A HEALTH REFERRAL SYSTEM FOR MIGRANTS

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An effective referral system is an important link in providing continuity of care to patients. The concept of continuity is accepted by clients and health workers, but its successful implementation requires a degree of sophistication. For more than 20 years health workers providing services to migrants have tried to cope with this problem.

Although migrant farmworkers are sometimes pictured as itinerants of the soil, wandering about aimlessly, the majority of workers who follow the crops migrate because they must. They have few alternatives since the existence of this group of workers is both a response to and the result of technical change in agricultural practice.

Continuity of Care

Cultural bias and naivete have contributed to the idea that continuity of health care for migrants is an "impossible dream." Some health professionals who worked with migrants knew, however, that their mobility was more structured than aimless. They also knew that the "health service community" of a migrant included many counties and States as the migrant moved about seeking work (*1*).

Delivery of health services to migrant families is often complicated by the complexity of the health delivery system. When provision of care involves a number of different agencies with different philosophies and policies, communication and coordination become more difficult. Artificial boundaries that are so frustrating to health workers and little understood by clients create barriers to the migrants' obtaining health care and interfere with its continuity. This situation occurs when migrants move over county or State lines seeking work. It also occurs when the Indian population flows on and off reservations, moving between health services provided by the Indian Health Service on the reservation and the services provided by the county where the families migrate for farmwork.

The Migrant Health Act of 1962 (PL 89-692), now extended to June 30, 1973, enabled the National Government, through the Public Health Service—Health Services and Mental Health Administration—to work with interested public or voluntary groups throughout the nation to upgrade health services and health conditions of migrant workers. The interagency referral system established by the Migrant Health Program has proved to be a useful tool in providing continuity of care for migrant families. Some of the principles involved in implementing this referral system could well be applied to other health care delivery systems to improve patients' care (*2*).

Expediting Referrals

The migrant is considered to be an individual possessing dignity, pride, and intelligence, who is capable of making a significant contribution to his own care. An important part of the referral process is educating the patient by helping him to comprehend the nature of his health problems and what action is desirable and necessary. The chances that a referral will be completed are better if the patient carries a complete copy of the referral form with him; this copy, of course, is in addition to the one sent to the service agency where he is referred.

Referral communications are most effective if confined to health matters of considerable importance or to conditions that require clear instructions from the referring agency to the re-

ceiving one. Multiple copies help expedite communication between all interested parties. Perhaps the most essential feature of the whole referral process is the partnership that is necessary between the migrant worker, the referring agency, the receiving agency, the migrant health program, and the community.

Families treated in migrant health centers often need additional health instructions and some assistance in adapting these instructions to their home settings. In the case of families of Indian farm laborers living off the reservation, a plan has to be formulated for nursing visits to the home. County health department nurses in a generalized program can often assume the responsibility for such home nursing visits. Communication can be started on the basis of an interagency referral form prepared by the Indian Health Service nurses before the family leaves the reservation. If there is some urgency, a telephone call can be made by the IHS nurse to expedite service.

Case History

The referral mechanism is a relatively simple procedure in theory. In actual practice it is often full of obstacles. The following case history provides an example of both the difficulties and the possibilities of interagency referral.

Alex, the patient referred, was the son of an Indian migrant farmer working in the cotton and melon fields of the Arizona Valley and the Cotton Bowl. He was the third child born to a young Indian family that lived in a remote desert area near the reservation—at first in a labor camp and later in a small house which the father built in Hidden Valley, a sprawling community of perhaps a dozen adobe huts, a general store, and a tavern. Born with a cleft lip and palate, Alex was referred for nursing services by the Indian Health Service through the Migrant Interagency Referral System.

The referral form, in addition to identifying information about the family and its location, gave the reason for referral:

Infant has cleft lip and palate. Was seen at Crippled Children's Hospital for evaluation. To have repair on lip in 2 weeks. Family will be notified regarding date. Father is a farm worker. Mother is in poor health with gastrointestinal problems and stricture of the esophagus. Infant needs intensive nursing visits for his special needs, especially in relation to feeding.

A report from the Plastic Surgery Clinic gave the following information:

This boy was born 11-12-70 and weighed 5 lbs. 10 oz. He demonstrated at birth a left unilateral incomplete cleft lip of modest width. There is associated deformity of the ala and floor of the nose. The alveolar arch shows a notching but there is continuity. There is evident hypoplasia of the left face of the maxilla. The palate shows a cleft involving the uvula and a submucous cleft coming forward through the entire soft palate. The palate is somewhat short. He is to return in two weeks for surgical care.

