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GUIDELINES

REPORT OF WORK GROUP DISCUSSION OF

INTER-AND INTRA-STATE REFERRAL OF MIGRANT PATIENTS

Migrant Health, Health Services Organization Branch
Division of Medical Care Administration
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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PREFACE

The need for continuity of health care is accepted. The problem of providing continuity of health care for migrant farm worker families is complicated by their intermittent movement in pursuit of jobs. For more than 20 years, health workers have tried to cope with this problem in a variety of ways.

Since 1962, more and more communities have developed family health service centers and other systematic arrangements to extend community health care to migrants under the Migrant Health Act. These arrangements now provide migrants points of contact for obtaining health care in about 300 counties of the United States. This greatly enhances the possibility of providing migrants continuity of care through the systematic linkage of service as they move from one place to another for seasonal farm work.

A Work Group comprised of migrant health project staff members and consultants met in Washington, D. C. in April 1967 and in March 1968 to discuss the content of inter-area referral forms and the means whereby an inter- and intra-State referral system could be made effective. The following report summarizes the Work Group's conclusions.

The Migrant Health Program staff members deeply appreciate the assistance of many individuals and groups in preparing these guidelines. At the end of the 1968-69 crop year, the comments and suggestions of migrant health project workers throughout the country will again be sought to determine whether these general guidelines need further refinement.

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March 21 23, 1968
and
April 24 25, 1967

For a patient to achieve his greatest potential and to maintain his rightful place in society, continuity of care is essential to assist the patient and his family. One of the most difficult problems in organizing health services for migratory farm workers is the workers' high mobility. Therefore, referrals from one health agency to another prove highly important in strengthening continuity of care.

The recommendations on patient referrals contained in this report reflect the consensus of project representatives from all parts of the United States. Discussions were held in two separate meetings on April 24 25, 1967, and March 21 22, 1968. It was not within the scope of this group to specify the details of a referral system for the local level. The group believed, however, that certain principles should be stressed and a degree of uniformity practiced on a nationwide basis in order to improve continuity of care for migrants.

The Migrant as a Partner in Referrals

The work group discussions emphasized that the migrant worker is an individual with intelligence, dignity and pride. He is capable in the referral process, of making significant contributions to his own care. The agency initiating a referral does well to remember that one of the major elements in a referral is to involve the patient, thus helping him to comprehend the nature of his health problem, what action is desirable, and the importance of continuing care.

The chances of successful referral improve when the referring agency not only sends a report to the service agency in the patient's anticipated work area, but also provides the migrant patient with a suitable referral form for his own use. The patient's possession of this form will help him take more initiative in finding service when he arrives, and will aid him if he has to change travel plans and seek care from sources unfamiliar with his health situation.

The group strongly recommended that, in addition to the use of the referral form for follow up care, all project personnel -- physicians, nurses, administrators, community aides and others -- stimulate the use of the Personal Health Record (PHS 3562), which is designed for individual migrants to carry. This form is available from the Migrant Health Program, U.S. Public Health Service, and has been used successfully in many projects for several years.

Conditions Requiring Special Referrals

Discretion should be used in making referrals. They are most effective when confined to health matters of importance, or conditions requiring clear guidance from the referring agency. The inundation of agencies by large numbers of forms may disrupt services to patients urgently needing care.

Detailed referrals, including data on all pertinent health findings and past care received, in addition to the individual Personal Health Record, should be prepared when continuity of medical treatment and health supervision are especially important. The following examples illustrate such conditions and the type of data needed:

a. Migrants with diagnosis of tuberculosis. Indicate whether the patient is on drugs for treatment or prophylaxis, and whether adequate drug supply has been provided to cover the interval before the next stop.

b. High risk prenatals. Pre-teens or early teens; grand multiparas; mothers with histories of previous complications of pregnancy such as hypertension, toxemia, or bleeding; mothers with histories of abortions, miscarriages, or stillborn infants, infants born prematurely, or with congenital malformations or other special problems.

c. Migrants with histories of diabetes, nephritis, hypertension, epilepsy, developmental problems requiring supervision, or cancer.

Content of Referral Form

Effective referrals result from a workable system. This, however, does not necessarily require the use of a standard referral form. In general, whatever form is used, it is recommended that multiple copies be made in order to expedite communication with all concerned.

