THE MIGRANT WORKER HEALTH RECORD--Why, How, What Problems?

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Agricultural migrants earn their living by seasonal work in the crops. Some move only within a State. Others move within or through a half-dozen States during a single crop year. They are not commuters who return to permanent homes each night. Instead they travel so far during each crop season that they must have living quarters for several weeks to several months at a time in each of several seasonal work areas.

The total migrant population includes single males recruited from outside the United States, chiefly "braceros" from Mexico. These foreign workers are an easily identifiable group, with health and other protection provided under international agreements.

The domestic migrant population, on the other hand, includes men, women and children. When work is plentiful, all family members may work in the fields. This is the group that is of chief concern to health workers, in part because of their non-resident status and lack of health and other protection afforded most citizens.

Most domestic migrants belong to social or economic minority groups. They include low-income Southern Negroes and whites, citizens from Texas and Puerto Rico whose usual language is Spanish, and Indians from both northern and southwestern reservations. Many have had limited formal education. Some of the older adults have had none.

1/ This paper was prepared for the New England Conference on Community Health Records Management on November 16, 1962, Boston, Massachusetts.

Surnames are essential for record purposes but surnames used by the same persons vary from time to time among some migrant groups. Among Southern Negroes, for example, Florida studies show that if there has been a legal marriage and there is no question of a child's paternity, the mother will give her child her husband's surname. For children born out of wedlock, on the other hand, the mother's surname is often used. The same child may bear several different names at different times, depending upon who is the mother's mate at the time by either legal or extra-legal marital arrangements. 1/

The use of nicknames is still another complication, particularly with the men. The entry of social security numbers on health records has been suggested for further identification. But some migrants have several different social security cards with different numbers; others have none.

Why an individual health record has evolved.

As migrants travel from place to place, they have the same kinds of illnesses and encounter the same types of mishaps other families are likely to face in the course of a year. A major difference is that when migrants obtain medical care, they get it from a variety of sources in a variety of places, and usually the places have little or no communication with each other concerning individual patients. A local outpatient clinic may even be unaware of the fact that the same person was actually their own patient in a previous year but possibly under a different name. The organizational "memory" represented by records kept in a single clinic, a single agency, or a single community is completely inadequate as an aid in assuring continuity of care to this group of people.

1/ "They Follow The Sun" and "On the Season." Florida State Board of Health, Jacksonville.

To cite an example, a prenatal patient who follows the crops northward from Florida to New York made her first prenatal visit to a health department clinic in Belle Glade, Florida. Her next visit was made to a hospital outpatient department on the eastern shore of Maryland, and her third to a local private physician in western New York State. Except for the little information the patient herself could tell them, none of the physicians or nurses who saw her during this pregnancy knew what others had recommended. Nor did any of them know the details of a previous delivery--a difficult one for which she received emergency care in an unspecified hospital in a town whose name she cannot now recall.2/

How the idea of an individual record to be carried by migrants evolved.

Local nurses in migrant work areas repeat stories of this kind over and over again. Migrant patients come in--there is no way of learning about their past history. Nor is there a way of learning for certain when they will leave or where they will go so that information can be sent ahead in advance of their next move. (Parenthetically, if information about future destination and time of leaving were available, there would still be a question as to its accuracy and as to where to send information. Would the health department be the appropriate place in the new community? Or the hospital outpatient department, if there was one? Just where might the patient be referred with some expectation that he would get the follow-up care needed?)

2/ Hypothetical case but many such cases could be documented.

Prenatal patients are not the only type with whom local nurses are concerned. Children sometimes receive their first injections in an immunization series; by the time the second is due, they have moved on. In each locality where they stop during a season, immunizations may be started over again, without knowledge of what has been done before.

Some localities offer diagnostic services for certain types of communicable disease. As a result, a single individual may have a number of chest-x-rays in a single season, or a number of blood tests. And each time he may move on to another job location before the results of the tests are known.

School teachers, as well as local nurses and physicians, complain that children suddenly appear in mid-semester with no record obtainable as to their school achievement, their physical health status, or whether they have had the examination and immunizations required for school entrance.

