÓN DE ENFERMERAS ESTADOUNIDENSES

- Para recibir horas de educación continua por esta capacitación, los participantes deben completar una evaluación una vez que la presentación termine.
- Una vez que se haya verificado que usted ha finalizado su participación con éxito, cada participante recibirá una copia electrónica de su certificado que detalla el número de horas de educativas concedidas.
- Los miembros del comité de planificación, los presentadores, los docentes, los autores y los revisores de contenido de esta actividad de educación continua de enfermería han declarado no tener ninguna relación profesional, personal o financiera relevante relacionada con la planificación o la implementación de esta actividad de educación continua.
- Esta actividad de educación continua de enfermería no recibió patrocinio ni apoyo comercial.
- Esta actividad de educación continua de enfermería no avala ningún producto.
- Si tiene preguntas o desea información adicional, comuníquese con Jillian Hopewell en jhopewell@migrantclinician.org

# Our Work

# Nuestro trabajo

Salud y seguridad de los trabajadores

Worker Health and Safety

Apoyo psicosocial para proveedores de salud

Psychosocial Support for Providers

Evaluación

Evaluation

Redes de proveedores

Peer Networking


Abogacía

Advocacy

# Our Work

# Nuestro trabajo


**Resource Development**

**Desarrollo de recursos**

**Education**

**Educación**

**Technical Assistance**

**Asistencia técnica**


**Research**

**Investigación**

**Bridge Case Management**

**Manejo de casos**

MIGRANT CLINICIANS NETWORK

# Where We Are/ Dónde estamos

# Constituents / Miembros

## Clinicians

**Proveedores de servicios de salud**

## Migrant & Community Health Centers

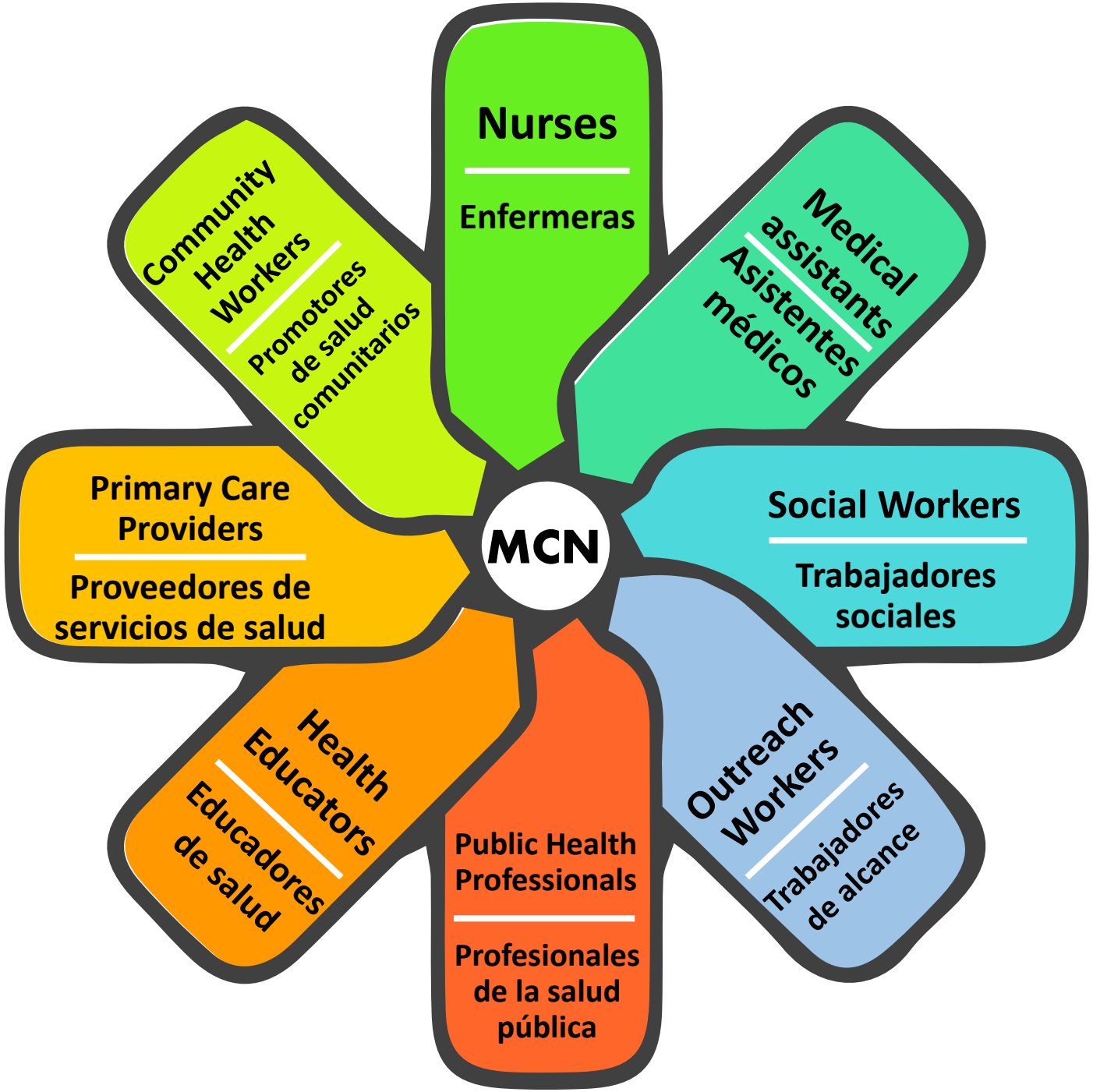
**Centros de salud comunitarios y para migrantes**

## State and local health departments

**Departamentos de salud estatales y locales**

## Underserved Migrants and Immigrants populations

**Poblaciones desatendidas de migrantes e inmigrantes**



MIGRANT CLINICIANS NETWORK

# La Red de Salud

Busca eliminar las disparidades en salud ocasionadas por la movilidad de los pacientes

Alan Pogue

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

La Red de Salud de MCN no discrimina a nadie por su condición de inmigrante y no comparte la información personal del paciente sin su permiso.