A referral form should include complete, concise, and explicit information. The Work Group offered the following items as their minimum recommendations for content:

A. Identifying information

1. Patient's full name, including nickname, if any, and woman's maiden name
2. Social Security number
3. Date of birth
4. Complete name of parent or guardian, if patient is a minor
5. a. Local address ____________________
   b. Permanent address ____________________

6. Name and permanent address of next of kin or person to be notified in case of emergency.
7. Name of crew leader

B. Additional identifying information as may be required.

C. Reason for referral and summary of care to date including name and address of examining physician.

D. Space for receiving agency's reply to referral by an attachment to be torn off, by letter or by other means.

Powerful Partnership

A partnership among the migrant worker, the referring agency, the receiving agency, the Migrant Health Program and the community is basic to the effective referral of migrants. Each partner has needs, and each has responsibilities. Some of the needs and responsibilities for the migrant worker, the referring agency, and the receiving agency are listed in the following table. Some of the included items are not directly related to health, but attention to them may facilitate meeting health needs.

NEEDS AND RESPONSIBILITIES IN THE REFERRAL PARTNERSHIP

The Migrant Worker

Needs to have:

1. Effective communication with the agencies serving him.
2. Recognition and acceptance as a worthwhile person.
3. Involvement in planning and implementing his own care.
4. Information concerning available community resources, including health services, family services, religious services and the availability of work, housing and food supplies in the work area.
5. Information on transportation, social activities and educational facilities.
6. Health instruction appropriate to his level of understanding.

The Referring Agency

Needs to have:

1. Adequate information about the patient, including personal identification, health needs, type of care given, and the proposed plan for future care.
2. Knowledge of services available at next location.
3. Awareness and understanding of patient's attitude.
4. Awareness and understanding of patient's ability to manage his personal affairs.
5. Cooperation of patient and family.

The Receiving Agency

Needs to have:

1. Complete identification of the patient.
2. Understanding of patient's attitude towards service.
3. Understanding of patient's needs, and reason for referral.
4. A source of information.
5. Significant non-health information.
6. Cooperation of patient and family.

The Migrant Health Program

Needs to have:

1. Good reporting from projects concerning referral activities and experiences.
2. Consensus among projects concerning objectives and procedures for improving continuity of care.
3. Understanding of the operation and requirements of the referral program in different areas.
4. Information about project changes so that directory of projects may be kept current.

NEEDS AND RESPONSIBILITIES IN THE REFERRAL PARTNERSHIP (Cont'd)

The Migrant Worker Has responsibilities to:

1. Seek information on the availability of health services.
2. Grant permission for necessary transmission of reports between agencies.
3. Assume responsibility for self and family in deciding source of care to use.
4. Participate, as he is able, in the provision and financing of his health care.
5. Keep appointments.
6. Make his needs known to professional workers.
7. Ask for *his* Personal Health Record when planning to move to a new area.
8. Present his Personal Health Record whenever he sees a physician or nurse.

The Referring Agency Has responsibilities to:

1. Determine the route or method of referral.
2. Tell the migrant worker (orally and in writing) about the nature of his referral and involve him in the plans.
3. Transmit information which will enable the receiving agency to help the patient, e.g. significant family data, name and address of examining physician, summary statement about health problems and results of care given to date.
4. Become familiar with the cultural background of the patient.
5. Meet immediate needs before attempting to persuade the patient about some future course of care.
6. Develop operating guidelines for the referral program in the agency and in the local area.
7. Orient staff to referral system.
8. Record and evaluate experiences in order to improve referral system.
9. Promote the use of Personal Health Record.

The Receiving Agency Has responsibilities to:

1. Locate the patient as soon as possible after a referral form is received since a referral indicates that care of a condition is urgent or needed.
2. Plan with the patient for immediate and continuing care.
3. Verify availability of local health services.
4. Acknowledge receipt of the referral to the sending agency.
5. Advise referring agency of follow-up.
6. Inform and involve crew leaders.
7. Stimulate community to develop needed resources if they do not exist.
8. Orient staff to referral system.
9. Ask for patient's Personal Health Record.
10. Record and evaluate experiences in order to improve referral system.

The Migrant Health Program Has responsibilities to:

1. Maintain current project directories, information on routing of referrals and other relevant materials.
2. Give consultation to local projects, where needed.
3. Hold periodic stream conferences in order to promote continuity of care.
4. Promote the use of the Personal Health Record.
5. Evaluate and report on referral experience nationally.
6. Provide other assistance as needed.

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