Experimental use of a record

About a dozen years ago, health workers in localities scattered widely over the Nation, confronted by the problem of inter-area communication complicated by the migrant's own difficulty in communicating with health professionals, conceived of a health record to be carried by the individual, or by the family, as a possible solution. A primary objective was to overcome the lack of continuity of services--identified as one of the greatest handicaps in the unsettled life of the migrant child and his family.

A few health departments in the Rio Grande Valley--the home-base area from which the largest number of migrants move--had long used record forms for all

their patients which stated on the cover - "Be sure to take this record with you when you move." Usually these were single-purpose records--one form for immunizations, one for prenatal care, and so on. Accordingly, a family that attended several clinics might be given several different records, of various shapes and sizes, each of which they were asked to carry with them.

The Palm Beach County Health Department in Florida approached the matter in another way. At the time the Children's Bureau first financed a special migrant project in the county, the health department designed a comprehensive family record to be carried by the mother in an impressive green plastic folder. Sheets for each member of the family were stapled together and inserted in the folder. One season's experimentation demonstrated that little or no use was made of the information on the records while the migrants were away from their "home" county. Some families discarded the records en route and used the folder for other purposes.

In Colorado a bright orange-red folder was developed with pages for records on each family member. California also developed a multipurpose record for all family members similar to the one in Colorado.

Several East Coast States, on the other hand, agreed one year to share in the experimental use of a simple card--about one-third the size of a postal card. On one side was space for identification and records of immunization and screening for tuberculosis and venereal disease. The reverse side was left blank for entering various other types of clinical information.

Still other public and private groups used forms they themselves developed, forms distributed by drug companies, or forms "borrowed" from other localities.

Evolution of record distributed by the Public Health Service

During 1957 and 1958, the Public Health Service accumulated samples of many of the records then in use. In discussions with State and local public health workers and private physicians, they sought some agreement on both the form and the content for a record to be carried by individuals, or by the migrant worker or the mother for the entire family.

The cover of the personal health record finally developed has space for a person's name, home address, sex, birthdate or age. A note in English and in Spanish advises the person to whom the record is issued to show it whenever he goes to a doctor or a nurse. After a year's experimentation with the form, a note addressed to physicians and nurses was added on the cover, requesting them to enter pertinent information and return the record to the bearer.

The remainder of the form contains spaces for record of immunizations, laboratory tests and results, obstetrical history, and important clinical conditions. For the two latter items, space is also included for the name and address of the person making the entry.

The forms are 10½ by 4 inches. Folded, they can be carried in a billfold, pocket, or a woman's pocketbook. For durability, the record is printed on heavy paper with high rag content.

Testing of record

During the spring of 1958, the record was issued to migrant family members who attended a special clinic in Laredo, Texas. The clinic was to help them prepare for their annual migratory trek. About 150 persons participated. One year later, when the migration cycle had been completed, a Spanish-speaking interviewer visited each of the families to determine--among other things--whether they still retained their record, what use had been made of it, and what value they attached to it.

About two-thirds of the persons who originially received the record could produce it a year later. The migrants reported varying experiences on the dozen-odd occassions when they reported presenting their record. Generally it was either kept by the physician or nurse to whom it was shown, or it was returned with a noncommittal response. Only in a single case did the record apparently serve the purpose for which it was intended--namely, to provide a health worker with information about an individual's past care in order to make it easier to serve his present needs effectively.

Although the health workers who originally issued the record were totally unaware of having communicated such a concept to the migrant patients, the follow-up interviews disclosed that migrants generally considered the health record important as an "identification card." Some believed, in addition, that it was a "passport" to free care or care at reduced rates because of their poor economic circumstances.

ASTHO recommendation

Discussion of health record forms was renewed at the 1960 annual conference of the Association of State and Territorial Health Officers. Conclusive evidence was lacking as to the effectiveness of a specific form for communication purposes. The health officers believe that the record prepared by the Public Health Service in cooperation chiefly with Michigan and Texas seemed generally acceptable in terms of its content, form, durability, and the ease with which its contents could be noted and additions made. The record seemed to them a fairly reasonable compromise between the single-purpose immunization or screening record, and the complex multi-purpose family record.