- ✓ 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


- ✓ **La confidencialidad es fundamental para todo el personal de MCN.** Todos los procedimientos que la Red de Salud utiliza cumplen con las normas HIPPA
- ✓ Todos los pacientes deben firmar (o hacer firmar a un testigo) un formulario de consentimiento antes de inscribirse en la Red de Salud

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

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

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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 ☐ Divorced ☐ Other: ☐ Married ☐ Widowed

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

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

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

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

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

# Forms Required for Enrollment

# Formularios necesarios para registrarse

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# 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 _____ | |

# 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 MC and future health care providers to have access to those medical rec 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 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** my participation in the Health Network has ended for another reas 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 rec file with MCN upon written request.

I HEREBY RELEASE MCN, ITS EMPLOYEES, OFFICERS, DIRECTORS, CONSULTANTS, REPRESENTATIVES, SUCCESSORS, AND ASSIGNS FROM AND A 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 ENRO IN THE HEALTH NETWORK.

*P

| | | | |
|---|---|---|---|
| ***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.*

**Must** have the participant's signature

Debe tener la firma del participante

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

Con el consentimiento de los participantes se autoriza al personal de MCN a transferir sus historiales médicos y a que les contacten.

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

El consentimiento es válido si se envía dentro de los 5 días hábiles siguientes a la firma del paciente. A partir de la fecha de la firma, es válido por 24 meses.

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

Los participantes pueden renovar su consentimiento después de que expire si aún siguen necesitando asistencia

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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 |
| Place of birth: State | | Marital Status: | ☐ Single ☐ Divorced ☐ Other: ☐ Married ☐ Widowed |
| Place of birth: Country | | | |
| 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:** |

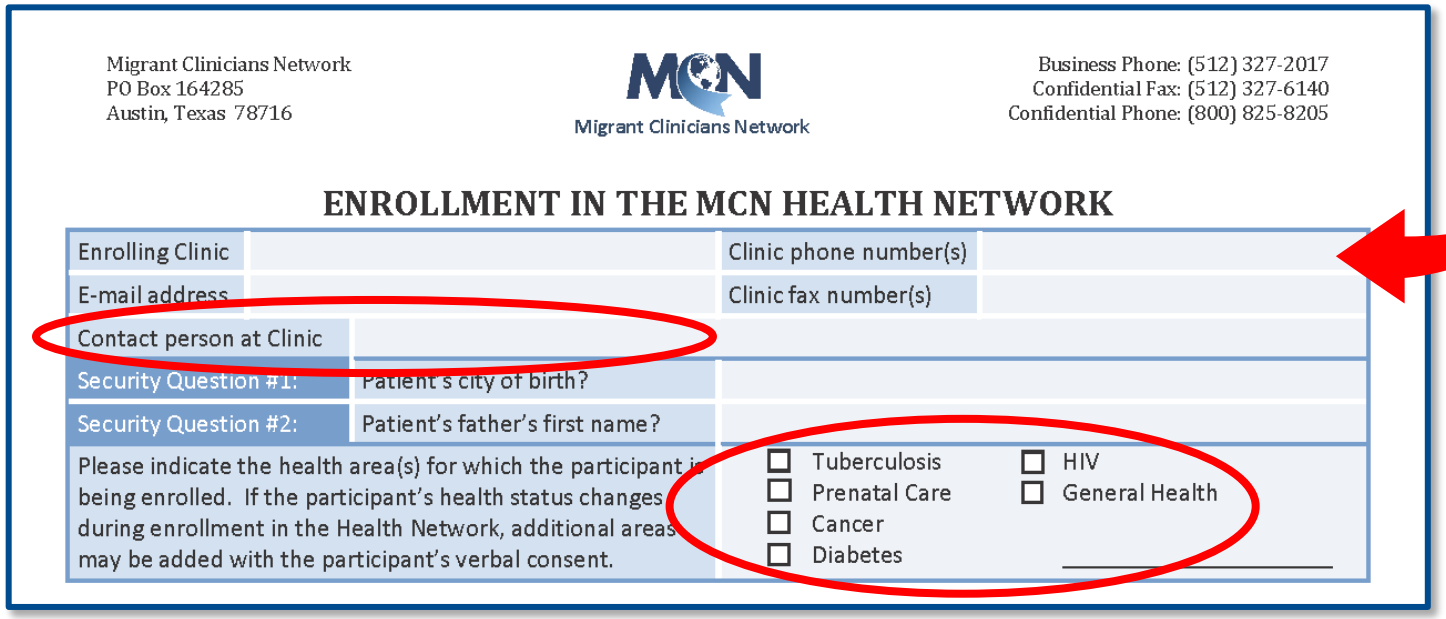
**Additional Contact:** Please list someone we can contact if we cannot reach you at either of the locations you provided. In doing this you give MCN permission to contact that family member or friend to assist you in receiving continued health care, which may require discussing your health condition(s) 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:** |