A birth defect has always been a serious matter to the Pimas, as shown by the extent of the ancient practice of infanticide—taking deformed babies to the arroyo to die. Even with the changing times, having offspring, especially a son, with a congenital defect was a bitter blow to this young couple. Their disappointment was apparent in spite of their attempts to hide their true feelings as plans were initiated for Crippled Children's Services. Persuading the family to plan for long-term treatment and arranging it was time-consuming, as the family required considerable support to cope with the prescribed treatment.

When the visiting nurse came to Alex's home, she found the family's poverty and lack of resources almost overwhelming. The small cookstove was not adequate to heat the large room occupied by the five members of the family. The house, of the "sandwich" type—that is, built with alternating strips of wood and adobe—was still under construction; the floors were mud. The house, when completed, would be airtight and warm, but in the meantime it was cold and drafty. Blowing dust, an ever-present problem on the desert, made it more difficult to keep the infant boy clean.

Then, too, the inevitable question had to be dealt with—Why? Why did it happen? The visiting nurse tried to help Mrs. O to understand by telling her:

Your infant's face has the chance for growing and developing normally. The cleft is not due to something missing; rather it is due to something that has not joined together during early development, and there is a way to repair this. . . . We are not certain why this occurs, but one in every 600 to 700 children have this condition. Experience at correcting the deformity shows that with your help your child can be expected to be no different than other children.

Alex was put on Similac formula soon after his birth when Mrs. O was unable to supply breast milk. It was continued at considerable sacrifice for the family even though a less expensive formula could have been substituted. Providing the formula was one of the mother's main concerns since her husband would soon be job hunting again when the plowing was finished.

The county nurse and the nutritionist from the Nutrition Action Program collaborated in planning and scheduling home

visits so that rather intensive home visits could be made to supervise Baby Alex's care and also so that a program of treatment could be begun for Mrs. O.

Feedback from the hospital and clinic was very helpful:

> Patient was in today with baby who has a beautiful plastic repair on lip and is also gaining weight. Car broke down, so cannot make return appointment to Crippled Children's Hospital, March 15, at 10:45 a.m. He can be brought to Phoenix by reservation bus if appointment can be made for Tuesday or Thursday. They will need transportation to the reservation to meet the bus.

This kind of communication among the agencies involved in treatment (Indian hospital and field service, county health department, Crippled Children's Services, and State health department) made it possible to help the family get to a Phoenix hospital 100 miles away and enabled the nursing consultant to meet the mother at the hospital when Alex was brought in for his appointments.

The nursing consultant's accompaniment of the mother for Alex's first postoperative examination provided her with support. The consultant was also helpful in interpreting instructions to the family and to the community health nurse visiting the home.

While waiting for the child to be seen, the nurse had an opportunity to talk with the mother about her own health problems. Mrs. O said that she had been hospitalized for several months when she was 16, but that her condition had not improved. During pregnancy her symptoms (gastrointestinal and inability to swallow) became more pronounced, and her condition was diagnosed as achalasia. She was encouraged to have additional diagnostic studies. Mrs. O was reluctant to leave her family at this time. Eventually, however, she was helped to arrange for hospitalization and treatment when her relatives agreed to keep the children and transportation was provided by a missionary living on the reservation.

Not all migrant families are this fortunate. Many children with crippling conditions have never received medical care. Others are not receiving consistent and adequate care after discharge from hospitals because of the lack of interagency communication through a referral system. Hospital nurses often are not aware of home conditions to which a child is being discharged, nor the problems the family will face following the child's discharge. The degree of success achieved in the case of Alex and his mother proves that interagency referral and dedication on the part of health workers can make continuity of health care a reality.

In an analysis of services in relation to contacts, the Florida Migrant Health Service Referral System has shown that over a 5-year period as many as 85 percent of all contacts with clients resulted in a health service being provided. Altogether, several thousand migrants were served through the referral system, and in some instances, the same migrants were served at widely separated locations. The participation of a migrant in his own referral indicates that however economically poor and socially depressed he may be, he will respond favorably to opportunities to obtain health care.

Conclusion

Lack of continuity of care is a problem that confronts all health workers and consumers of health care regardless of social class or economic status. And one of the most difficult problems in organizing health services for migratory farmworkers is in providing this continuity. Workers must often move to a new location before treatment has been completed. Referrals for health care from one area and one agency to another have been a useful tool in such circumstances, making continuity of care possible.

At the 1971 Migrant Health Conference in Florida, Holmes (*3*) suggested that the burden of proof rests with the system and not with the migrant. Health providers seem to have a "Lone Ranger" mystique about their roles. They see them only in terms of geographic responsibility, rather than in terms of migrant-patient responsibility.

Coles (*4*) and others dealing with the dilemma of migrants have called for health providers to try to develop empathy for the culture and ecology of the patient so that they will understand why events happen. Along the same line, the health provider needs to have empathy for his fellow health providers.

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