With these factors in mind, and with the feeling that uniformity is desirable since migrants are likely to be in many different places during a single crop season, the Association asked the Public Health Service to make the form available for nationwide use with domestic migrant families. Since 1960 about 1/4 of a million record forms were distributed by the Public Health Service upon requests received from State and local departments, State Migratory Labor Committees, the Rural Health Council of the American Medical Association, the Migrant Ministry of the National Council of Churches, the National Council of Catholic Women, the American Academy of Pediatrics, and many other groups and individuals.

What has been accomplished

The simple evaluation conducted during the 1958-59 crop season, involving a small group of Spanish-speaking families, indicated that a fairly large

proportion of migrants will retain, carry, and present a record form on suitable occasions--at least when a record is issued to them under circumstances where an obvious concern is indicated for each person as an individual and instructions to carry the record are specific. A similar limited study in California led to similar findings. About three-fourths of the families interviewed in California retained their records in good condition several months after issuance.

Neither study showed that the families themselves were generally aware of what the records were for, or exactly when they should be presented. Both studies provided evidence that physicians and nurses seldom--if ever--ask a migrant whether he has a record, or honor and use it if he presents one voluntarily. They are more prone to assume that he has no record, and to issue him one of their own, often with little or no instruction except to keep it carefully. This instruction may be followed to the letter--but the record will have little beneficial effect if it remains in a migrant's pocket, never asked for, and never presented!

Problems in developing widespread, effective use of the record

The Public Health Service has received many requests for supplies of the health record form. Information, however, is available at present only on requests--not on use.

Organizations employing seasonal farm workers on a few occasions have given copies of the record to their recruits, asking that the migrants go to their physicians for examinations and have the proper entries made before they leave

their homes in the spring. In view of the low economic level of migrant families, this is hardly realistic. Many migrant families have to have advances from their northern employers to pay for food and travel on their annual trek northward.

A major breakdown in the effectiveness of personal health records at the present time seems to be in the failure of health workers to ask for, and to make use of, a record that a migrant may carry with him. On the side of the migrant, there is usually a lack of understanding of just what is expected of him, and when, where, or to whom he should present his record.

Other apparent problems, as reported by State and local health workers, include:

1. The time consumed in making entries on another record, in addition to those kept for official purposes.

2. Where migrants represent only a part of the total patient load to assure that all migrants receive a personal health record may entail issuing such a record to every clinic participant. This represents a great deal of duplication since the official file record will suffice for residents.

3. If carried in a worker's pocket, the record may not withstand perspiration and ordinary wear and tear.

4. Interpretation of entries by physicians or nurses may be difficult. The name and address of the person filling in information may not have been entered, and there is no way of getting in touch with him for clarification.

5. Health workers generally show strong preference for a locally devised record form.

6. Agreement on the desirability of a single standardized form is fairly general. There is still no general agreement on what that form should be.

Summary

Domestic migrant workers number about one million in the United States. Most are seasonal farm workers who follow the planting and harvesting of crops from the Mexican border to Canada and return. They work in one-third of the counties of the United States. They are mostly uneducated and lack appreciation of health services. They could not be expected to understand or remember correctly any isolated health services they might receive in different areas.

Since they have at least as many health problems as any other population, they come to the attention of health personnel, who are at a disadvantage for lack of any record of previous treatment.

Health departments in various parts of the country attempted to institute the use of individual health records. These efforts developed independently of each other and follow-up revealed poor use of all of them.

The U.S.P.H.S. and the Children's Bureau were asked to develop a uniform record, for migrant use. This was accomplished by form PHS-3652. However, an intensive

follow-up study carried out in two states revealed that this Personal Health Record (P.H.R.) was not used by the workers or by the local health personnel. Many workers felt that the P.H.R. entitled them to free care and were disturbed to discover that it did not. The necessary constant effort by local health personnel to interpret the use of the P.H.R. was lacking. They complained of the time required to complete the P.H.R. plus their own records. They strongly preferred to limit recording to their own records. It proved difficult to get constructive suggestions from them as to a solution of the problem of health records for migrant workers.

There are many reasons favoring an individual health record. It is useful for patient safety against medication or injections harmful to an individual. It provides continuity of care and valuable basic data. It could be useful in research.