# Single Point of Contact at the Health Center

# Un solo punto de contacto en el Centro de Salud



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## ENROLLMENT IN THE MCN HEALTH NETWORK

| | | | |
|---|---|---|---|
| Enrolling Clinic | | Clinic phone number(s) | |
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| Contact person at Clinic | | | |
| Security Question #1: | Patient's city of birth? | | |
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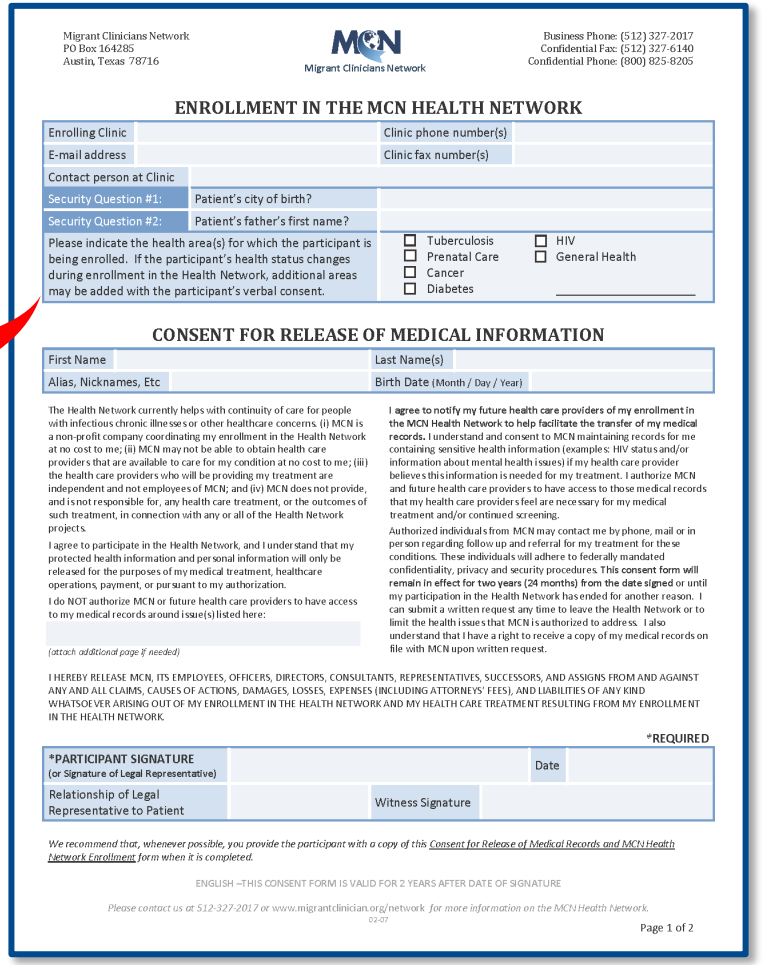
| Please indicate the health area(s) for which the participant is being enrolled. If the participant's health status changes during enrollment in the Health Network, additional areas may be added with the participant's verbal consent. | ☐ Tuberculosis ☐ Prenatal Care ☐ Cancer ☐ Diabetes ☐ HIV ☐ General Health _____ | | |



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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)*

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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.

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*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.*

02-07

Migrant Clinicians Network

MCN

**Formato de concentimiento para la red de salud**

***Health Network Consent***

**Cuidado prenatal / Atención posparto**

***Prenatal Care/Postpartum Care***

Yo/I _____ _____

Nombre del paciente / *Name of patient* Fecha de nacimiento / *Date of birth*

*Doy mi consentimiento para que el programa, Health Network, piden, retengan y envíen mis expedientes médicos para fines de coordinación de la atención médica durante y después de mi embarazo por el tiempo que necesite atención. Entiendo que puedo pedir en cualquier momento no necesitar asistencia y poder dejar de participar sin afectar el cuidado que recibiré.* / I give my consent for Health Network to receive and send my medical records to any medical provider during and after my pregnancy for the time I need attention. I understand that at any moment, if I no longer need assistance, I can stop participating without it affecting the health care services I receive.

_____ _____

Firma/ *Signature* Fecha de Firma / *Date of Signature*

_____

Fecha de caducidad / *Expiration Date*

_____ _____

Firma de Testigo / *Signature of Witness* Fecha de Firma del Testigo /*Signature of Witnessing*

Un contacto el los EEUU que siempre sabrá del paciente con quien Health Network se puede comunicar/ *A contact person in the United States with whom Health Network can communicate who will always know the patient's location.*

_____ _____

**Nombre del contacto / *Name of contact*** **Telefónico o correo electrónico / *Phone # or email***

*Para que este formulario de consentimiento pueda ser vigente, toda la información solicitada DEBE ser incluida/ *So that this consent form can be valid, all requested information MUST be included.*

**Para el proveedor de servicios de salud / *For the health care provider.***

**Medical reason to request continuity of care support from Health Network:**

**Health care services required by the patient:**

Please attach all medical records (screening results, hospital discharge plans, lab results) to this consent.

Migrant Clinicians Network

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**Health Network Consent**

**(Infant Program)**

Yo/I _____ _____

**Nombre del paciente / Name of patient** Fecha de nacimiento / Date of birth

*Doy mi consentimiento para que el programa, Health Network piden, retengan y envíen los expidientes médicos de mi niña/o para fines de coordinación de la atención médica durante el tiempo que ella/el necesita atención/* I give my consent for Health Network to request, hold and send my child's medical records to any medical provider who may provide her/him with medical care.

_____ _____

**Firma / Signature** **Fecha / Date**

_____

Fecha de caducidad / Expiration Date

_____ _____

**Firma de la persona que testifica el consentimiento / Signature of Person Witnessing Consent** **Fecha / Date**

Un contacto el los EEUU que siempre sabrá del paciente con quien Health Network se puede comunicar/ A contact person in the United States with whom Health Network can communicate who will always know the patient's location.

_____ _____

**Nombre del contacto / Name of contact** **# telefónico/ correo electrónico / Phone #/email**

*Para que este formulario de consentimiento puede ser vigente toda la información solicitada DEBE ser incluida/ So that this consent form can be valid, all requested information must be included.

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**Medical reason to request continuity of care support from Health Network:**

**Health care services required by the patient:**

Please attach all medical records (screening results, hospital discharge plans, lab results) to this consent.

Migrant Clinicians Network

MCN

# Health Network General Consent
# Formato de concentimiento general

Yo/I _____ _____
Nombre del paciente / Name of patient — Fecha de nacimiento / Date of birth

*Doy mi consentimiento para que el programa, Health Network, piden, retengan y envíen mis expedientes médicos para fines de coordinación de la atención médica por el tiempo que necesite atención. Entiendo que puedo pedir en cualquier momento no necesitar asistencia y poder dejar de participar sin afectar el cuidado que recibiré.* / I give my consent for Health Network to request, receive and send my medical records to any medical provider for the time I need attention. I understand that at any moment, if I no longer need assistance, I can stop participating without it affecting the health care services I receive.

_____ _____
Firma/ Signature — Fecha de Firma / Date of Signature

_____
Fecha de caducidad / Expiration Date

_____ _____
Firma de Testigo / Signature of Witness — Fecha de Firma del Testigo /Signature of Witnessing

Un contacto el los EEUU que siempre sabrá del paciente con quien Health Network se puede comunicar/ A contact person in the United States with whom Health Network can communicate who will always know the patient's location.

_____ _____
Nombre del contacto / Name of contact — # telefónico o correo electrónico / Phone # or email

*Para que este formulario de consentimiento pueda ser vigente, toda la información solicitada DEBE ser incluida/ So that this consent form can be valid, all requested information must be included.

---

## Para el proveedor de servicios de salud / For the health care provider.

**Medical reason to request continuity of care support from Health Network:**

**Health care services required by the patient:**

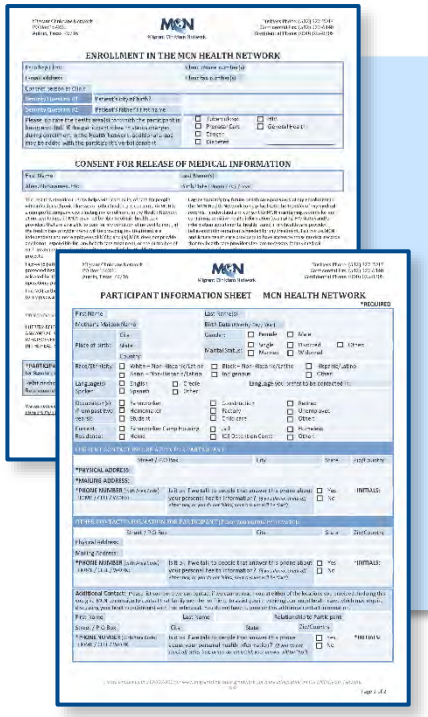
**Please attach all medical records (screening results, hospital discharge plans, lab results) to this consent.**

# These enrollment resources are available:
# Estos recursos para el registro están disponibles en:

## www.migrantclinician.org/health-network/enrollment

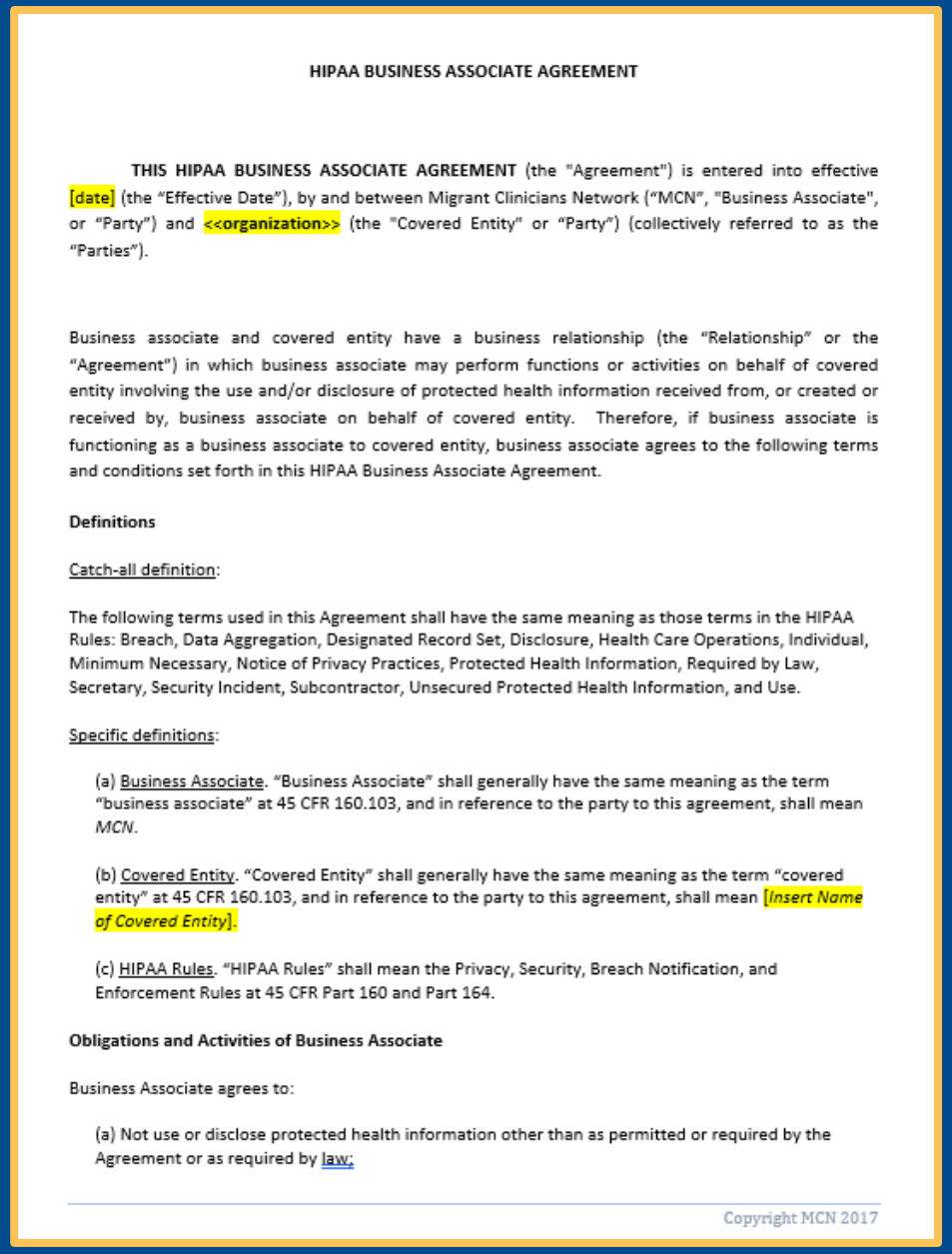

**Informational Videos about Health Network**

**Vídeos informativos sobre la Red de Salud**




**Download Enrollment Packets in English, Haitian Creole, Portuguese and Spanish**

**Descargue los paquetes para registrarse en inglés, criollo haitiano, portugués y español**



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

## Business Associates Agreements

Required to be compliant with HIPAA

## Acuerdos de asociación

Se requiere para cumplir con las regulaciones de HIPAA

# Recap of Health Network Enrollment Criteria

# Resumen de los criterios utilizados para el registro de pacientes a la Red de Salud

**1 Patient is**:

- ✓ Mobile / Migrant
- ✓ Thinking of leaving area of care

**1 El paciente es:**

- ✓ Móvil / Migrante
- ✓ Piensa dejar el área en la que recibe cuidados de salud

**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

**2 El paciente tiene:**

- ✓ necesidad de que se le haga seguimiento a los cuidados de salud
- ✓ un número de teléfono del trabajo o de un familiar
- ✓ un formulario de consentimiento de MCN firmado
- ✓ una clínica base o clínica en la que se registró como paciente

# Steps to Maintaining a Patient in Care

# Pasos para mantener al paciente bajo los cuidados de la salud

# MCN's Health Network Associate:
# Asociado de la Red de Salud de MCN:

- ✓ Contacts patients on a scheduled basis
- ✓ Contacta a los pacientes de forma programada

- ✓ Contacts clinics monthly, other healthcare clinics receive updates as requested, and when treatment has completed.
- ✓ Contacta a las clínicas mensualmente. Ofrece actualizaciones a otras clínicas cuando lo solicitan y cuando se ha terminado el tratamiento.

- ✓ Assists patients in locating clinics for services and resources
- ✓ Ayuda a los pacientes a localizar clínicas para obtener servicios y recursos

- ✓ Reports back to the enrolling clinic and notifies them of final outcomes
- ✓ Informa a la clínica base o de registro y les notifica de los resultados de las gestiones.

# The Patient's Role…

# El papel del paciente…

As many
phone numbers
as possible

Proveer tantos
números de teléfono
como pueda

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

---

**Informar a los asociados de la Red de Salud (HN) de cualquier cambio del número de teléfono o de la dirección y ponerse en contacto con el personal de HN al llegar al nuevo lugar de destino**

**Continue treatment as long as indicated by their physician**

---

**Continuar con el tratamiento por el tiempo que el doctor se lo pida**


Over 15,100 total
HN enrollments
Más de 15.100
participantes (pacientes)
registrados en
el programa de HN


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

**Más de 3.000** clínicas en E.E. U.U. y más de 114 países se han comprometido a eliminar la movilidad como obstáculo en la continuidad de la atención en salud

El programa de la Red de Salud de MCN comenzó inicialmente como una red para prestar apoyo a los pacientes con tuberculosis

**Se han recomendado 2,125 tratamientos**

(26 casos de TB resistente a múltiples medicamentos; 65 casos de TB resistentes a al menos un medicamento)

*37 fallecidos*

---

MCN's Health Network program began initially as TB NET

**2,125 Treatment Recommended**

(26 MDR; 65 resistant to at least one drug)

*37 deceased*

**Se les hizo seguimiento a 2.088 pacientes por TB activa**

211 pacientes desaparecieron sin continuar con la labor de seguimiento

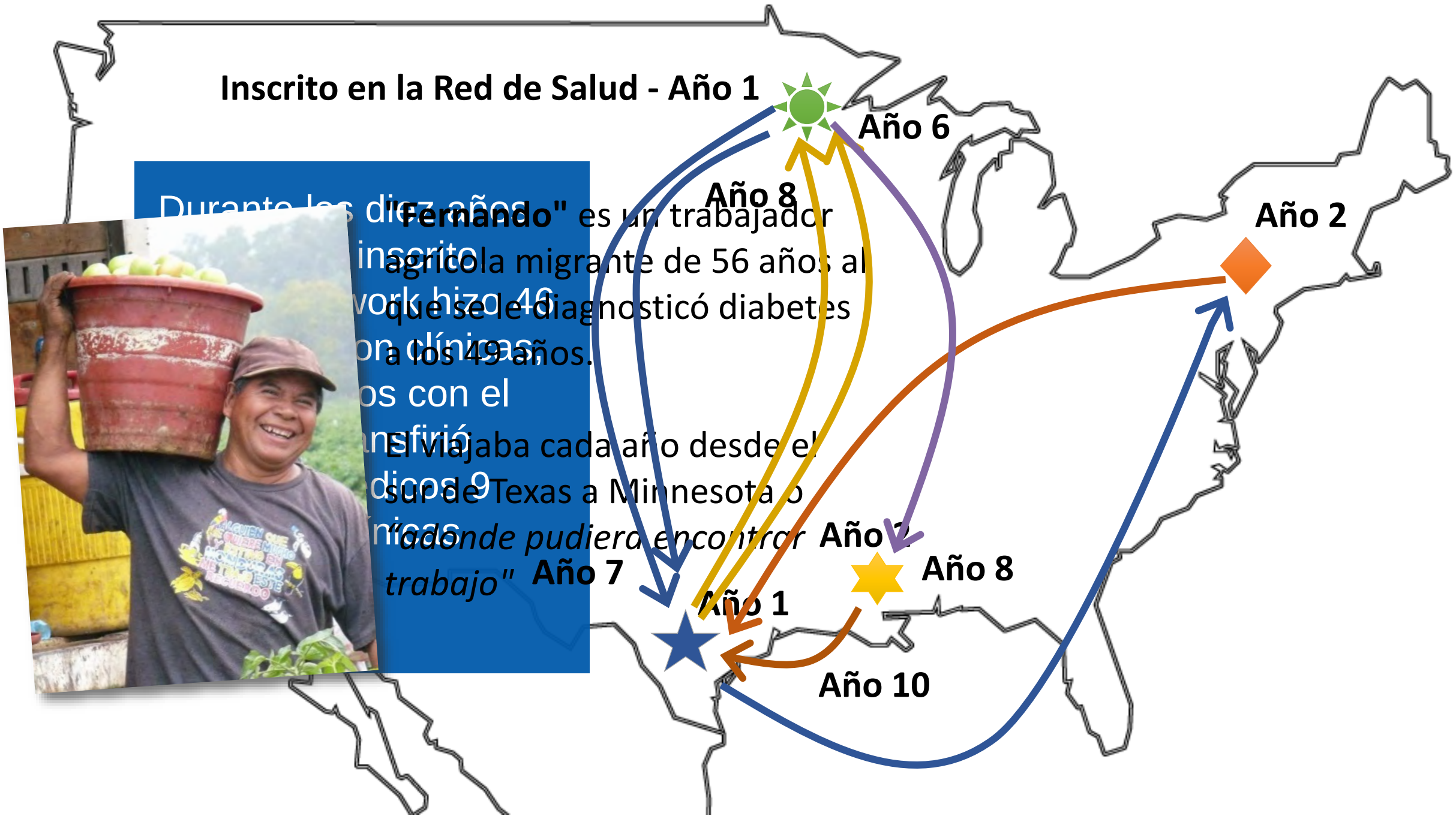
106 pacientes rechazaron el tratamiento

**2,088 Followed for Active TB**

211 lost to follow up

106 refused treatment


1,771 Complete Treatment
84.8%
1.771 Pacientes completaron
todo el tratamiento



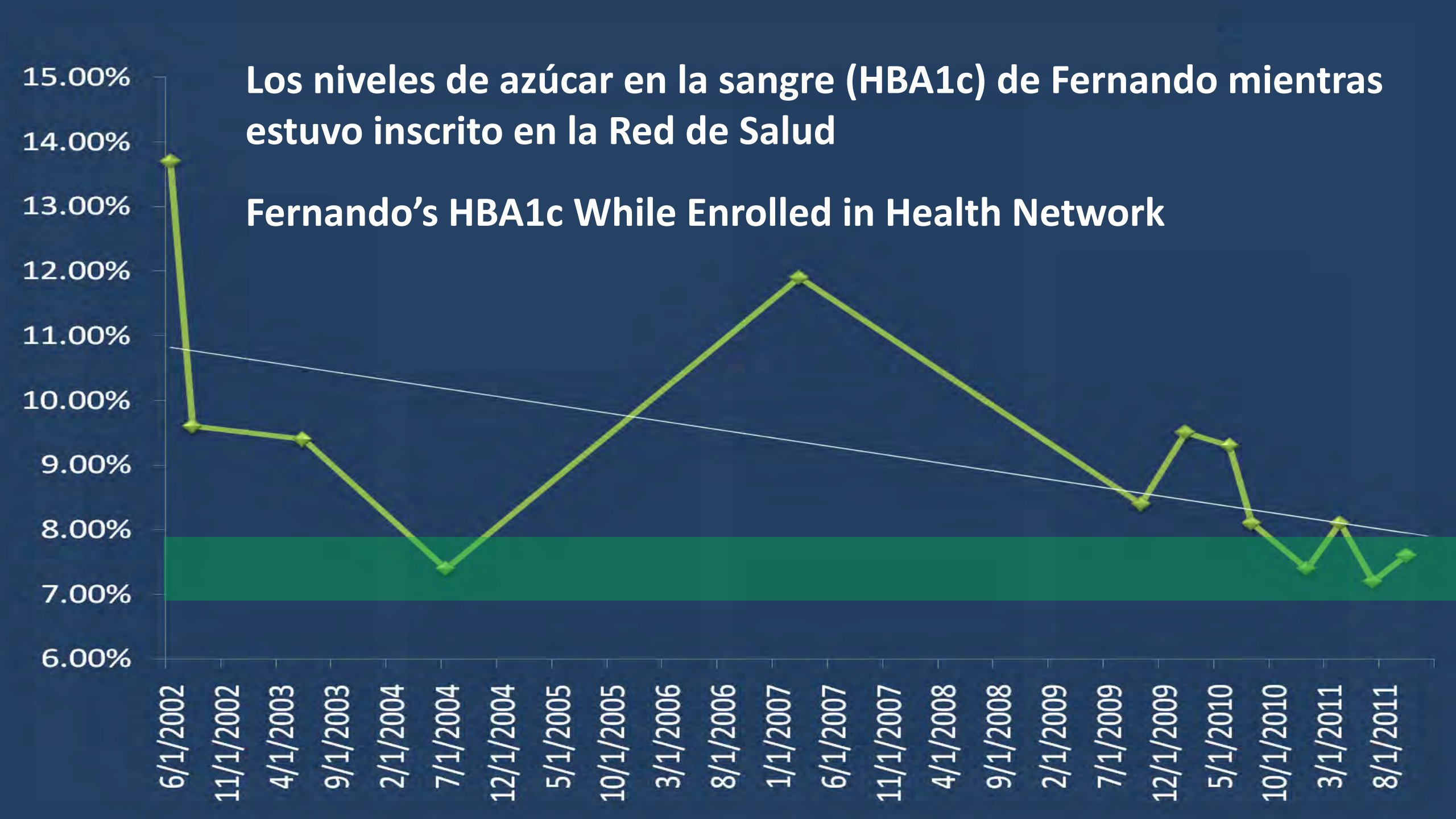

Durante los diez años
inscrito
work hizo 46
on clínicas
os con el
nsfirió
dicos 9
nicas

**Fernando"** es un trabajador agrícola migrante de 56 años al que se le diagnosticó diabetes a los 49 años.

El viajaba cada año desde el sur de Texas a Minnesota o *"adonde pudiera encontrar trabajo"*

# Los niveles de azúcar en la sangre (HBA1c) de Fernando mientras estuvo inscrito en la Red de Salud

# Fernando's HBA1c While Enrolled in Health Network




## ¿Cómo puede la Red de Salud de MCN tener una tasa de éxito tan alta en 114 países?

- Los navegadores de casos multilingües/multiculturales que utilizan múltiples técnicas de comunicación.

- Los navegadores de casos de MCN hablan varios idiomas (inglés, español, criollo haitiano, francés y portugués, y utilizan Language Line para todos los demás)

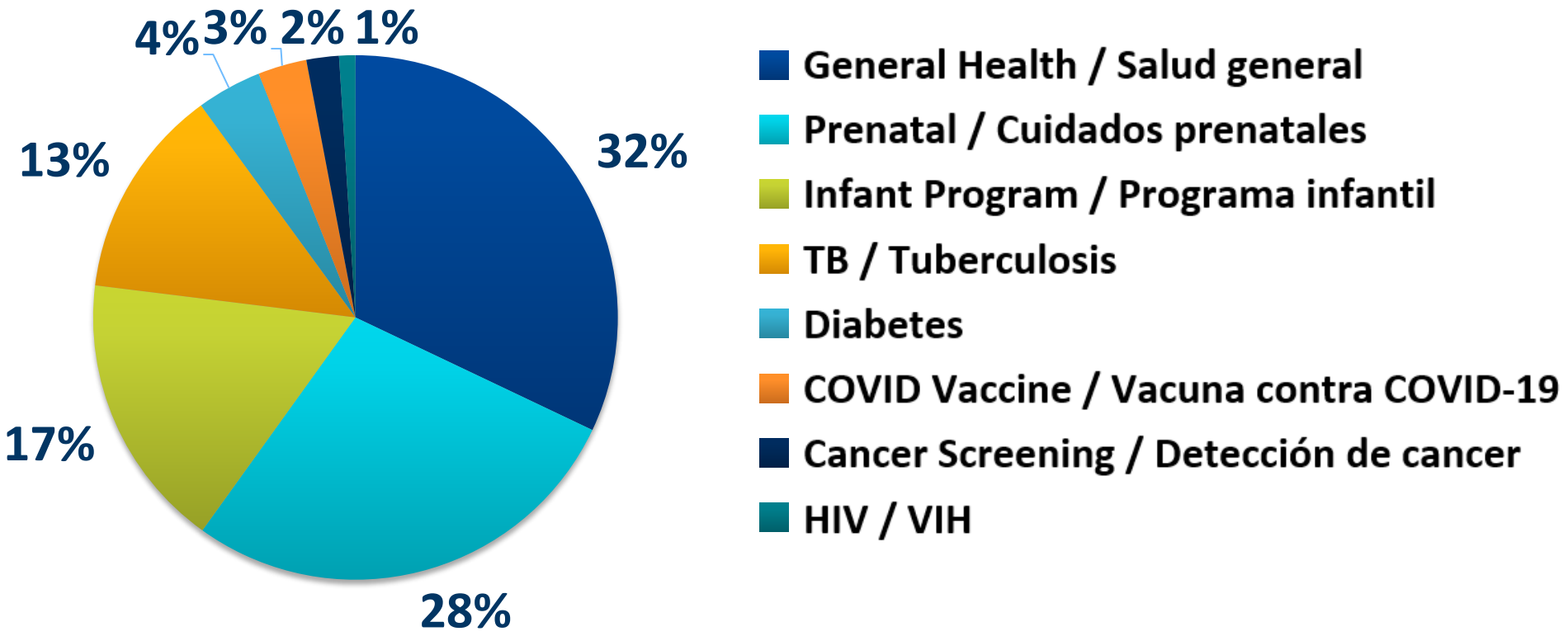
## How Can MCN's Health Network Have such a high completion rate to 114 countries?

- 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)

# La Red de Salud de MCN / MCN Health Network

## Porcentaje de inscripciones en la Red de Salud según el primer diagnóstico
## Percent of Health Network Enrollments by Primary Diagnosis




UNICEF/ECU/2020/Arcos

# ¿Qué es el programa SCAN?

# What is the SCAN Program?

- **SCAN** es la abreviatura en inglés de **Red de acceso a la atención especializada**

El objetivo principal de SCAN es asistir en la coordinación de servicios de salud para pacientes menores de 18 años en áreas de subespecialidades pediátricas.

- **SCAN** stands for the **Specialty Care Access Network**

SCAN's primary goal is to assist with the coordination of pediatric patients into sub-specialty care.

# Referencia al programa SCAN

# Referral into the SCAN program

- ✓ Una clínica, un programa, una organización o un miembro del equipo de SCAN puede darse cuenta de que el paciente necesita ser atendido por un subespecialista pediátrico.

- ✓ La Red de Salud orienta y les dice a los pacientes cómo completar el paquete de inscripción.

- ✓ A clinic, program, organization or SCAN member identifies a patient with sub-specialty need

- ✓ Health Network helps to guide and instruct on how to complete the enrollment packet.

UNICEF/ECU/2020/Arcos

# Referencia al programa SCAN

# Referral into the SCAN program

El objetivo de SCAN es tener preparada con antelación la información necesaria para que haya continuidad en los cuidados de salud y coordinar dichos cuidados con un miembro del equipo de SCAN:

- Información del paciente
- Formulario de consentimiento firmado
- Resumen de la visita del paciente (si el paciente ha sido anteriormente atendido por un proveedor de salud)
- Próximos pasos

SCAN's goal is to have the following information prepared to help with the continuation of care and coordination with the SCAN Team Member:

- Patient's information
- Signed consent form
- Patient Care Summary (if the patient has already been seen by a previous provider)
- Next Steps

UNICEF/ECU/2020/Arcos

# Referencia al programa SCAN

# Referral into the SCAN program

- ✓ Si es necesario, el coordinador de atención del paciente de SCAN se pondrá en contacto con la familia para hacerles una presentación del programa y completar la inscripción del paciente.
- ✓ El coordinador de atención del paciente informará a la familia quien es el miembro apropiado de SCAN a contactar y esta persona de contacto se encargará de solicitar al proveedor de salud el resumen de la visita del paciente.

- ✓ The SCAN Patient care coordinator will contact the family to introduce the program and complete patient enrollment if needed.
- ✓ Patient care coordinator will identify the appropriate SCAN Member to contact and send out a request for assistance with the patient's summary.

UNICEF/ECU/2020/Arcos

# Ejemplo del resumen de inscripción del paciente.

**ABCD es una niña de 5 años nacida en Guatemala con un retraso en el desarrollo que incluye el habla e independencia para ir al baño.**

La niña llegó a **Welcome Center** en Tucson el 01/01/2021.

Su madre habla español con fluidez y sabe leer y escribir. Hablé con la madre para referir a la paciente y ella estuvo de acuerdo. La madre también me dijo que en el pasado le dijeron que la niña podría tener microcefalia. La mandaron a hacerle unas  pruebas a la niña, pero la madre nunca la llevó.

# Example of Patient Enrollment Summary

**ABCD is a 5-year-old girl born in Guatemala with Developmental Delay to include Speech and Toileting.**

The child arrived at **Welcome Center** in Tucson on 01/01/2021.

Her mother speaks the Spanish language fluently and is literate. I talked with the mother about the referral and mom agreed: Mom also told me that in the past she was told that the child might have microcephaly, and was sent for tests, but mom never took her.

## Ejemplo del resumen de inscripción del paciente.

La madre dice que básicamente la niña no ha recibido ningún cuidado de salud. Hoy le he hecho a la niña una evaluación EPSDT (por sus siglas en inglés) o control de la niña sano completo.

El examen físico es normal: la altura está en el percentil 50, el peso en el percentil 25. Incluiré el formulario EPSDT y la tabla de crecimiento cuando envíe el historial que tengo. La niña no habla y usa pañales, no puede ir al baño sola en lo absoluto.

## Example of Patient Enrollment Summary

Mom says the child has had, essentially, no health care. Today I accomplished a complete EPSDT (Well Child Evaluation) on the child.

The physical exam is normal: height in 50%ile, weight in 25%ile: I will include the EPSDT form and growth chart when I send the records I have. The child has essentially no speech and uses diapers – does not toilet at all.

# Ejemplo del resumen de inscripción del paciente.

**La familia viaja hoy mismo a California.** Tengo la dirección y el número de teléfono de su familia patrocinante. La madre ha firmado la referencia a MCN. Seguiré las instrucciones de Luis y veré si puedo enviarle los documentos por un correo electrónico seguro. Si no, utilizaremos un fax seguro para enviarlos.

**Las posibles necesidades de seguimiento que he identificado son:**

- Pediatra
- Neurólogo Pediátrico
- Terapia de lenguaje
- Terapia ocupacional

# Example of Patient Enrollment Summary

**The family is traveling to California later today**.
I have the address and telephone number of their sponsoring family. Mom signed the referral to the MCN. I will follow Luis' instructions and see if I can get the documents to you in a secure email. If not, we will use a secure fax to send them.

**The possible follow-up needs that I have identified are**:

- Pediatrician
- Peds Neurology
- Speech Therapy
- Occupational Therapy

# ¿A quién se le envía la referencia en SCAN?

# Who do you send the referral to for SCAN?

**Coordinadora de atención al paciente de SCAN - Camila Velásquez**

- Completará la referencia
- Identificará al miembro apropiado de SCAN a quien puede contactar
- Continuará la coordinación de la atención al paciente con el miembro del equipo de SCAN

**Patient care coordinator for SCAN – Camila Velasquez**

- Will complete the referral
- Identify the appropriate SCAN team member to contact
- Continue patient care coordination with SCAN Team member

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Get updates from the field

Obtenga actualizaciones desde el campo


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Asista a nuestra gran variedad de capacitaciones

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# Contáctenos

- Teléfono de la Red de Salud : **800-825-8205** (U.S.)
- Fax de la Red de Salud : **512-327-6140**
- Página de Internet de MCN: http://www.migrantclinician.org/

Si tiene más preguntas sobre el programa o tiene necesidades adicionales sobre la capacitación y asistencia técnica, también puede ponerse en contacto con:

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

**Por favor, recuerde enviar la evaluación.** Es necesario someter la evaluación si desea recibir un certificado de asistencia o un certificado de educación continua en enfermería.

Usted puede tener acceso a la evaluación al escanear el código QR, al hacer clic en el enlace que aparece en el chat, o espere a que se cierre la sesión y la evaluación se abrirá automáticamente en una nueva ventana. ¡**Gracias!**

**Please remember to submit the evaluation.** Submission is required if you would like to receive a Certificate of Attendance or a Certificate of Continuing Nursing Education.

You can access the evaluation by scanning the QR code, clicking on the link provided in the chat, or wait until the session is closed and the evaluation will automatically open in a new window.
**Thank you!**

En la esquina superior derecha de la evaluación, puede seleccionar el idioma en el que le gustaría completarla.


On the top right-hand corner of the evaluation, you can select the language you would like to complete it in.